SIGNIFICANT ISSUE UPDATE
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IRS Issues Rules Addressing Reporting of Third-Party Payors of Sick Pay. The IRS recently issued Notice 2015-6, addressing reporting of certain sick pay paid by a third party on behalf of employers where the liability for FICA (Social Security and Medicare) taxes on the sick pay is split between the employer and a third party.

Under IRC Sections 3121(a) and 3306(b), any third party that pays sick pay included in wages is treated as the employer for purposes of FICA and FUTA (unemployment) taxes with respect to such wages. A third-party payor can be either an agent of the employer or a third party that is not an agent of the employer. Additionally, the method for determining the amount of withholding depends on whether the sick pay is paid by the employer, by an agent of the employer, or by a third party that isn't the employer's agent (i.e., a third party insurer of the risk with respect to sick pay benefits).

Sick pay paid by the employer or an agent of the employer is taxable wages subject to income tax withholding. Sick pay that is paid by a third party that is not an agent of the employer is not taxable wages and not subject to mandatory income tax withholding.

IRS Form 8922 is used to reconcile differences between the wage and tax amounts reported on Form 941 and on Forms W-2 arising from the payment of third-party sick pay. Notice 2015-6 requires Form 8922 to be filed to report total payments of certain sick pay paid by third parties on or after January 1, 2014. This includes filing "third-party sick pay recaps" to reconcile the reporting of sick pay paid by a third party on behalf of employers to employees in situations in which the liability for FICA taxes on the sick pay is split between the employer and the third party.

Notice 2015-6 also contains rules regarding the responsibility for the withholding, payment and reporting of employment taxes and wages with respect to third-party sick pay Beginning with sick pay paid on or after January 1, 2014, an employer or third party is required to file Form 8922 if the employer is including the employer FICA tax on sick pay wages on the employer's Form 941 but the third party (whether as an agent that has agreed to be responsible for the reporting or not as an agent) is including the employee FICA tax on the same sick pay wages on the third party's Form 941 (i.e., "a split liability situation").

Whether the employer or the third party is required to file the Form 8922 depends on which entity is filing Form W-2 with respect to the sick pay. In a split-liability situation where the sick pay is reported on Forms W-2 under the name and EIN of the third party (whether as an agent that has agreed to be responsible for such reporting or not as an agent), Form 8922 must be filed by the employer. In a split liability situation where the sick pay is reported on Forms W-2 under the name and EIN of the employer, the third party (whether as an agent or not as an agent) must file Form 8922.

In short, the requirement to file Form 8922 can arise in the following three situations:

(1) A third party is required to file Form 8922 when the third party is liable for the employee FICA tax but the liability for the employer FICA tax and for reporting the sick pay on Forms W-2 lies with the employer;

(2) An employer is required to file Form 8922 when the third party is liable for the employee FICA tax and income tax withholding, the liability for the employer FICA tax remains with the employer, and the third party has agreed to act as the employer's agent for reporting on Forms W-2; and

(3) A third party that is an agent of the employer is required to file Form 8922 when the agency agreement provides that (a) the third-party agent will withhold and pay employee FICA tax and report the taxes on its Form 941, and (b) the employer will pay the employer FICA tax, report the employer FICA tax on its Form 941, and report the employee's wages on Forms W-2.

When there is no split reporting of sick pay on Forms 941, there is no obligation to file Form 8922. Except as provided in (3) above, there is generally no obligation to file Form 8922 for sick pay paid by an agent. There is also no obligation to file Form 8922 when the third party paying the sick pay isn't an agent and doesn't transfer liability for the FICA employer tax on the sick pay to the employer.

A copy of Notice 2015-6 can be found at: http://www.irs.gov/pub/irs-drop/n-15-06.pdf.

IRS Issues Pilot Program and Rules Regarding "Wraparound Coverage" as Excepted Benefits. Recently, the IRS, EBSA, and HHS jointly issued proposed regulations allowing group health plans to offer limited benefits that "wrap around" either eligible individual insurance policies or coverage issued under the ACA's Multi-State Plan Program offered through the Marketplaces. The rules contain five (5) requirements for wraparound coverage covering the scope of coverage, cost limits, nondiscrimination, eligibility and reporting. The purpose of the rules is to help employees who may not be able to afford their employer's primary group health plan and thus qualify for subsidized coverage through an ACA Marketplace. The rules encourage employers to offer "wraparound" coverage for employees who end up getting coverage through an ACA Marketplace by providing overall coverage comparable to group health plan coverage.

Requirements. Wraparound benefits are considered "excepted benefits," and therefore would not disqualify an employee from eligibility for subsidized coverage through an ACA Marketplace, if five (5) requirements are met.

1. **Scope of Coverage.** Coverage must be specifically designed to wrap around eligible individual coverage and it must provide meaningful benefits beyond cost sharing, such as expanded in-network providers or benefits not covered under the individual insurance. The wraparound coverage is not permitted to provide benefits solely under a coordination-of-benefits provision and cannot be solely an account-based reimbursement arrangement.

2. **Cost Limits.** The total annual cost of the wraparound coverage for the employee and dependents is limited to the maximum annual contribution to a health flexible spending account (health FSA) (e.g., $2,550 in 2015). This limit includes both employer and employee contributions.

3. **Nondiscrimination**. There are three nondiscrimination requirements: (1) the coverage cannot impose any pre-existing condition exclusions; (2) there can be no discrimination as to eligibility, benefits or premiums based on any health factors; and (3) both the employer's primary group health plan and the wraparound coverage must comply with the ACA's prohibition on discrimination in favor of highly compensated individuals.

4. **Eligibility**. Individuals enrolling in the wraparound coverage cannot also be enrolled in a health FSA providing excepted benefits. In addition, plans must comply with one of two alternative sets of eligibility and benefit standards: (1) eligibility requirements that apply to wraparound benefits offered in conjunction with eligible individual health insurance for persons who are not full-time employees; or (2) a set of standards that apply to coverage that wraps around certain multi-state plan coverage.

5. Reporting. A self-insured group health plan, or a health insurance issuer offering multi-state plan wraparound coverage, must report to the federal Office of Personnel Management (OPM), information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the regulations. The plan sponsor must report to HHS information that HHS reasonably requires to determine whether the exception for wraparound coverage under the regulations is effective, without causing an erosion of coverage.

Pilot project. Under the proposed regulations, wraparound coverage may be offered as excepted benefits to coverage that is first offered no later than December 31, 2017, and that ends on the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective

bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered).

A copy of the proposed regulations can be found at: http://www.irs.gov/irb/2015-2_IRB/ar14.html.

Proposed Regulations Modifying Summary of Benefits and Coverage (SBC) and Uniform Glossary for Health Plans. The IRS, EBSA, and HHS have also jointly issued proposed regulations that would amend the existing 2012 final regulations relating to the content and disclosure requirements of the summary of benefits and coverage (SBC) and uniform glossary of health plan terms. The proposed regulations are intended to clarify SBC delivery requirements, streamline and shorten the SBC template, add certain additional elements thought to be useful to consumers.

The 2012 final regulations established the standards and content for the SBC and the accompanying uniform glossary. The proposed regulations incorporate some of the feedback the departments have received into a new set of proposed SBC templates, instructions, an updated uniform glossary, and other materials, available online at http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

Among other things, the proposed regulations:

- Clarify that if an issuer provides an SBC before application for coverage, the issuer is not required to provide another SBC on application so long as there is no change to the information in the SBC.
- Clarify that if a plan sponsor is still negotiating coverage terms after insurance coverage has been applied for and the information required to be in the SBC changes, the plan or issuer would not be required to provide an updated SBC until the first day of coverage. The updated SBC would have to reflect the final coverage terms under the insurance policy.
- End a temporary enforcement safe harbor which permitted statements about minimum essential coverage and minimum value to be included in a cover letter rather than in the SBC.
- Require disclosure in the SBC whether abortion services are covered or excluded and whether coverage is limited to services for which federal funding is allowed (excepted abortion services).
- Clarify that all plans and issuers must include contact information for questions, and issuers must also include an Internet address where participants can obtain a copy of the actual policy or certificate of coverage.

The new SBC template also eliminates some prior information that should make it easier for plans to include all required information within the statutory page limit.

Effective date. The proposed changes apply, for disclosures with respect to open enrollment periods, beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. For disclosures with respect to enrollments outside of an open enrollment period (e.g., newly eligible employees), the changes apply beginning on the first day of the first plan year that begins on or after September 1, 2015.

A copy of the proposed regulations can be found at: http://www.irs.gov/irb/2015-2_IRB/ar15.html.

IRS Sets 2015 Monthly National Avg. Premium for Bronze Health Plans. The IRS recently issued Rev. Proc. 2015-15, which sets the 2015 monthly national average premium for qualified bronze-level health plans under the Affordable Care Act at $207 per individual. Taxpayers use this figure to determine their maximum individual shared responsibility payments. If a taxpayer or a dependent is without minimum essential coverage for one or more months in a taxable year and no exemption applies, the taxpayer is liable for the shared responsibility payment, which is the lesser of the sum of (a) the monthly penalty amount (which, in turn, is the greater of $325 per individual or 2% of income in 2015), or (b) the sum of the monthly national average bronze plan premiums. The $207 per individual limit effectively serves as a cap on the maximum penalty.

A copy of Rev. Proc. 2015-15 is available at: http://www.irs.gov/pub/irs-drop/rp-15-15.pdf.

IRS Publication 5187 Explains How to Report Health Care Coverage on Income Tax Returns. The IRS has issued Publication 5187, *Health Care Law: What's New for Individuals & Families.* The publication is intended to help taxpayers report whether they have minimum essential coverage, qualify for one of the available exemptions, or must pay the "individual shared responsibility penalty. For those taxpayers who purchased coverage through an ACA Marketplace and obtained a premium tax credit via the ACA's advance payment processes, the publication also walks taxpayers through the tax credit requirements and the filing of Form 8962, with respect to formally claiming the credit.

A copy of the Publication 5187 can be found at: http://www.irs.gov/pub/irs-pdf/p5187.pdf.

Congressional Research Service Report on the Potential Impact of the *King v. Burwell* Decision. In March 2015, the U.S. Supreme Court is scheduled to hear oral arguments in the *King v. Burwell* case dealing with whether the Affordable Care Act's (ACA's) premium tax credit under Code Section 36B is valid for coverage obtained through the federal Marketplace. The Congressional Research Service (CRS) has issued a report examining the potential implications of the Court's decision.

Background. The IRC Section 36B premium tax credit is designed to help cover the cost of health insurance for taxpayers who meet certain qualifying requirements. It is available for individuals who purchase health insurance coverage through the state or federal Marketplaces. Under the ACA, states may establish and operate their own insurance Marketplaces or they can use the federal Marketplace required to be established by the federal government and used when a state has opted to not establish its own Marketplace.

One function of the Marketplaces is to facilitate premium assistance payments to health plans based on information available at the time of an individual's enrollment. In describing the premium assistance amount, IRC Section 36B(b)(2)(A) states that "the monthly premiums for...qualified health plans offered in the individual market...which were enrolled in through an Marketplace established by *the State*" under § 1311 (emphasis added).

Although the statute uses the term "State," the IRS regulations issued in May 2012, interpret IRC Section 36B to allow credits for insurance purchased on either a state or federally-established Marketplace. Specifically, the regulations state that a taxpayer may receive a premium tax credit if the taxpayer is enrolled in a qualified health plan through a Marketplace, which is defined in 45 C.F.R. 155.20 to include any Marketplace serving the individual market, *regardless of whether the it is established and operated by a state or by HHS.* By making credits more widely available, the regulations give the individual and employer mandate provisions of the ACA broader effect than they would have if the premium tax credits were limited to just state-established Marketplaces because these provisions are tied to receipt of a premium tax credit. Thus, by making tax credits available in the 36 states that use the federal Marketplace, the IRS has significantly expanded the size of the group that must purchase health insurance or face a penalty.

Case History. Taxpayers brought suit against IRS and HHS arguing that the regulations were an invalid interpretation of the statute. The Supreme Court agreed to resolve a Circuit split between the Fourth Circuit upholding the regulation and the DC Circuit invalidating the regulation, by reviewing *King v. Burwell*, (CA 4 July 22, 2014) 114 AFTR 2d 2014-5259. The Supreme Court is scheduled to hold oral arguments on the case on March 4, 2015.

Implications of Court's upholding the Regulation. The CRS Report notes that if the Court upholds the regulation, the IRS would not need to take any action for the premium tax credits to remain available for individuals participating in state and federally run Marketplaces.

Implications of Court's invalidation of the Regulation. If the Court determines the IRS regulation is invalid, taxpayers participating in federal Marketplace would no longer be eligible for the credit. The CRS report notes the following implications would flow from this decision:

- First, the CRS Report states IRS would presumably act to address the problematic aspects of the

regulations and may determine that additional rulemaking or guidance is appropriate.

- Second, the IRS might also confront issues arising out of the timing of the Court's decision, which will likely occur after taxpayers claiming the credit for tax year 2014 will have generally filed their tax returns, and many taxpayers will have started receiving the credit for 2015 in the form of advanced payments made through the Marketplaces. Thus, in addition to raising questions about whether taxpayers who received the credit must repay it, the Court's decision will likely issues with respect to ongoing 2015 insurance contracts.
- The CRS report then states that the ACA's operation could be affected in the following ways:

  (1) *Impact on affordable coverage.* The ACA requires health insurers to accept every individual who applies for coverage, without regard to preexisting conditions, and it prevents insurers from charging higher premiums based on an individual's health status. In order to prevent adverse selection the ACA also includes the "individual mandate" which requires individuals to buy insurance or pay a tax. The premium tax credit is intended to make the required coverage affordable. Eliminating premium tax credits would have a significant adverse impact on this framework and the ACA's goals of expanding health insurance coverage and promoting a functioning individual insurance market in each state. It has been predicted that eliminating the premium tax credits in states using the federal Marketplace would make coverage unaffordable for most of the individuals receiving the credits.

  (2) *Exemption of more individuals from individual mandate.* If premium tax credits are unavailable to individuals enrolled through the federal Marketplace, fewer individuals will be required to have health insurance under the ACA's individual mandate. There is an exemption from the individual mandate for individuals whose health coverage costs more than 8% of household income. However, the cost is calculated based on the annual premium for the lowest cost plan available on a Marketplace in the state, minus any allowable premium tax credit. Thus, if an individual is not allowed the premium tax credit, coverage becomes more expensive, so this exemption is more likely to apply. Consequently, the many individuals would not be subject to the individual mandate.

  (3) *Debilitating effect on Marketplaces.* Without the premium tax credits, many healthy people may decide not buy health coverage, but, individuals with more serious health conditions would probably remain in the market. The population enrolled in Marketplace plans could become skewed toward participants who will likely be high users of medical care, which would likely lead to a rise in premiums in affected Marketplaces.

  (4) *Impact on the employer mandate.* Liability for the excise tax under the employer mandate is triggered when a full-time employee receives a premium tax credit through a Marketplace. Thus, if credits are not available in states using the federal Marketplace, large employers may not be subject to penalties if they fail to offer affordable coverage to employees.

  (5) *Impact on taxpayers who already claimed credits.* Taxpayers who bought insurance through the federal Marketplace may be required to pay back any claimed credit to IRS. They may also wish to drop current coverage, if they must pay the full price. The CRS report notes the Court, Congress, or IRS could take actions to mitigate the severity of these consequences.

A copy of the CRS report can be found at: http://www.fas.org/sgp/crs/misc/R43833.pdf.

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