



ACA COMPLIANCE BULLETIN

HIGHLIGHTS

- The proposed regulations clarify a number of issues related to the ACA's premium tax credit, the individual mandate and the employer shared responsibility rules.
- The clarifications in the proposed regulations generally do not make substantive changes to these rules.
- Provisions related to opt-out payments adopt guidance previously provided in IRS Notice 2015-87.

IMPORTANT DATES

Dec. 31, 2016

The proposed regulations are generally proposed to take effect for taxable years beginning after Dec. 31, 2016.

Dec. 31, 2018

The rules relating to the benchmark plan in the proposed regulations are proposed to apply for taxable years beginning after Dec. 31, 2018.

Provided By:
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IRS ISSUES OPT-OUT PAYMENT PROPOSED RULES

OVERVIEW

On July 8, 2016, the Internal Revenue Service (IRS) issued [proposed regulations](#) on the Affordable Care Act's (ACA) **premium tax credit** and **individual mandate**. The regulations also impact employers through the **employer shared responsibility rules**.

The proposed regulations focus primarily on the effect of opt-out payments on the affordability of employer-sponsored coverage:

- ✓ Opt-out payments made under an **unconditional opt-out arrangement** will increase an employee's required contribution; and
- ✓ Opt-out payments made under a **conditional opt-out arrangement** are disregarded in determining the required contribution.

These rules will apply to opt-out arrangements beginning on Dec. 31, 2016, unless the arrangement was adopted after Dec. 16, 2015.

The proposed regulations also make minor clarifications to other issues related to these ACA provisions.

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Background

Several key ACA reforms measure the affordability of employer-sponsored health coverage. Under the ACA, affordability of an employer's plan may be assessed in the following three contexts:

- ✓ The employer shared responsibility penalties for applicable large employers (ALEs) (also known as the pay or play rules or the employer mandate);
- ✓ An exemption from the individual mandate penalty imposed on individuals who fail to obtain health insurance coverage; and
- ✓ The premium tax credit for low-income individuals to purchase health coverage through an ACA Exchange.

Whether an opt-out payment will need to be counted toward affordability depends on whether the payment is made under a conditional or an unconditional opt-out arrangement.

The proposed regulations include a number of clarifications related to these three ACA provisions.

Opt-out Payments

The proposed regulations focus primarily on the effect of opt-out payments on the affordability of employer-sponsored coverage. An **opt-out payment** is defined as a payment made by an employer to an employee that:

- ✓ Is available only if the employee declines coverage (which includes waiving coverage in which the employee would otherwise be enrolled) under the employer-sponsored plan; and
- ✓ Cannot be used to pay for coverage under the employer-sponsored plan.

The arrangement under which the opt-out payment is made available is known as an **opt-out arrangement**. An amount provided as an employer contribution to a Section 125 cafeteria plan that may be used by the employee to purchase minimum essential coverage **is not an opt-out payment**, whether or not the employee may receive the amount as a taxable benefit.

The IRS previously issued guidance on opt-out payments and affordability in [Notice 2015-87](#). Under this guidance, whether an opt-out payment will need to be counted toward affordability depends on whether the payment is made under a **conditional** or an **unconditional** opt-out arrangement.

Conditional opt-out arrangement

An opt-out arrangement under which payments are conditioned not only on the employee declining employer-sponsored coverage, but also on the satisfaction of one or more additional meaningful conditions (such as the employee providing proof of enrollment in coverage provided by a spouse's employer or other coverage).

Unconditional opt-out arrangement

An arrangement providing payments conditioned solely on an employee declining employer-sponsored coverage, 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 through a plan of a spouse's employer).

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Unconditional Opt-out Arrangements

The proposed regulations generally adopt the approach described in Notice 2015-87. As a result, under the proposed regulations, opt-out payments made available to an employee under an **unconditional opt-out arrangement** will increase an employee's required contribution beyond the amount of salary reduction elections. Thus, the employee's required contribution would be equal to:

The amount the employee is otherwise required to pay for health coverage + **The amount of the opt-out payment that the employee must forgo as a result of electing coverage**

For example, if an employer offers employees group health coverage through a Section 125 cafeteria plan requiring employees who elect self-only coverage to contribute \$200 per month toward the cost of that coverage, and it 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.

This guidance is proposed to take effect for taxable years beginning after Dec. 31, 2016, once final regulations are issued and become applicable. Before final regulations are issued, opt-out payments generally will not be treated as increasing an employee's required contribution for purposes of the employer shared responsibility rules and the related reporting requirements under Section 6056.

However, the IRS plans to apply these rules beginning Dec. 16, 2015, for any opt-out arrangements that are adopted after Dec. 16, 2015. For this purpose, an opt-out arrangement will be treated as adopted after Dec. 16, 2015, unless:

- ✓ 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 Dec. 16, 2015;
- ✓ A board, committee or similar body, or an authorized officer of the employer specifically adopted the opt-out arrangement before Dec. 16, 2015; or
- ✓ The employer had provided written communications to employees on or before Dec. 16, 2015, indicating that the opt-out arrangement would be offered to employees at some time in the future.

The proposed regulations clarify that this includes an unconditional opt-out arrangement that is required under the terms of a collective bargaining agreement (CBA) in effect before Dec. 16, 2015. As a result, employers participating in the CBA are not required to increase the amount of an employee's required

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contribution by amounts made available under the opt-out arrangement for purposes of the employer shared responsibility rules or Section 6056 reporting until the later of:

- ✓ The beginning of the first plan year that begins following the expiration of the CBA in effect before Dec. 16, 2015 (disregarding any extensions on or after Dec. 16, 2015); or
- ✓ The applicability date of these regulations with respect to the employer shared responsibility rules and Section 6056 reporting.

This treatment will apply to any successor employer adopting the opt-out arrangement before the expiration of the CBA in effect before Dec. 16, 2015 (disregarding any extensions on or after Dec. 16, 2015).

Conditional Opt-out Arrangements

According to the proposed regulations, the effect of the availability of a **conditional opt-out payment** is less clear. In particular, under an unconditional opt-out arrangement, an individual who enrolls in the employer coverage loses the opt-out payment as a direct result of enrolling in the employer coverage. By contrast, in the case of a conditional opt-out arrangement, the availability of the opt-out payment may depend on information that is not generally available to the employer (who, if it is an ALE, must report the required contribution under Section 6056 and whose potential employer shared responsibility liability may be affected).

In an effort to provide a workable rule, the proposed regulations provide that amounts made available under **conditional opt-out arrangements** are disregarded in determining the required contribution only if the arrangement satisfies certain conditions (that is, it is an eligible opt-out arrangement). For this purpose, an **eligible opt-out arrangement** is an arrangement under which the employee's right to receive the opt-out payment is conditioned on:

- ✓ The employee declining to enroll in the employer-sponsored coverage; and
- ✓ The employee annually providing reasonable evidence that the employee and the employee's expected tax family have or will have minimum essential coverage (other than coverage in the individual market) during the period of coverage to which the opt-out arrangement applies.

For example, if an employee's expected tax family consists of the employee, the employee's spouse and two children, the employee would meet this requirement by providing reasonable evidence that the employee, the employee's spouse and the two children will have coverage under the group health plan of the spouse's employer for the period to which the opt-out arrangement applies.

The IRS invites comments on this proposed rule, including suggestions for other workable rules that result in the required contribution more accurately reflecting the individual's cost of coverage while minimizing undesirable consequences and incentives.

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Premium Subsidy Eligibility

The proposed regulations also address the following issues related to eligibility for the **premium tax credit**, which may impact employers:

- ✓ If an individual declines to enroll in employer-sponsored coverage for a plan year and **does not have the opportunity to enroll in that coverage for one or more succeeding plan years**, the individual is treated as ineligible for that coverage for the succeeding plan year or years for which there is no enrollment opportunity.
- ✓ **A plan consisting solely of excepted benefits is not MEC.** Accordingly, an individual enrolled in or offered a plan consisting solely of excepted benefits may still be eligible for the premium tax credit. Taxpayers may rely on this rule for all taxable years beginning after Dec. 31, 2013.

In addition, the proposed regulations provide restrictions on eligibility for individuals who intentionally or recklessly provide incorrect information to the Exchange.

The Benchmark Plan Premium

Under the ACA, the amount of a taxpayer's premium tax credit is equal to the sum of the premium assistance amounts for all coverage months in the taxable year for individuals in the taxpayer's family. The premium assistance amount for a coverage month is calculated based on the QHP premiums for the taxpayer and his or her family, or a benchmark plan, whichever is less.

The benchmark plan with respect to an applicable taxpayer is the second lowest cost silver plan offered by the Exchange through which the applicable taxpayer (or a family member) enrolled and which provides:

- ✓ Self-only coverage, in the case of unmarried individuals (other than a surviving spouse or head of household) who do not claim any dependents, or any other individual who enrolls in self-only coverage; and
- ✓ Family coverage, in the case of any other applicable taxpayer.

In general, the benchmark plan's adjusted monthly premium is the premium an insurer would charge for the plan, adjusted only for the ages of the covered individuals. The applicable percentage is provided in a table that is updated annually, and represents the portion of a taxpayer's household income that the taxpayer is expected to pay if the taxpayer's coverage family enrolls in the benchmark plan.

Pediatric Dental Benefits

Under the ACA, a QHP must offer the essential health benefits (EHB) package, which includes pediatric dental benefits. However, if an Exchange offers a standalone dental plan, QHPs do not have to offer pediatric dental benefits.

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For purposes of calculating the premium tax credit amount for a taxpayer who enrolls in both a QHP and a standalone dental plan, the enrollment premium includes a portion of the premium for the standalone dental plan. The proposed regulations would extend this rule to apply to the determination of the benchmark plan premium.

Families Residing in Different Locations

Currently, a taxpayer's applicable benchmark plan is the second lowest cost silver plan offered at the time a taxpayer or family member enrolls in a QHP through the Exchange for the rating area where the taxpayer resides. If members of a taxpayer's family reside in different states and enroll in separate QHPs, the premium for the taxpayer's applicable benchmark plan is the sum of the premiums for the applicable benchmark plans for each group of family members living in the same state.

However, because premiums and plan availability may vary based on location, the IRS noted that the existing rule for a taxpayer whose family members reside in different locations in the same state may not accurately reflect the cost of available coverage. As a result, the proposed regulations provide that if a taxpayer's coverage family members reside in multiple locations (whether within the same state or in different states) the taxpayer's benchmark plan is determined based on the cost of available coverage in the locations where members of the taxpayer's coverage family reside.