

Further Guidance on the Application of the Group Health Plan Market Reform Provisions of the Affordable Care Act to Employer-Provided Health Coverage and on Certain Other Affordable Care Act Provisions

Notice 2015-87

I. PURPOSE AND OVERVIEW

This notice provides further guidance on the application of various provisions of the Affordable Care Act¹ to employer-provided health coverage. Part II of this notice applies to provisions within the jurisdiction of the Treasury Department (Treasury) and the Internal Revenue Service (IRS), the Departments of Health and Human Services (HHS), and Labor (DOL) (collectively the Departments). Parts III through VI of this notice apply only to provisions of the Internal Revenue Code, and accordingly the guidance on these parts is provided solely by Treasury and IRS. For purposes of this notice, references to sections refer to sections of the Internal Revenue Code unless otherwise indicated.

Part II of this notice provides guidance on the application of the market reforms² that apply to group health plans under the Affordable Care Act (the market reforms) to various types of employer health care arrangements. The notice covers, among other health care arrangements: (1) health reimbursement arrangements (HRAs), including HRAs integrated with a group health plan, and similar employer-funded health care arrangements, and (2) group health plans under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, such as a reimbursement arrangement described in Revenue Ruling 61-146, 1961-2 CB 25, or an arrangement under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee (collectively, an employer payment plan). This notice supplements the guidance

¹ The “Affordable Care Act” refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10) and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (enacted July 31, 2015, Pub. L. No. 114-41).

² Section 1001 of the ACA added new Public Health Service Act (PHS Act) §§ 2711-2719. Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (that is, the market reforms) are subject to shared interpretive jurisdiction by the Departments.

provided in Notice 2013-54, 2013-40 IRB 287; FAQs about Affordable Care Act Implementation (Part XXII) issued by the Department of Labor on November 6, 2014; Notice 2015-17, 2015-14 IRB 845; and final regulations implementing the market reform provisions of the ACA published in the Federal Register on November 18, 2015, 80 FR 72192. DOL and HHS have reviewed Part II of this notice and have advised Treasury and the IRS that they agree with this guidance.

Part III of this notice clarifies certain aspects of the employer shared responsibility provisions of § 4980H, including the identification of employee contributions when employers offer HRAs, flex credits, opt-out payments, or fringe benefit payments required under the McNamara-O’Hara Service Contract Act or other similar laws, the application of the adjusted 9.5 percent affordability threshold under § 36B(c)(2)(i)(II) to the safe harbor provisions under § 4980H, and the employer status of certain entities for § 4980H purposes.

Part IV of this notice clarifies certain aspects of the application to government entities of § 4980H, the information reporting provisions for applicable large employers under § 6056, and application of the rules for health savings accounts (HSAs) to persons eligible for benefits administered by the Department of Veterans Affairs (VA).

Part V of this notice clarifies the application of the COBRA continuation coverage rules to unused amounts in a health flexible spending arrangement (health FSA) carried over and available in later years pursuant to Notice 2013-71, 2013-47 IRB 532, and conditions that may be put on the use of carryover amounts.

Part VI of this notice addresses relief from penalties under §§ 6721 and 6722 that has been provided for employers that make a good faith effort to comply with the requirements under § 6056 to report information about offers made in calendar year 2015.

II. FURTHER GUIDANCE ON THE APPLICATION OF THE GUIDANCE UNDER NOTICE 2013-54 (APPLICATION OF THE MARKET REFORMS TO EMPLOYER PAYMENT PLANS)

A. Further Guidance on the Application of the Guidance under Notice 2013-54 to HRAs

Question 1: May an HRA that covers fewer than two participants who are current employees be used to purchase individual market coverage after an employee covered by the HRA ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms?

Answer 1: Yes. As explained in Notice 2013-54, Q&A-10, an HRA that covers fewer than two participants who are current employees (such as one covering only retirees or other former employees) is not subject to the market reforms. This includes a retiree-only HRA under which available amounts are determined in whole or in part by amounts

credited during the period that the individual was a current employee covered by an HRA integrated with another group health plan. However, this former-employee-only HRA constitutes an eligible employer-sponsored plan under § 5000A(f)(2) for any month during which funds are retained in the HRA (including amounts retained in the HRA during periods after the employer has ceased making contributions). As a result, a participant in an HRA with available funds for any month will not be eligible for a premium tax credit under § 36B for that month. See Notice 2013-54, Q&A-10.

Question 2: Notice 2013-54, Q&A-5 provides that unused amounts that were credited to an HRA while it was integrated with other group health plan coverage may be used to reimburse medical expenses in accordance with the terms of the HRA after an employee ceases to be covered by the other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. May an HRA or similar employer-funded health care arrangement that covers two or more participants who are current employees (a current-employee HRA) be used to purchase individual market coverage after the employee covered by the HRA ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms?

Answer 2: No. A current-employee HRA fails to be integrated with another group health plan if the amounts credited to the HRA may be used to purchase individual market coverage. This answer is intended to clarify the intent of Notice 2013-54, Q&A-5, which in permitting unused amounts credited to an HRA while it was integrated with other group health plan coverage to be used in accordance with the preexisting terms of the HRA, assumed that those HRA terms would not provide a current employee the ability to purchase duplicative or substitute individual market coverage. Accordingly, this failure occurs, for example, even if the current-employee HRA terms provide that it may be used to purchase individual coverage while the current employee is covered by a group health plan with which it is integrated (which coverage generally would be duplicative and thus not purchased by the current employee) or, alternatively, provide that unused amounts previously credited to the HRA may be used to purchase individual market coverage in periods during which the participant is no longer covered by a group health plan with which the HRA is integrated. Accordingly, a current-employee HRA that includes terms permitting the purchase of individual market coverage will constitute a group health plan that fails to meet the market reforms because it is not integrated with another group health plan.

Question 3: On January 24, 2013, the Departments issued FAQs that address the application of the annual dollar limit prohibition to certain HRAs (HRA FAQs).³ The HRA FAQs stated that it was anticipated that future guidance would provide that, whether or not an HRA was integrated, certain HRA amounts that were credited prior to January 1, 2014 under terms that were in effect prior to January 1, 2013 could be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition. Notice 2013-54 summarized this FAQ but did not include its substance in the guidance section of the notice. Does the guidance in the HRA FAQs remain unchanged, such that whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014, including any amounts credited before January 1, 2013 and any amounts that were credited during 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition and the preventive services requirements?

Answer 3: Yes. Whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014, including any amounts credited before January 1, 2013 and any amounts that were credited during 2013 under the terms of an HRA in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition or the preventive services requirements. If the HRA terms in effect on January 1, 2013, did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited during 2013 may not exceed the amounts credited for 2012 and may not be credited on an earlier schedule or at a faster rate than the crediting schedule or rate that applied during 2012.

Question 4: Notice 2013-54, Q&A-4 explains the circumstances under which an HRA may be integrated with a group health plan. May an HRA available to reimburse the medical expenses of an employee's spouse and/or dependents (a family HRA) be integrated with self-only coverage under the employer's other group health plan?

Answer 4: No. An HRA is permitted to be integrated with the employer's other group health plan coverage for purposes of the application of the group market reforms only as to the individuals who are enrolled in both the HRA and the employer's other group health plan. If the spouse and/or dependents are not enrolled in the employer's group

³ See Affordable Care Act Implementation FAQs Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> and at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

health plan coverage, the coverage of these individuals under the HRA cannot be integrated with the coverage under the employer's group health plan, and the HRA coverage generally would fail to meet the group market reforms. Note that an HRA could be structured to be continuously integrated if eligibility for coverage under the HRA automatically applied only to individuals covered under the employer's other group health plan, so that eligibility for expense reimbursement would expand automatically if the employee changed coverage from employee-only coverage to coverage including a spouse and/or dependents (and vice versa, for example, if the employee changed coverage from family coverage to employee-only coverage).

Treasury and IRS are aware that many HRAs do not currently contain the restriction necessary to integrate an HRA with employee-only coverage under the employer's other group health plan because the HRA is intended to reimburse only limited expenses such as co-pays and employees have been permitted to use them for these types of expenses of other family members regardless of whether those family members were also enrolled in the employer's other group health plan. To facilitate transition to compliance with the group market reforms through the use of integrated HRAs, Treasury and IRS will not treat an HRA available for the expenses of family members not enrolled in the employer's other group health plan for plan years beginning before January 1, 2016, as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2016, nor will they treat an HRA and group health plan that otherwise would be integrated based on the terms of the plan as of December 16, 2015 as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2017, solely because the HRA covers expenses of one or more of an employee's family members even if those family members are not also enrolled in the employer's other group health plan. To be integrated with the employer's group health plan, however, the HRA must meet all the other requirements of the applicable guidance on integration with a group health plan. In addition, the employer will be responsible under § 6055 for reporting the coverage as minimum essential coverage for each individual the medical expenses for whom are reimbursable by the HRA who is not also enrolled in the employer's group health plan. See Notice 2015-68, 2015-41 IRB 547.

B. Further Guidance on the Application of the Guidance under Notice 2013-54 to Other Arrangements

Question 5: If the terms of an HRA or employer payment plan provide that the HRA or employer payment plan may only be used to reimburse (or pay directly for) premiums for individual market coverage consisting solely of excepted benefits⁴ (such as dental coverage), does the HRA or employer payment plan fail to satisfy the market reforms?

⁴ See Code § 9832(c), ERISA § 733(c) and PHS Act § 2791(c)

Answer 5: No. An HRA or employer payment plan that, by its terms, reimburses (or pays directly for) premiums for individual market coverage only if that individual market coverage covers only excepted benefits does not fail to comply with the market reforms solely due to the ability to reimburse the employer for that individual market coverage. The market reforms do not apply to a group health plan that is designed to provide solely excepted benefits. As a result, an HRA or employer payment plan and the excepted benefits individual market coverage for which the arrangement pays are not subject to the annual dollar limit prohibition or the preventive services requirement and therefore do not fail to satisfy those market reforms.

Example 1. Facts: The terms of an HRA provide that the HRA may only be used to reimburse premiums for individual market coverage that covers only excepted benefits, but not individual market coverage that covers benefits other than excepted benefits.

Conclusion: The HRA is not subject to the annual dollar limit prohibition or the preventive services requirement.

Example 2. Facts: The terms of an HRA provide that the HRA may be used to reimburse premiums for individual market coverage, with no requirement that the individual market coverage cover only excepted benefits. A covered employee is reimbursed by the HRA for premiums for individual market coverage that covers only excepted benefits.

Conclusion: The HRA is subject to the annual dollar limit prohibition and the preventive services requirement, because the terms of the HRA would have permitted reimbursement of premiums for individual market coverage that is not limited to excepted benefits.

Question 6: Notice 2013-54 provides that a group health plan used to purchase coverage on the individual market is not integrated with that individual market coverage. If the group health plan is an employer payment plan offered through a cafeteria plan under § 125 (referred to throughout this notice as a cafeteria plan) that uses salary reduction or other contributions to purchase coverage on the individual market, is the employer payment plan integrated with the individual market coverage?

Answer 6: No. An employer arrangement reimbursing the cost of individual market coverage offered under a cafeteria plan is an employer payment plan (whether or not funded solely by salary reduction or also including other employer contributions, such as flex credits), which (as set forth in Notice 2013-54) is a group health plan for purposes of the market reforms. This separate group health plan (in this case, the employer payment plan offered under the cafeteria plan) cannot be integrated with the individual market coverage purchased through that employer payment plan.

As a separate arrangement that is a group health plan under the Code, that employer

payment plan offered through the cafeteria plan generally must satisfy the requirements for group health plans (unless the individual market coverage the premiums for which the plan pays or reimburses covers only excepted benefits, see Q&A-5 above). However, because the employer payment plan offered through the cafeteria plan cannot be integrated with any individual market coverage purchased under the arrangement, it will fail to comply with (1) the annual dollar limit prohibition, because it is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) the preventive services requirements, because it does not provide preventive services without cost-sharing in all instances. Consequently, an employer payment plan that reimburses the cost of individual coverage offered through a cafeteria plan will fail to satisfy the market reforms.

III. ADDITIONAL MISCELLANEOUS GUIDANCE ON AFFORDABILITY OF EMPLOYER-SPONSORED HEALTH COVERAGE

Question 7: How are contributions to an HRA taken into account for purposes of determining whether an applicable large employer has made an offer of affordable minimum value coverage under an eligible employer-sponsored plan under §§ 36B and 5000A and any related consequences under § 4980H(b) (including application of the affordability safe harbors in § 54.4980H-5(e)(2))?

Answer 7: An applicable large employer (as defined in § 54.4980H-1(a)(4)) may be subject to an assessable payment under § 4980H(b) for any month for which a full-time employee (as defined in § 54.4980H-1(a)(21)) has received a premium tax credit under § 36B in connection with enrollment in a qualified health plan through the Marketplace. Under § 36B(c)(2)(C), an employee is not eligible for the premium tax credit for any month for which the employee is eligible for coverage under an eligible employer-sponsored plan that provides minimum value and is affordable (or for any month for which the employee enrolls in an eligible employer-sponsored plan, regardless of whether the plan is affordable or provides minimum value). For this purpose, an offer of coverage is affordable if the employee's required contribution (within the meaning of § 5000A(e)(1)(B)) for coverage under the plan is 9.5 percent (as adjusted annually) or less of the employee's household income. See § 36B(c)(2)(C)(II).

The amount of an employee's required contribution for purposes of determining affordability under § 36B is determined under § 5000A and the related regulations. Section 5000A(e)(1)(B)(i) provides that the term "required contribution" means, in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible employer-sponsored plan, the portion of the annual premium that would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage. As a result, the determination of whether an applicable large employer has made an offer of affordable, minimum value coverage under an eligible employer-sponsored plan for purposes of any related consequences under § 4980H(b) generally is based on the standards set forth in §§ 5000A and 36B.

The treatment of employer contributions to HRAs for purposes of determining the employee's required contribution is determined under the rules provided in §§ 1.5000A-3(e)(3)(ii)(D) and 1.36B-2(c)(v)(A)(5). Under those rules, amounts made available for the current plan year under an HRA that an employee may use to pay premiums for an eligible employer-sponsored plan, or that an employee may use to pay premiums for an eligible employer-sponsored plan and also may use for cost-sharing and/or for other health benefits not covered by that plan in addition to premiums, are counted toward the employee's required contribution (and thus reduce the dollar amount of that required contribution) if the HRA would be integrated, as that term is used in Notice 2013-54 or in any successor published guidance, with the eligible employer-sponsored plan for an employee enrolled in the plan.

Employer contributions to an HRA count toward an employee's required contribution only to the extent the amount of the employer's annual contribution to the HRA is required under the terms of the arrangement or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan. Sections 1.5000A-3(e)(3)(ii)(D) and 1.36B-2(c)(v)(A)(5). A contribution that meets this requirement relates to the immediately subsequent period of coverage for which the employee could enroll and use the HRA contribution. For purposes of § 4980H(b) and the related reporting under § 6056 (Form 1095-C, Employer-Provided Health Insurance Offer and Coverage), the employer contribution to an HRA (and any resulting reduction in the employee contribution) is treated as made ratably for each month of the period to which it relates.

Example. Facts: The employee contribution for health coverage under the major medical group health plan offered by the employer is generally \$200 per month. For the current plan year, the employer makes newly available \$1,200 under an HRA that the employee may use to pay the employee share of contributions for the major medical coverage, pay cost-sharing, or pay towards the cost of vision or dental coverage. The HRA satisfies all requirements for integration with the major medical group health plan as provided in Notice 2013-54.

Conclusion: The \$1,200 employer contribution to the HRA reduces the employee's required contribution for the coverage under §§ 36B and 5000A. For purposes of § 4980H(b) and the related reporting under § 6056, the employee's required contribution for the major medical plan is \$100 (\$200 - \$100) per month because 1/12 of the \$1,200 HRA amount per month is taken into account as an employer contribution whether or not the employee uses the HRA to pay the employee share of contributions for the major medical coverage.

Section 54.4980H-5(e)(2) provides three affordability safe harbors for purposes of § 4980H(b), but those safe harbors relate to the calculation of the employee's household income and not the calculation of the employee's required contribution. For purposes of applying those safe harbors to determine whether an offer of coverage is affordable, the treatment of employer contributions to an HRA is consistent with the

treatment of those contributions for purposes of determining whether coverage is affordable under §§ 5000A and 36B(c)(2)(C)(II) as described above.

Question 8: How are employer flex contributions to a cafeteria plan taken into account for purposes of determining whether an applicable large employer has made an offer of affordable minimum value coverage under an eligible employer-sponsored plan under §§ 36B, and 5000A and any related consequences under § 4980H(b) (including application of the affordability safe harbors in § 54.4980H-5(e)(2))?

Answer 8: As discussed in Q&A-7, the affordability of an employer's offer of eligible employer-sponsored coverage for purposes of §§ 36B and 5000A, and any related consequences under § 4980H(b) (including under the § 54.4980H-5(e)(2) affordability safe harbors), depends on whether the employee's required contribution exceeds the applicable required contribution percentage of household income (under §§ 36B and 5000A) or wages (under the § 4980H affordability safe harbors). As provided in §§ 1.5000A-3(e)(3)(ii)(A) and 1.36B-2(c)(3)(v)(A)(1), an employee's required contribution is the portion of the annual premium that the employee must pay for self-only coverage (whether by salary reduction or otherwise).

Under a § 125 cafeteria plan, the employee's enrollment in a group health plan generally is funded by salary reduction but may also be funded by employer flex contributions. Whether these employer flex contributions reduce the amount of an employee's required contribution depends on the nature of the available flex contribution. Specifically, the amount of the employer contribution reduces the employee's required contribution if the amount constitutes a "health flex contribution" under §§ 1.5000A-3(e)(3)(ii)(E) and 1.36B-2(c)(3)(v)(A)(6). Sections 1.5000A-3(e)(3)(ii)(E) and 1.36B-2(c)(v)(A)(6) provide that an amount is a health flex contribution if (1) the employee may not opt to receive the amount as a taxable benefit, (2) the employee may use the amount to pay for minimum essential coverage, and (3) the employee may use the amount exclusively to pay for medical care, within the meaning of § 213. For purposes of § 4980H(b) and the related reporting under § 6056 (Form 1095-C), a health flex contribution is treated as made ratably for each month of the period to which it relates.

An employer flex contribution that is not a health flex contribution does not reduce an employee's required contribution. Consistent with §§ 1.5000A-3(e)(3)(ii)(E) and 1.36B-2(c)(v)(A)(6), this means, for example, that if an employer flex contribution that is available to pay for health care is also available to pay for any non-health care benefits under the § 125 cafeteria plan (such as dependent care or group term life insurance), that contribution is not a health flex contribution and, as a result, does not reduce the required employee contribution. Similarly, an employer flex contribution that is available to pay for health care but also could be received as cash is not a health flex contribution and does not reduce the employee's required contribution. (See Q&A-9, however, concerning treatment of amounts that are not available to pay for coverage under an eligible employer-sponsored health plan and are available only if the employee declines that coverage.)

The treatment of non-health flex contributions differs from the treatment of health flex contributions and contributions to HRAs discussed in Q&A-7 of this notice because, as explained in the preamble to the final regulations under § 5000A, the appropriate measure of an employee's required contribution is the amount of compensation that the employee could apply to something other than health-related expenses that the employee must forgo to obtain coverage under the employer's health plan.⁵ Thus, if an employer provides employees with an HRA contribution or a health flex contribution that may be used only to pay health expenses, the employee's cost of coverage (the amount of salary or other non-health benefits that the employee must forgo to obtain coverage under the employer's health plan) is reduced by the amount of the health flex contribution or HRA contribution. In that case, it is fair to assume that the employee would use the health flex contribution or HRA contribution to pay for the employer's health coverage (because the health flex contribution or HRA contribution can be used only for health benefits), and if the employee does not use it for that purpose the employee does not gain any other economic benefit. Therefore, the employee's required contribution is equal to the amount that the employer otherwise requires the employee to pay for health coverage, reduced by the amount of the health flex contribution or HRA contribution.

If, however, the employer provides an employee with a flex contribution that may be used to pay health expenses but also may be used for non-health benefits (that is, a non-health flex contribution), an employee who elects coverage under the employer's health plan must forgo the non-health benefits in order to take the health coverage. Because a non-health flex contribution (unlike a health flex contribution or HRA contribution) may be used for benefits other than health benefits, it is not appropriate to assume that the employee would use the non-health flex contribution to pay for health coverage; the employee might choose to use that flex contribution for another non-health benefit. Accordingly, the employee's required contribution in this case is equal to the stated amount the employee must pay for health coverage (whether that amount is paid by the employee in the form of a flex contribution, a salary reduction, or otherwise) and is not reduced by the non-health flex contribution.

Example 1 (Health Flex Contribution Reduces Dollar Amount of Employee's Required Contribution). Facts: Employer offers employees coverage under a group health plan through a § 125 cafeteria plan. An employee electing self-only coverage under the health plan is required to contribute \$200 per month toward the cost of coverage. Employer offers employer flex contributions of \$600 for the plan year that may only be applied toward the employee share of contributions

⁵ 79 FR 70464, 70465 (Nov. 26, 2014).

for the group health coverage or contributed to a health flexible spending arrangement (health FSA).

Conclusion: The \$600 employer flex contribution is a health flex contribution and reduces the employee's required contribution for the coverage under §§ 36B and 5000A and for purposes of any related consequences under § 4980H(b) (including application of the § 54.4980H-5(e)(2) affordability safe harbors). Because the \$600 employer flex contribution is a health flex contribution, the \$600 is taken into account as an employer contribution (and therefore reduces the employee's required contribution) regardless of whether the employee elects to apply the health flex contribution toward the employee contribution for the group health coverage or elects to contribute it to the health FSA. For purposes of § 4980H(b) and the related reporting under § 6056 (Form 1095-C), the employee's required contribution for the group health coverage is \$150 (\$200 - \$50) per month.

Example 2 (Employer Flex Contribution Does Not Reduce Dollar Amount of Employee's Required Contribution).

Facts: Employer offers employees coverage under a group health plan through a § 125 cafeteria plan. An employee electing self-only coverage under the health plan contributes \$200 per month toward the cost of coverage. Employer offers employer flex contributions of \$600 for the plan year that can be used for any benefit under the § 125 cafeteria plan (including benefits not related to health) but are not available as cash.

Conclusion: Because the \$600 employer flex contribution is not usable exclusively for medical care, it is not a health flex contribution and therefore does not reduce the employee's required contribution for the coverage under §§ 36B and 5000A and any related potential consequences under § 4980H(b). For purposes of § 4980H(b) and the related reporting under § 6056 (Form 1095-C), the employee's required contribution is \$200 per month.

Example 3 (Employer Flex Contribution Does Not Reduce Dollar Amount of Employee's Required Contribution).

Facts: Same as in Example 2, except that the employee may also elect to receive the \$600 employer flex contribution as cash or other taxable compensation.

Conclusion: Same as conclusion for Example 2 because the employer flex contribution is not a health flex contribution. The same conclusion would apply if the employer flex contribution were available to pay for health benefits or to be taken as cash or other taxable compensation but not available to pay for other types of benefits.

Solely for purposes of § 4980H(b) and solely for coverage for plan years beginning before January 1, 2017, an employer flex contribution that is not a health flex

contribution because it may be used for non-health benefits (including non-taxable benefits and/or cash or another taxable benefit), but that may be used by the employee towards the amount the employee is otherwise required to pay for the health coverage, will be treated as reducing the amount of an employee's required contribution. This relief is not available with respect to a flex contribution arrangement offering non-health benefits that is adopted after December 16, 2015 or that substantially increases the amount of the flex contribution after December 16, 2015 (a "non-relief-eligible flex contribution arrangement"). For this purpose, a flex contribution arrangement will be treated as adopted after December 16, 2015 unless (1) the employer offered the flex contribution arrangement (or a substantially similar flex contribution arrangement) for a plan year including December 16, 2015; (2) a board, committee, or similar body or an authorized officer of the employer specifically adopted the flex contribution arrangement before December 16, 2015; or (3) the employer had provided written communications to employees on or before December 16, 2015 indicating that the flex contribution arrangement would be offered to employees at some time in the future.

In addition, solely for coverage for plan years beginning before January 1, 2017, an employer may reduce the amount of the employee's required contribution by the amount of a non-health flex contribution (other than a flex contribution made under a non-relief-eligible flex contribution arrangement) for purposes of information reporting under § 6056 (line 15 of Form 1095-C). Because treating a non-health flex contribution as reducing an employee's required contribution may affect the employee's eligibility for the premium tax credit under § 36B, employers are encouraged not to reduce the amount of the employee's required contribution by the amount of a non-health flex contribution for purposes of information reporting under § 6056. If an employee's required contribution is reported in this manner (that is, without reduction for the amount of a non-health flex contribution) and the employer is contacted by the IRS concerning a potential assessable payment under § 4980H(b) relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief described in this Q&A-8 to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the non-health flex contribution or to the extent that the employer would have qualified for an affordability safe harbor under § 54.4980H-(4)(e)(2) if the required employee contribution had been reduced by the amount of the non-health flex contribution. See also Q&A-26 for certain relief with respect to employer information reporting under § 6056.

For individual taxpayers, the rules in §§ 1.5000A-3(e)(3)(ii)(E) and 1.36B-2(c)(3)(v)(A)(6) apply for months beginning after December 31, 2013, as provided in those regulations. Accordingly, an employer non-health flex contribution, as illustrated in **Example 2** and **Example 3** of this Q&A-8, does not reduce the amount of an employee's required contribution for purposes of § 5000A and for determining eligibility for the premium tax credit under § 36B.

Nothing in this notice, including this Q&A-8, modifies the guidance in Notice 2012-40 treating flex contributions under a health flexible spending account (health FSA) that an

employee may elect to receive as cash or a taxable benefit as a salary reduction contribution for purposes of the limit on salary reduction contributions to health FSAs under § 125(i). See also the definition of “employer flex credits” in Prop. Treas. Reg. § 1.125-5(b).

Question 9: How are employer payments that are available only if an employee declines coverage under an eligible employer-sponsored plan taken into account for purposes of determining whether an applicable large employer has made an offer of affordable minimum value coverage under an eligible employer-sponsored plan under §§ 36B and 5000A and any related consequences under § 4980H(b) (including application of the affordability safe harbors in § 54.4980H-5(e)(2))?

Answer 9: As discussed in Q&As-7 and 8, the affordability of an employer’s offer of eligible employer-sponsored coverage for purposes of any related consequences under § 4980H(b) (including under the § 54.4980H-5(e)(2) affordability safe harbors) depends on whether the employee’s required contribution exceeds the applicable required contribution percentage of household income (under § 36B) or wages (under the § 4980H affordability safe harbors). As provided in §§ 1.5000A-3(e)(3)(ii)(A) and 1.36B-2(c)(3)(v)(A)(1), an employee’s required contribution is the portion of the annual premium that the employee must pay for self-only coverage (whether by salary reduction or otherwise).

If an employer offers to an employee an amount that cannot be used to pay for coverage under the employer’s health plan and is available only if the employee declines coverage (which includes waiving coverage in which the employee would otherwise be enrolled) under the employer’s health plan (an opt-out payment), this choice between cash and coverage presented by the offer of an opt-out payment is analogous to the cash-or-coverage choice presented by the option to pay for coverage via salary reduction. In both cases, the employee may purchase the health plan coverage only at the price of forgoing a specified amount of cash compensation that the employee would otherwise receive – salary, in the case of a salary reduction, or other compensation, in the case of the opt-out payment. For example, an employee who must reduce his or her compensation by \$1,000 to pay for employer-provided health coverage has a choice that is similar to the choice of an employee who is ostensibly not required to pay anything for employer-provided coverage, but who would receive an additional \$1,000 in compensation only if he or she declined coverage. In each case, the price of obtaining employer-provided health coverage is forgoing \$1,000 in compensation that otherwise would be available to the employee.

An opt-out payment may have the effect of increasing an employee’s contribution for health coverage beyond the amount of any salary reduction contribution. For example, if an employer offers employees group health coverage through a § 125 cafeteria plan, requiring employees who elect self-only coverage to contribute \$200 per month toward the cost of that coverage, and offers an additional \$100 per month in taxable wages to each employee who declines the coverage, the offer of \$100 in additional compensation has the economic effect of increasing the employee’s contribution for the coverage. In

this case, the employee contribution for the group health plan effectively would be \$300 (\$200 + \$100) per month, because an employee electing coverage under the health plan must forgo \$100 per month in compensation in addition to the \$200 per month in salary reduction.

Consistent with this analysis, Treasury and IRS have determined that it is generally appropriate to treat an unconditional opt-out arrangement (that is, an arrangement providing for a payment conditioned solely on an employee declining coverage under an employer's health plan and not on an employee satisfying any other meaningful requirement related to the provision of health care to employees, such as a requirement to provide proof of coverage provided by a spouse's employer) in the same manner as a salary reduction for purposes of determining an employee's required contribution under §§ 36B and 5000A and any related consequences under § 4980H(b). Accordingly, Treasury and IRS intend to propose regulations reflecting this rule and requesting comments on the treatment of employer offers of opt-out payments under one or more of these sections. It is anticipated that the proposed regulations will also address and request comments on the treatment of opt-out payments that are conditioned not only on the employee declining employer-sponsored coverage but also on satisfaction of additional conditions (such as the employee providing proof of having coverage provided by a spouse's employer or other coverage).

Treasury and IRS anticipate that the regulations generally will apply only for periods after the issuance of final regulations. However, Treasury and IRS also anticipate that mandatory inclusion in the employee's required contribution of amounts offered or provided under an unconditional opt-out arrangement (as defined in the preceding paragraph) that is adopted after December 16, 2015 (a "non-relief-eligible opt-out arrangement") will apply for periods after December 16, 2015. For this purpose, an opt-out arrangement will be treated as adopted after December 16, 2015 unless (1) the employer offered the opt-out arrangement (or a substantially similar opt-out arrangement) with respect to health coverage provided for a plan year including December 16, 2015; (2) a board, committee, or similar body or an authorized officer of the employer specifically adopted the opt-out arrangement before December 16, 2015; or (3) the employer had provided written communications to employees on or before December 16, 2015 indicating that the opt-out arrangement would be offered to employees at some time in the future.

For the period prior to the applicability date of regulations, employers are not required to increase the amount of an employee's required contribution by the amount of an opt-out payment (other than a payment made under a non-relief-eligible opt-out arrangement) for purposes of § 6056 (Form 1095-C), and an opt-out payment (other than a payment made under a non-relief-eligible opt-out arrangement) will not be treated as increasing an employee's required contribution for purposes of any potential consequences under § 4980H(b). However, until the applicability date of any further guidance (and in any event for plan years beginning before January 1, 2017), individual taxpayers may rely on the treatment of unconditional opt-out payments described in this Q&A-9 for purposes of §§ 36B and 5000A and treat these payments as increasing the employee's

required contribution. In addition, for this same period with respect to any individual who could demonstrate that the individual meets a condition (in addition to declining the employer's health coverage) that must be satisfied to receive an opt-out payment (such as demonstrating that the employee has coverage under a spouse's group health plan), the individual may treat the opt-out payment as increasing the employee's required contribution for purposes of §§ 36B and 5000A.

Question 10: How are employer payments for fringe benefits made pursuant to the McNamara-O'Hara Service Contract Act ("SCA"),⁶ the Davis-Bacon Act,⁷ or the Davis-Bacon Related Acts (collectively with the Davis-Bacon Act, the "DBRA")⁸ taken into account for purposes of determining whether an applicable large employer has made an offer of affordable minimum value coverage under an eligible employer-sponsored plan under §§ 36B and 5000A and any related consequences under § 4980H(b) (including application of the affordability safe harbors in § 54.4980H-5(e)(2))?

Answer 10: The SCA and DBRA require that workers employed on certain federal contracts be paid prevailing wages and fringe benefits. Under the SCA and DBRA, an employer generally can satisfy its fringe benefit obligations by providing a particular benefit or benefits, as determined by the employer, that have a sufficient dollar value. Alternatively, an employer generally may satisfy its fringe benefit obligations by providing the cash equivalent of benefits or some combination of cash and benefits, or it may permit employees to choose among various benefits or among various benefits and cash. If an employer chooses to provide fringe benefits under the SCA or DBRA by offering an employee the option to enroll in health coverage provided by the employer (including an option to decline that coverage), and the employee declines the coverage, that employer would then generally be required by the SCA or DBRA to provide the employee with cash or other benefits of an equivalent value.

Q&A-8 of this notice addresses employer flex contributions that are available to pay for health care and non-health care benefits (including cash or other taxable compensation) under a § 125 cafeteria plan and that, because they are non-health flex contributions, would not reduce the required employee contribution for purposes of §§ 36B and 5000A or for purposes of any related consequences under § 4980H(b). However, Treasury and IRS have been made aware that, as applied to employers with employees who are subject to the SCA or DBRA, the interaction of this treatment with SCA or DBRA fringe benefit requirements could create certain difficulties. In the case of an employer that chooses to provide fringe benefits under the SCA or DBRA by offering employees the option to enroll in health coverage provided by the employer (including an option to

⁶ 41 U.S.C. Chapter 67.

⁷ 40 U.S.C. Chapter 31, Subchapter IV.

⁸ See 29 CFR 5.1(a) (listing many of the Related Acts).

decline that coverage), the amount that must be provided to employees who decline to enroll in the group health plan as a cash payment or other benefits in lieu of coverage under the group health plan is substantial, would not count as an employer contribution toward the cost of coverage, and therefore would not reduce the employee's required contribution for purposes of §§ 36B and 5000A or for purposes of any related consequences under § 4980H(b). Accordingly, an employer that chooses to satisfy its obligation to provide fringe benefits under the SCA or DBRA by offering an employee the option to enroll in health coverage provided by the employer (including an option to decline that coverage) generally would need to provide a significant additional subsidy to make the offer affordable for purposes of § 36B and avoid any related consequences under § 4980H(b). While the SCA and DBRA require employers to pay covered employees no less than prevailing wage and fringe benefit rates, this additional subsidy would result in certain employees receiving amounts significantly in excess of SCA and DBRA minimum rates.

Treasury and IRS continue to consider how the requirements of the SCA, the DBRA, and the employer shared responsibility provisions under § 4980H may be coordinated. However, until the applicability date of any further guidance, and in any event for plan years beginning before January 1, 2017, employer fringe benefit payments (including flex credits or flex contributions) under the SCA or DBRA that are available to employees covered by the SCA or DBRA to pay for coverage under an eligible employer-sponsored plan (even if alternatively available to the employee in other benefits or cash) will be treated as reducing the employee's required contribution for participation in that eligible employer-sponsored plan for purposes of § 4980H(b), but only to the extent the amount of the payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBRA. In addition, for these same periods an employer may treat these employer fringe benefit payments as reducing the employee's required contribution for purposes of reporting under § 6056 (Form 1095-C), subject to the same limitations that apply for purposes of § 4980H(b). Employers are, however, encouraged to treat these fringe benefit payments as not reducing the employee's required contribution for purposes of reporting under § 6056. If an employee's required contribution is reported without reduction for the amount of the fringe benefit payment and the employer is contacted by the IRS concerning a potential assessable payment under § 4980H(b) relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief described in this Q&A-10 to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the fringe benefit payment or to the extent that the employer would have qualified for an affordability safe harbor under § 54.4980H-(4)(e)(2) if the required employee contribution had been reduced by the amount of the fringe benefit payment. See also Q&A-26 for certain relief with respect to employer information reporting under § 6056.

For purposes of §§ 36B and 5000A, individual taxpayers are not required to take these amounts into account as reducing the employee's required contribution.

Treasury and IRS continue to consider other methods for reporting the amount of the required contribution for employees subject to the SCA or DBRA, including the possible use of indicator codes; however, no such other reporting methods, if ultimately adopted, will be required to be implemented for reporting on plan years beginning before January 1, 2017.

Example. Facts: Employer offers employees subject to the SCA or DBRA coverage under a group health plan through a § 125 cafeteria plan, which the employees may choose to accept or reject. Under the terms of the offer, an employee may elect to receive self-only coverage under the plan at no cost, or may alternatively decline coverage under the health plan and receive a taxable payment of \$700 per month. For the employee, \$700 per month does not exceed the amount required to satisfy the fringe benefit requirements under the SCA or DBRA.

Conclusion: Until the applicability date of any further guidance (and in any event for plan years beginning before January 1, 2017), for purposes of §§ 4980H(b), and 6056, the required employee contribution for the group health plan for an employee who is subject to the SCA or DBRA is \$0. However, for purposes of §§ 36B and 5000A, that employee's required contribution for the group health plan is \$700 per month.

Question 11: Q&As 7 through 10 of this notice address the determination of an employee's required contribution under §§ 36B and 5000A in cases in which an employer offers certain HRA contributions, flex credits, or opt-out payments. Some of these Q&As also provide transition relief for employers that treat these amounts differently for purposes of reporting the employee's required contribution under § 6056. Could this different treatment have any implications for employees?

Answer 11: The vast majority of individuals offered employer-provided coverage will not be affected by the guidance provided in Q&As 7 through 10 of this notice. Specifically, the guidance, including the relief for employers, will not affect the following individuals' eligibility for the premium tax credit: (1) employees who enrolled in the employer-sponsored coverage; (2) employees who enrolled in other health coverage that was not coverage offered through the Marketplace; (3) employees who were offered health coverage that does not include an arrangement described in Q&As 7 through 10; (4) employees who for any other reason would not qualify for a premium tax credit (for example, an employee who qualifies for Medicare or has household income in excess of the limits); (5) generally, employees who enrolled in coverage through the Marketplace and received the benefit of advance payments of the premium tax credit based on a determination by the Marketplace that their offer of employer-sponsored coverage was not affordable (see § 1.36B-2(c)(3)(v)(A)(3)); and (6) employees who did not enroll in any coverage.

Certain employees, however, may be affected by the transition relief for employers in Q&As 8 through 10. (Q&A-7 does not involve any relief for employers.) Because

employers are permitted to report a lower amount as the employee's required contribution by not taking into account the modifications described in Q&As 8 through 10 (including reporting an offer as a qualifying offer on Form 1095-C that, taking into account the modifications, would not be a qualifying offer), employees who enrolled in coverage through the Marketplace, who did not receive the benefit of advance payments of the premium tax credit, but whose household income is in the range for premium tax credit eligibility, may need additional information from their employers regarding their required employee contribution to determine whether they may claim the premium tax credit.

Employers using the § 6056 relief in Q&As 8 through 10 are encouraged to notify employees that they may obtain accurate information about their required contribution taking into account the modifications provided in Q&A-8 through 10 using the employer contact telephone number provided to the employee on Form 1095-C. Without regard to how the employee obtains that information, as determined under Q&A-8 through 10, if the modified required contribution is not affordable for purposes of § 36B and the employee is otherwise entitled to the premium tax credit, the employee may claim it on Form 8692, Premium Tax Credit, which is filed with the employee's annual income tax return (regardless of the required contribution or qualifying offer information reported on that employee's Form 1095-C).

Question 12: How are the adjustments to the affordability threshold under § 36B(c)(2)(C)(i)(II) that are made in accordance with § 36B(c)(2)(C)(iv) taken into account for purposes of the following provisions of the regulations under §§ 4980H and 6056: (1) the affordability safe harbors under § 54.4980H-5(e), (2) the reference to an offer of coverage under § 54.4980H-4, (3) the multiemployer plan interim relief described in section XV.E of the preamble to the final regulations under § 4980H, and (4) the definition of a qualifying offer for purposes of § 301.6056-1(j)(1) (reporting by applicable large employers)?

Answer 12: In each case, the reference to 9.5 percent is adjusted to reflect the adjustment to the affordability provisions under § 36B(c)(2)(C)(iv). Section 36B(b)(1) generally provides that an individual may be eligible for a premium assistance credit amount with respect to any coverage month. Section 36B(c)(2)(B) provides that a coverage month does not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in § 5000A(f)(1)(C) (relating to coverage in the individual market). Section 36B(c)(2)(C)(i) provides that an employee is not treated as eligible for minimum essential coverage if such coverage (1) consists of an eligible employer-sponsored plan (as defined in § 5000A(f)(2)), and (2) the employee's required contribution (within the meaning of § 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent (as adjusted annually) of the applicable taxpayer's household income. Section 36B(c)(2)(C)(iv) provides that in the case of plan years beginning after 2014, the Secretary shall adjust the 9.5 percent under § 36B(c)(2)(C)(i)(II) in the same manner as the percentages are adjusted under § 36B(b)(3)(A)(ii). See Rev. Proc. 2014-37, 2014-33 IRB 363

(adjustment to 9.56 percent for plan years beginning in 2015); Rev. Proc. 2014-62, 2014-50 IRB 948 (adjustment to 9.66 percent for plan years beginning in 2016).

The affordability safe harbors in the regulations under § 4980H are based on 9.5 percent of an employee's wages reported on the Form W-2, Wage and Tax Statement (§ 54.4980H-5(e)(2)(ii), Form W-2 safe harbor), 9.5 percent of an amount equal to 130 hours multiplied by the lower of the employee's hourly rate of pay as of the first day of the coverage period or lowest rate of pay during the calendar month (§ 54.4980H-5(e)(2)(iii), rate of pay safe harbor), or 9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12 (§ 54.4980H-5(e)(2)(iv), federal poverty line safe harbor). The 9.5 percent standard set forth in each of the affordability safe harbors is derived from § 36B(c)(2)(C)(i), basing affordability on a required contribution not exceeding 9.5 percent of the applicable taxpayer's household income. The § 4980H(b) affordability safe harbors are intended to provide safe harbors with respect to the determination of the employee's household income as part of the affordability calculation because an employer generally will not have access to that information with respect to its employees. The safe harbors are not intended to otherwise alter the affordability calculation, and accordingly Treasury and IRS intend to amend the regulations under § 4980H to reflect that the applicable percentage in the affordability safe harbors should be adjusted consistent with § 36B(b)(3)(A)(ii), so that employers may rely upon the 9.56 percent for plan years beginning in 2015 and 9.66 percent for plan years beginning in 2016.

Similarly, when determining if there is an offer of coverage for purposes of § 54.4980H-4 (requirement that employees be permitted to decline enrollment in coverage absent certain conditions in order for the arrangement to be treated as an offer of coverage), or whether coverage under a multiemployer plan is affordable under the Interim Guidance with respect to Multiemployer Arrangements in the preamble to the final regulations under § 4980H (79 FR 8576), an applicable large employer may use the 9.5 percent standard as indexed pursuant to § 36B(c)(2)(C)(iv).

Treasury and IRS also intend to amend the regulations under § 6056 that provide alternative reporting methods for certain types of offers of coverage, referred to as qualifying offers of coverage. Specifically, a qualifying offer under § 301.6056-1(j)(1)(i) is an offer at employee cost for employee-only coverage not exceeding 9.5 percent of the mainland single federal poverty line. Treasury and IRS intend to amend § 301.6056-1(j)(1)(i) to reflect that the reference to 9.5 percent is adjusted to reflect any adjustments under § 36B(c)(2)(C)(iv), and for those changes to be applicable back to December 16, 2015. For all periods, applicable large employers may rely on the 9.5 percent standard as adjusted pursuant to § 36B(c)(2)(C)(iv) in applying the alternative reporting method for qualifying offers.

Question 13: Under § 4980H(c)(5), in the case of any calendar year after 2014, the applicable dollar amounts of \$2,000 and \$3,000 under § 4980H(c)(1) and (b)(1) are increased based on the premium adjustment percentage as defined in § 1302(c)(4) of

the Affordable Care Act (4.213431463 for 2015⁹ and 8.316047520 for 2016¹⁰) rounded to the lowest multiple of \$10. What are those amounts for calendar years 2015 and 2016?

Answer 13: For calendar year 2015, the adjusted \$2,000 amount in § 4980H(c)(1) is \$2,080 ($\$2,000 \times .04213431463 = \84.27 plus \$2,000 rounded down to \$2,080), and the adjusted \$3,000 amount in § 4980H(b)(1) is \$3,120 ($\$3,000 \times .04213431463 = \126.40 plus \$3,000 rounded down to \$3,120). For calendar year 2016, the adjusted \$2,000 amount in § 4980H(c)(1) is \$2,160 ($\$2,000 \times .08316047520 = \166.32 plus \$2,000 rounded down to \$2,160), and the adjusted \$3,000 amount in § 4980H(b)(1) is \$3,240 ($\$3,000 \times .08316047520 = \249.48 plus \$3,000 rounded down to \$3,240). Treasury and IRS anticipate that adjustments for future years will be posted on the IRS.gov website.

Question 14: To determine status as a full-time employee for purposes of § 4980H, § 54.4980H-1(a)(24) provides that the term “hour of service” means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which the employee is paid, or entitled to payment by the employer, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR 2530.200b-2(a)). To what extent are the rules under 29 CFR 2530.200b-2(a) incorporated into the definition of hour of service under § 4980H?

Answer 14: The definition of hour of service under § 54.4980H-1(a)(24), and specifically the reference to 29 CFR 2530.200b-2(a), was intended to provide parallels between the two regulatory provisions on the basic definition of an hour of service, without incorporating certain mechanical rules contained in the DOL regulations that do not fit into the general structure of § 4980H and specifically the identification of employees as full-time employees. This Q&A-14 clarifies how this reference to the DOL regulations applies. Treasury and IRS intend to include these clarifications as proposed regulations under § 4980H effective as of December 16, 2015.

The § 4980H regulations did not incorporate the provisions of 29 CFR 2530.200b-2(a)(2) that require hours of service to be credited for certain periods of time during which no duties are performed “irrespective of whether the employment relationship has terminated.” Because the purpose of the crediting of hours of service is to determine whether a current employee is a full-time employee (and to accumulate the hours of service of current non-full-time employees to calculate an employer’s number of full-time

⁹ See 79 FR 13744, 13802 (Mar. 11, 2014).

¹⁰ See 80 FR 10750, 10825 (Feb. 27, 2015).

equivalent employees), an hour of service for purposes of § 4980H does not include any hours after the individual terminates employment with the employer.

The reference to 29 CFR 2530.200b-2(a) is intended to incorporate the limitations of 29 CFR 2530.200b-2(a)(2)(ii) and (iii) which are substantive exclusions of the type of payments the right to which will not result in an hour of service. Accordingly, an hour of service does not include (1) an hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed if such payment is made or due under a plan maintained solely for the purpose of complying with applicable workmen's compensation, or unemployment or disability insurance laws; and (2) an hour of service for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

However, the reference to 29 CFR 2530.200b-2(a) was not intended to incorporate the limitation on hours of service contained in 29 CFR 2530.200b-2(a)(2)(i), which is not a substantive part of the definition of an hour of service but instead a mechanical limitation on the crediting of those hours appropriate in the contexts to which the DOL regulations apply but not with respect to § 4980H and the definition of a full-time employee and a full-time equivalent employee. Accordingly, there is no 501-hour limit on the hours of service required to be credited to an employee on account of any single continuous period during which the employee performs no duties if the hours of service would otherwise qualify as hours of service.¹¹

Finally, the § 4980H regulations defining an "hour of service" are intended to incorporate the remaining provisions of 29 CFR 2530.200b-2 relating to the source of the payment for the hour of service for which no duties were performed. For purposes of determining whether an hour of service must be credited, a payment is deemed to be made by or due from an employer regardless of whether the payment is made by or due from the employer directly, or indirectly through, among others, a trust fund or insurer to which the employer contributes or pays premiums, and regardless of whether contributions made or due to the trust fund, insurer, or other entity are for the benefit of particular employees or are on behalf of a group of employee in the aggregate.

Accordingly, periods during which an individual is not performing services but is receiving payments due to short-term disability or long-term disability result in hours of service for any part of the period during which the recipient retains status as an employee of the employer, unless the payments are made from an arrangement to which the employer did not contribute directly or indirectly. For this purpose, a disability

¹¹ Note, however, that the 501-hour limit on hours of service required to be credited to an employee of an educational organization during employment break periods in a calendar year under § 54.4980H-3(c)(6)(ii)(B) continues to apply.

arrangement for which the employee paid with after-tax contributions (so that the benefits received under the arrangement are excluded from income under § 104(a)(3)) would be treated as an arrangement to which the employer did not contribute, and payments from the arrangement would not give rise to hours of service. Periods during which the employee is not performing services but is receiving payments in the form of workers compensation wage replacement benefits under a program provided by the state or local government do not result in hours of service.

Question 15: Is an employee who primarily performs services for one or more educational organizations but is not the employee of the educational organization(s) (because, for example, the individual is an employee of a staffing agency) subject to the special rehire rules under §§ 54.4980H-3(c)(4)(ii) and 54.4980H-3(d)(6) (and the related definition of “employment break period” at § 54.4980H-1(a)(17)) and thus only treated as a new employee after a break of at least 26 consecutive weeks and, if the employer is using the lookback measurement method, subject to the special hours of service averaging rules?

Answer 15: Treasury and IRS intend to amend the regulations under § 4980H to address the application of the special rehire rules under §§ 54.4980H-3(c)(4)(ii) and 54.4980H-3(d)(6)(ii) to employees who primarily perform services for one or more educational organizations.

Because Treasury and IRS have concluded that it would not be appropriate for employees who had become eligible for coverage prior to a break in service to be subjected to a new period of exclusion from a plan (which applies in certain circumstances for new employees) based upon a brief break in service, Treasury and IRS adopted rehire rules under which an employee may be treated as a new employee only after a break in service of at least 13 weeks. Treasury and IRS concluded, however, that without special rehire rules, this general rehire rule may be inequitable to employees of educational organizations who had become eligible for coverage prior to the break. Similarly, Treasury and IRS concluded that without special rules under the lookback measurement method for employees of educational organizations, application of those rules could be inequitable to those employees if, for purposes of determining the average weekly hours of service over the entire lookback period, employers counted the summer recess periods (or other periods) during which some of these employees may not provide services as periods during which no hours of service were performed. To provide more appropriate rules for employees of educational organizations, the final regulations under § 4980H provide two special rules.

Sections 54.4980H-3(c)(4)(ii) and 54.4980H-3(d)(6)(ii)(A) address the treatment of a new employee after a period of absence for employees of educational organizations for purposes of determining the status of these employees as full-time employees, under both the monthly measurement method and the lookback measurement method. These sections provide that for an employer that is an educational organization, an employee who resumes providing service to (or is otherwise credited with an hour of service for) an applicable large employer after a period during which the individual was not credited

with any hours of service may be treated as having terminated employment and having been rehired, and therefore may be treated as a new employee upon the resumption of services, only if the employee did not have an hour of service for the applicable large employer for a period of at least 26 consecutive weeks immediately preceding the resumption of services. Section 54.4980H-3(d)(6)(ii)(B) applies to educational organizations applying the lookback measurement method of determining full-time employee status and provides special rules to account for the periods during which the employee may not be providing services, such as a summer break period.

Treasury and IRS have been made aware that some educational organizations are attempting to avoid application of these rules by, for example, using a third-party staffing agency for certain individuals providing services. Because the staffing agency is not an educational organization subject to the special rule, the staffing agency could apply the lookback measurement method or the rules on new hires to treat some or all of these individuals as failing to be full-time employees or as new employees after a break in service of less than 26 weeks. In some cases, the facts and circumstances may demonstrate that the staffing agency is not the common law employer of the individual for purposes of § 4980H, but rather that the individual remains the employee of the educational organization and the special lookback measurement rule and rehire rule would continue to apply. But even if the individuals are the employees of the staffing agency or other third party, this structure would circumvent the intent of the special rules. Accordingly, Treasury and IRS intend to propose amendments to the regulations under § 4980H to provide for application of the special rule in certain circumstances in which the services are being provided to one or more educational organizations, even if the employer is not an educational organization. The amendments will apply as of the applicability date specified in the regulations, but in no event will the applicability date be earlier than the first plan year beginning after the date on which the proposed regulations are issued.

Specifically, Treasury and IRS anticipate amending the regulations under § 4980H to provide that the special rules under §§ 54.4980H-3(c)(4)(ii) and 54.4980H-3(d)(6)(ii) (and the related definition of “employment break period” at § 54.4980H-1(a)(17)) apply not only to employees of educational organizations, but also to any employee providing services primarily to one or more educational organizations for whom a meaningful opportunity to provide services during the entire year (to an educational organization or any other type of service recipient) is not made available. For example, the special rule would apply to an employer with respect to a bus driver who is primarily placed to provide bus driving services, or a cafeteria worker who is primarily placed to provide services in a cafeteria, at one or more educational organizations and who is not provided a meaningful opportunity to provide services during one or more months of the calendar year (for example, the summer recess period). In contrast, an employer that primarily places bus drivers or cafeteria workers at educational organizations would not apply the special rule to an employee if the individual was offered a meaningful opportunity to provide services during all months of the year (for example, in the case of a cafeteria worker, by working at a hospital cafeteria during the summer recess period of the educational organization at which the individual generally is placed).

Question 16: Is an AmeriCorps member providing services to a grantee receiving assistance under the national service laws an employee (of either AmeriCorps or the grantee) for purposes of the employer shared responsibility provisions of § 4980H?

Answer 16: No. The National and Community Service Act provides that participants in AmeriCorps programs are not considered to be employees of the grantee receiving assistance under the national service laws through which the participant is engaging in service (42 U.S.C. § 12511(30)(B)). Similarly, AmeriCorps members generally are not considered Federal employees and are not subject to the provisions of law relating to Federal employment (42 U.S.C. § 12655n). Consistent with these provisions, for purposes of § 4980H, participants in the AmeriCorps programs are not employees of AmeriCorps or the grantee receiving assistance through AmeriCorps for which the participant is providing services.

Question 17: How is an offer of coverage under TRICARE due to employment which results in eligibility for coverage under TRICARE treated for purposes of §§ 4980H and 6056?

Answer 17: For purposes of determining any potential liability under § 4980H and for purposes of the related information reporting requirements under § 6056, an offer of coverage under TRICARE for any month due to employment with an employer that results in eligibility for TRICARE is treated as an offer by that employer of minimum essential coverage under an eligible employer-sponsored plan for that month.

IV. GOVERNMENT ENTITIES, HEALTH SAVINGS ACCOUNTS, AND BENEFITS ADMINISTERED BY THE DEPARTMENT OF VETERANS AFFAIRS

Question 18: For purposes of determining whether an employer had 50 or more full-time employees (including full-time equivalents) in the previous year and therefore is an applicable large employer (or ALE member), § 4980H(c)(2)(C)(i) and § 54.4980H-1(a)(16) require that employers apply the aggregation rules under § 414(b), (c), (m) and (o) and treat all the aggregated employers as a single employer. How do these aggregation rules apply to employers that are government entities?

Answer 18: The aggregation rules under § 414(b), (c), (m), and (o) provide that (1) corporations that are part of a controlled group of corporations, (2) groups of other types of entities that are under common control, and (3) members of an affiliated service group, may in each case be treated as a single employer for certain employee benefit requirements. Section 4980H(c)(2)(C)(i) and § 54.4980H-1(a)(16) apply these standards in determining whether an employer is an applicable large employer (or ALE member). The regulations under § 414(b), (c), (m), and (o) do not specifically address the application of these standards to government entities. Accordingly, as provided in section V.D of the preamble to the final regulations under § 4980H, government entities may apply a reasonable, good faith interpretation of the employer aggregation rules under § 414(b), (c), (m), and (o) for purposes of determining whether a government

entity is an applicable large employer or an ALE member, and thereby subject to the employer shared responsibility provisions under § 4980H and the related reporting requirements under § 6056.

If two government entities would independently be applicable large employers (because each of the entities, in the previous year, had 50 or more full-time employees, including full-time equivalents), the aggregation analysis will be of limited consequence. That is because each of those two entities would be subject to § 4980H and the related reporting requirements under § 6056 regardless of the aggregation analysis and any consequences of application of the employer aggregation rules would be limited (generally relevant only to the allocation of the reduction by 30 full-time employees for the calculation of any assessable payment under § 4980H(a) or the cap on any assessable payment under § 4980H(b)).

Question 19: Is a separate employer identification number (EIN) required for each government entity employer that is subject to a reporting requirement (as an applicable large employer or ALE member, or if neither, because it has employees receiving self-insured health coverage)?

Answer 19: Yes, each separate employer entity (not applying any aggregation rules) that is an applicable large employer (or ALE member), or that provides self-insured health coverage to its employees, must use its own EIN for purposes of the applicable reporting requirements. Accordingly, separate Forms 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, must be filed by each employer that is an ALE member of an applicable large employer group, and each Form 1094-C must have a separate EIN that is the EIN of the ALE member filing the form. For example, assume that a state treats the state executive and executive agencies, the state judiciary, and the state legislature as three separate employers that are ALE members of the applicable large employer group that reflects the state government. Each of the three employers is required to have a separate EIN and to file the Forms 1094-C and 1095-C reflecting the EIN of the employer.

The analysis is not changed by a government entity's use of a designated government entity (DGE). In that case, the government entity has transferred the responsibility for reporting to the DGE, but the DGE is still reporting on behalf of the government entity that retains its separate status as an applicable large employer (or ALE member) subject to the employer shared responsibility provisions. For example, if ten counties that are applicable large employers enter into agreements with a state government entity that the state will be the DGE for each of the counties, the state government entity should file a Form 1094-C on behalf of each of the counties (as well as a Form 1094-C on behalf of itself as an employer of its own employees). Each Form 1094-C would list the name and EIN of the state government entity as the DGE, and the name and EIN of the county as the employer. The Form 1094-C for each county would be accompanied by the Forms 1095-C for each employee of that county and would identify the county as the employer.

Question 20: Notice 2004-50, 2004-2 C.B. 196, Q&A-5 provides guidance on the eligibility to contribute to an HSA of an individual who is eligible to receive medical benefits administered by the Department of Veterans Affairs (VA), stating that the individual is not eligible to make HSA contributions for any month if the individual has received medical benefits from the VA at any time during the previous three months. Notice 2008-59, 2008-29 IRB 123, Q&A-9 clarified that although an individual actually receiving medical benefits from the VA at any time in the previous three months generally is not eligible to contribute to an HSA, the disqualification rule does not apply if the medical benefits consist solely of disregarded coverage or preventive care. Section 4007(b) of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (the Surface Transportation Act) amends § 223 to provide that an individual shall not fail to be treated as an eligible individual for any period merely because the individual receives hospital care or medical services under any law administered by the Secretary of Veterans Affairs for a service-connected disability (within the meaning of § 101(16) of title 38, United States Code).

How does § 4007(b) of the Surface Transportation Act affect the prior guidance on the interaction of the receipt of VA health care and eligibility to contribute to an HSA?

Answer 20: As modified by the legislation, an individual actually receiving medical benefits from the VA is not disallowed from making HSA contributions if the medical benefits consist solely of (1) disregarded coverage, (2) preventive care, or (3) hospital care or medical services under any law administered by the Secretary of Veterans Affairs for service-connected disability (within the meaning of § 101(16) of title 38, United States Code). Distinguishing between services provided by the VA for service-connected disabilities and other types of medical care is administratively complex and burdensome for employers and HSA trustees or custodians. Moreover, as a practical matter, most care provided for veterans who have a disability rating will be such qualifying care. Consequently, as a rule of administrative simplification, for purposes of this rule, any hospital care or medical services received from the VA by a veteran who has a disability rating from the VA may be considered to be hospital care or medical services under a law administered by the Secretary of Veterans Affairs for service-connected disability.

V. APPLICATION OF COBRA CONTINUATION COVERAGE RULES AND HEALTH FSA CARRYOVERS AS PERMITTED BY NOTICE 2013-71

Question 21: Notice 2013-71 modifies the rules for cafeteria plans to allow a carryover of up to \$500 of unused amounts remaining at the end of the plan year in a health FSA. Section 54.4980B-2, Q&A-8(e) provides that a health FSA is not obligated to make COBRA continuation coverage available for the plan year in which a qualifying event occurs unless as of the date of the qualifying event, the amount the qualified beneficiary may become entitled to receive during the remainder of the plan year as a benefit exceeds the amount the health FSA may require to be paid for COBRA continuation coverage for the remainder of the plan year.

In determining the amount of the benefit that a qualified beneficiary is entitled to receive during a plan year, is any amount that has been carried over from a prior plan year as permitted by Notice 2013-71 included?

Answer 21: Yes. Any carryover amount is included in determining the amount of the benefit that a qualified beneficiary is entitled to receive during the remainder of the plan year in which a qualifying event occurs. The following example illustrates the application of this rule:

Example. Facts: An employer maintains a calendar year health FSA that qualifies as an excepted benefit. Under the health FSA, during the open season an employee has elected to reduce salary by \$2,500 for the year. In addition, the employee carries over \$500 in unused benefits from the prior year. Thus, the maximum benefit that the employee can become entitled to receive under the health FSA for the entire year is \$3,000. The employee experiences a qualifying event that is a termination of employment on May 31. As of that date, the employee had submitted \$1,100 of reimbursable expenses under the health FSA.

Conclusion: The maximum benefit that the employee could become entitled to receive for the remainder of the year as a benefit under the health FSA is \$1,900 (\$2,500 plus \$500) minus \$1,100.

Question 22: Section 4980B(f)(2)(C) provides that the maximum amount that a group health plan is permitted to charge for COBRA continuation coverage is 102 percent of the applicable premium for the period of COBRA continuation coverage. Section 4980B(f)(4) generally defines “applicable premium” as the cost to the plan of providing coverage during such period for similarly situated beneficiaries who have not incurred a COBRA qualifying event (nonCOBRA beneficiaries). Under § 4980B(f)(4)(B), a self-insured plan may base the applicable premium on a reasonable estimate of the cost of providing coverage for nonCOBRA beneficiaries, provided that the reasonable estimate is determined on an actuarial basis and satisfies any other applicable requirements under the regulations. An example under Q&A-8(f) of § 54.49890B-2 illustrates that with respect to a health FSA, an employer may base its reasonable estimate of the cost of providing coverage for similarly situated nonCOBRA beneficiaries on the maximum amount available under the health FSA for the period, taking into account both the employee salary reduction and any additional employer contribution.

What is the maximum amount that a health FSA is permitted to require to be paid for COBRA continuation coverage if the maximum benefit that an employee is entitled to receive under the health FSA for the entire year includes carryover amounts?

Answer 22: The maximum amount that a health FSA is permitted to require to be paid for COBRA continuation coverage (that is, 102 percent of the applicable premium) does not include unused amounts carried over from prior years. The applicable premium is based solely on the sum of the employee’s salary reduction election for the year and

any nonelective employer contribution. The following example illustrates the application of this rule:

Example. Facts: An employee elects salary reduction with respect to a health FSA of \$2,000. The employer provides a matching contribution of \$1,000. In addition, the employee carries over \$500 in unused benefits from the prior year. The employee experiences a qualifying event that is a termination of employment on May 31.

Conclusion: The maximum amount the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the year is 102 percent of 1/12 of the applicable premium of \$3,000 (\$2,000 of employee salary reduction election plus \$1,000 of employer contributions) times the number of months remaining in the year after the qualifying event. The \$500 of benefits carried over from the prior year is not included in the applicable premium.

Question 23: Is a health FSA that allows carryovers of unused amounts for similarly situated nonCOBRA beneficiaries obligated to allow a carryover of unused amounts to a qualified beneficiary who elected COBRA continuation coverage with respect to the health FSA, even if the result is that the COBRA continuation coverage under the health FSA continues beyond the plan year?

Answer 23: If a health FSA allows carryovers of unused amounts for similarly situated nonCOBRA beneficiaries, notwithstanding § 54.4980B-2, Q&A-8(d), the health FSA must allow carryovers by similarly situated COBRA beneficiaries, subject to the same terms applicable with respect to nonCOBRA beneficiaries. However, the health FSA is not required to allow a COBRA beneficiary to elect additional salary reduction amounts for the carryover period, or to have access to any employer contributions to the health FSA made during the carryover period. In addition, the carryover is limited to the applicable COBRA continuation period.

As noted in Q&A-22 of this notice, the maximum amount that a health FSA can require to be paid as the applicable premium does not include unused amounts carried over from prior years. Thus, if a qualified beneficiary is allowed a carryover of unused amounts to a later year, the applicable premium for that later year period is zero. The following example illustrates the application of this rule.

Example. Facts: An employer maintains a calendar year health FSA which qualifies as an excepted benefit. Under the health FSA, during the open season an employee may elect to reduce salary by \$2,500 for the year. In addition, the plan allows a carryover of up to \$500 in unused benefits remaining at the end of the plan year.

An employee elects salary reduction of \$2,500 for the year. The employee experiences a qualifying event that is a termination of employment on May 31. As of that date, the employee had submitted \$400 of reimbursable expenses

under the health FSA. The employee elects COBRA continuation coverage and pays the required premiums for the rest of the year. As a qualified beneficiary, the former employee submits additional reimbursable payments in the amount of \$1,600. At the end of the plan year, there is \$500 of unused benefits remaining.

Conclusion: The qualified beneficiary is allowed to continue to submit expenses under the same terms as similarly situated nonCOBRA beneficiaries in the next year, for up to \$500 in reimbursable expenses. The maximum amount that can be required as an applicable premium for the carryover amount for periods after the end of the plan year is zero. The maximum period the carryover is required to be made available is the period of COBRA continuation coverage. In this case, the period is 18 months and terminates at the end of November of the next year. Thus, the health FSA need not reimburse any expense incurred after that November.

Question 24: May a health FSA condition the ability to carry over unused amounts on participation in the health FSA in the next year?

Answer 24: Yes. A health FSA may limit the availability of the carryover of unused amounts (subject to the \$500 limit) to individuals who have elected to participate in the health FSA in the next year, even if the ability to participate in that next year requires a minimum salary reduction election to the health FSA for that next year.

Example. Facts: Employer sponsors a cafeteria plan offering a health FSA that permits up to \$500 of unused health FSA amounts to be carried over to the next year in compliance with Notice 2013-71, but only if the employee participates in the health FSA during that next year. To participate in the health FSA, an employee must contribute a minimum of \$60 (\$5 per calendar month). As of December 31, 2016, Employee A and Employee B each have \$25 remaining in their health FSA. Employee A elects to participate in the health FSA for 2017, making a \$600 salary reduction election. Employee B elects not to participate in the health FSA for 2017. Employee A has \$25 carried over to the health FSA for 2017, resulting in \$625 available in the health FSA. Employee B forfeits the \$25 as of December 31, 2016 and has no funds available in the health FSA thereafter.

Conclusion: This arrangement is a permissible health FSA carryover feature under Notice 2013-71.

Question 25: May a health FSA limit the ability to carry over unused amounts to a maximum period?

Answer 25: Yes. A health FSA may limit the ability to carry over unused amounts to a maximum period (subject to the \$500 limit). For example, a health FSA can limit the ability to carry over unused amounts to one year. Thus, if an individual carried over \$30

and did not elect any additional amounts for the next year, the health FSA may require forfeiture of any amount remaining at the end of that next year.

VI. RELIEF RELATING TO EMPLOYER REPORTING

Question 26: For employer reporting required under § 6056 (Forms 1094-C and 1095-C), is relief available from penalties for incomplete or incorrect returns filed or statements furnished to employees in 2016 for coverage offered (or not offered) in calendar year 2015?

Answer 26: Yes. To assist with the implementation of the information reporting requirements, Treasury and IRS have provided certain relief applicable for reporting in early 2016 related to the coverage offered (or not offered) in calendar year 2015. See preamble to the final regulations under § 6056, section XIII, 79 FR 13231, 13246 (Mar. 10, 2014). This relief is intended to provide additional time to develop appropriate procedures for collection of data and compliance with the new reporting requirements. Accordingly, the IRS will not impose penalties under §§ 6721 and 6722 on ALE members that can show that they have made good faith efforts to comply with the information reporting requirements. Specifically, relief is provided from penalties under §§ 6721 and 6722 for returns and statements filed and furnished in 2016 to report offers of coverage in 2015 for incorrect or incomplete information reported on the return or statement. This relief does not apply in the case of ALE members that cannot show a good faith effort to comply with the information reporting requirements or that fail to timely file an information return or furnish a statement. However, consistent with existing information reporting rules, ALE members that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under § 6724 are satisfied. Similar relief has also been provided with respect to reporting on coverage under § 6055. See preamble to the regulations under § 6055, section 7, 79 FR 13220, 13226 (Mar. 10, 2014).

VII. REQUEST FOR COMMENTS

Q&A-9, Q&A-12, Q&A-14, and Q&A-15 of this notice provide certain guidance that Treasury and IRS intend to incorporate into proposed regulations. These proposed regulations will provide stakeholders an opportunity for comment on the issues addressed in the proposed regulations. However, to assist in development of those proposed regulations, Treasury and IRS request comments on the guidance provided in those Q&As.

Public comments should be submitted no later than February 18, 2016. Comments should include a reference to Notice 2015-87. Send submissions to CC:PA:LPD:PR (Notice 2015-87), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2015-87), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20044, or sent electronically, via the

following e-mail address: *Notice.comments@irs counsel.treas.gov*. Please include "Notice 2015-87" in the subject line of any electronic communication. All material submitted will be available for public inspection and copying.

VIII. APPLICABILITY DATE AND RELIANCE PERIOD

Except as otherwise explicitly provided in this notice, the guidance provided in this notice applies for plan years beginning on and after December 16, 2015, but taxpayers may apply the guidance provided in this notice for all prior periods.

IX. DRAFTING INFORMATION

The principal author of this notice is Shad Fagerland of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice contact at (202) 317-5500 (not a toll-free call).