The Advisory Board Company | Health Care Law Roundtable

General Counsel Agenda

A Quarterly Legal Perspective on Today's Top-of-Mind Issues
June 2015

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As Health Systems Grow, So Do Human Resources Concerns

Gain Insights into Emerging Human Resources Legal and Compliance Issues

The Health Care Law Roundtable is pleased to present the 2015 second quarter edition of the General Counsel Agenda, a publication written for the hospital and health system in-house counsel audience. The Agenda offers legal analyses on a broad set of pressing issues in health care law, allowing your organization to stay abreast of the top concerns facing providers nationwide.

In this edition, we explore recent human resources challenges faced by providers navigating the new health care landscape. From the most up-to-date information on why employers are paying more attention to telemedicine as a benefits offering, our experts highlight actionable recommendations for your team. Next, our experts spotlight antitrust risk in communications and discuss how providers can avoid documentation and communication pitfalls. In addition, our experts discuss why simply establishing a code of conduct and a response process is not enough to address disruptive physicians. Also, our experts discuss how the PRIME Act is negatively impacting providers and ways to mitigate the increased cost and compliance burdens. Lastly, our experts give an update on the IRS's "pay or play" rules for large-employer providers.

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Why Employers are Paying More Attention to Telemedicine

The Legal and Regulatory Issues Providers Should Know Before Integrating Telemedicine into Benefit Offerings

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Employers are under increasing pressure to reduce the health care costs of their employees, while at the same time reducing absenteeism and increasing employee productivity. Beginning in 2018, a 40 percent excise tax known as the "Cadillac tax" will be imposed annually on health plans with premiums exceeding $10,200 per year for individuals and $27,500 per year for families. According to various projections, the Cadillac tax may impact at least one-third of U.S. employers because it generally will be applicable to employer-sponsored health plan coverage, including coverage under any group health plans offered by employers to their employees.

Many employees hesitate to take time off work, particularly for ailments they perceive as minor. According to the American Medical Association an average physician's visit can take up to four hours out of an employee's day. Indeed, many employees forego seeing physicians entirely, often causing relatively minor health issues to escalate into more complex conditions requiring more intensive and costlier services. While some employers have established onsite clinics where their employees can access providers to receive care, there are high costs associated with creating and operating these onsite clinics—not to mention that onsite clinics are not particularly effective for employers with decentralized workforces that cannot easily access the clinic. As a result, workplace-sponsored telemedicine is increasing viewed as cost-effective and viable solution to help manage employee health care costs.

Telemedicine, the remote diagnosis and treatment of patients using electronic communication modalities, has gone mainstream. The facts and figures speak for themselves, and employers are paying increasing attention. In a recent study focused on U.S. employers with at least 1,000 employees, Towers Watson predicted that employers could save up to $6 billion annually if employees would routinely engage in remote consults for certain, appropriate medical issues. Effective use of telemedicine services could eliminate 15 percent of physician office visits, 15 percent of emergency room visits, and 37 percent of urgent care visits.

Increasingly, the use of telemedicine technologies is viewed as an efficient and cost-effective method for delivering and accessing quality health care services. Patients also have become more adept and comfortable with using technology in lieu of face-to-face interactions with physicians and other health care professionals for certain types of health care conditions. This shift can be attributed to several factors, including a health care system rapidly transitioning from fee-for-service to one in which reimbursement is closely tied to quality and patient outcomes.

According to a 2013 Forbes article, annual utilization of telemedicine services was projected to increase to an estimated 3 million patients by 2018 from 250,000 in 2013. While only 20 percent of U.S. employers currently offer their employees access to telemedicine services, nearly 40 percent of U.S. employers surveyed by Towers Watson said they plan to offer access to such services in 2015, and an additional 33 percent surveyed said they are considering offering access to these services within the next three years.

Despite the growth and benefits, however, employers considering using telemedicine in their benefit offerings should be aware of some significant legal and regulatory issues implicated by the use of telemedicine, including the following:

Licensure

State professional licensure laws are a major stumbling block to interstate practice of telemedicine. With limited exceptions, providers must be licensed in every state in which they intend to practice and each state has its own licensure requirements. Generally, out-of-state physicians, absent certain exceptions, must obtain full and unrestricted licenses to practice medicine on patients in a particular state. Employers should understand how the state(s) in which they are located deal with licensure.

The Federation of State Medical Boards developed an Interstate Medical Licensure Compact to facilitate license portability and the practice of interstate telemedicine. So far, 9 states have enacted the Compact and an additional 10 states have introduced legislation seeking to become Compact states. Similarly, a Nurse Licensure Compact currently is in place in 24 states but only covers registered nurses and licensed vocational nurses (compacts for nurse practitioners and physician assistants are being separately developed).

Physician-Patient Relationships

States have various criteria for establishing proper physician-patient relationships, one of which is an evaluation or examination of a patient by the treating physician. This is important when a physician is prescribing medications and cannot physically evaluate new patients face-to-face before writing prescriptions. Some states (e.g., Arkansas) explicitly require a face-to-face examination or evaluation before a physician may engage in any online prescribing. Other states (e.g., Missouri), while requiring a physical examination or evaluation, do not explicitly use terms such as "in-person" or "face-to face" to describe the nature of such exams, but medical boards in these states have interpreted the applicable laws to mean that the treating physician must conduct a face-to-face encounter with the patient. A growing number of states (e.g., Maryland, Virginia) explicitly allow physical examinations or evaluations to be performed by electronic means or via telemedicine technologies. Employers need to understand how the relevant rules work in the state(s) in which they are located.

Privacy and Security

Compared to face-to-face encounters, telemedicine encounters are more vulnerable to risks such as third-party interference, signal errors, and data transmission outages. These risks may result in loss of data, interrupted communications, or alteration of important clinical information and, in turn, make telemedicine encounters extremely vulnerable to breaches of protected health information. The federal Health Insurance Portability and Accountability Act's privacy and security regulations are extremely relevant to telemedicine encounters and the various types of electronic data they generate. State by state, analogous privacy and security laws must be carefully considered. The Federal Trade Commission also is taking a more active role in the area of health information breaches.

Medical Liability

Adapting existing principles of malpractice liability to telemedicine is a challenging task, especially the question of what constitutes an appropriate "standard of care." There are many unresolved issues and questions regarding malpractice liability as it relates to telemedicine, including the nature of physician-patient relationships, informed consent, practice standards and protocols, supervision, and availability and provision of professional liability insurance coverage.

Employers seeking to explore the use of telemedicine must carefully analyze the legal and regulatory risks and limitation implicated by telemedicine.

Managing Antitrust Risk in Communications

How Providers Can Avoid "Bad" Documentation and Communication Pitfalls in Antitrust Risk Management

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One of the critical issues in antitrust risk management is understanding the pitfalls of "bad" documents and communications. The federal antitrust enforcement agencies make no secret of the fact that a party's own documents are frequently one of their most productive sources of information when investigating or challenging a proposed transaction. Litigated health care antitrust cases are rife with examples of providers whose transactions were torpedoed by their own words.

For example, in the Federal Trade Commission's successful 2011 challenge to the acquisition of St. Luke's Hospital (SLH) in Toledo, Ohio, by ProMedica, the FTC's Administrative Law Judge cited numerous St. Luke's documents to the effect that, "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." More sensationally, the Judge also cited comments by members of St. Luke's due diligence team, that a ProMedica affiliation could "stick it to employers, that is, to continue forcing high rates on employers and insurance companies."

The Judge in the ProMedica case also cited a ProMedica bond rating agency presentation to support the conclusion that ProMedica holds a "dominant position" in the market. This is an excellent illustration of how documents prepared and used in an entirely different context can become relevant in an antitrust investigation. It would be expected that a health system would make the strongest case possible for its competitive strength in order to obtain a favorable bond rating. However, such contentions may well constrain future arguments that consumers in the market have significant competitive alternatives.

Another troubling example of the FTC's use of party documents came in the agency's well-publicized 2004 post-merger challenge to Evanston Northwestern Healthcare's (ENH) 2000 acquisition of Highland Park Hospital. That case was premised in large measure on price increases paid by contracting health plans subsequent to the merger, and party documents played a

significant role in establishing that price increases were an intended objective of the transaction. For example, the Initial Decision of the Administrative Law Judge cited various CEO communications prior to the merger recommending "strengthen[ing] negotiating positions with managed care through merged entities and one voice." In a similar vein, the ALJ cited a report by ENH's CEO that the Highland Park merger would "increase our leverage" with health plans. The Initial Decision also cited presentations to the ENH Board indicating that the merger would foreclose the possibility of Highland Park's acquisition by another large system, which ENH feared would increase competitive pricing pressures on it.

In the current environment, where potential mergers and strategic alliances among providers are almost a daily topic of conversation, it pays to educate provider organization leadership on the ins and outs of managing communications from an antitrust perspective. Among the more of these points are the following:

1. The first rule is one of common sense. No one in the organization should create a communication that would embarrass the author or the organization if it were to be read by a competitor, a government investigator, or a judge. Assume everything you write will be read by the FTC.
2. Keep communications objective. There are two corollaries to this advice. First, speculation about the meaning of particular data or information should be reserved to those whose job it is to do so. Second, there is no place for dramatic, hyperbolic, or disparaging statements, which can distort the meaning and intent of an otherwise ordinary communication.
3. In that regard, word choices matter. Words of aggression convey bad intent. Words such as: crush, defeat, defend, dominate, clout, leverage, force, and pressure are inevitably associated with the "bad guy." Even when used in jest, the humor is usually lost in retrospect.

   Of course, not all statements of competitive animus are troublesome. Intent to harm or displace one's competitors, standing alone, affords no basis for antitrust liability, as such an outcome is as likely to result from strong competition as from anticompetitive methods. However, where aggressive statements are directed toward a provider's customers (e.g., health plans) or are made in a context suggesting an intent to harm competitors by means other than competition on the merits, they may be considered probative by an investigator or a court.
4. Use words that have competitive meanings carefully. Used inappropriately, such words can be used to impeach an organization's position in an antitrust matter. For example, it is not uncommon to find hospital strategic planning documents that refer broadly and indiscriminately to other hospitals as "competitors" even when they are not.
5. Re-read and edit communications before sending. Visualize how a communication might be misunderstood. Don't be cute. Unless instructed otherwise by counsel, do not save drafts.
6. Consult counsel if there is concern about communicating a sensitive issue.
7. Use the telephone (but not voice mail) to communicate without creating a "document."
8. Keep the focus of transaction-related communications on the benefits to stakeholders (patients, employers, payors), such as the opportunities to improve efficiency, quality, and access. Whether correctly or not, a singular focus on profitability can be equated with an intent to raise prices and reduce competition.
9. Remember that antitrust investigations are all-encompassing. A request for "documents" from an antitrust investigator could include files and communications stored on personal devices (such as home computers, personal email accounts, social media, smartphones, tablets) or in the "cloud," as well as those stored in a company location. Communications cannot be shielded by calling them "personal."

How Providers Should Address Disruptive Physicians

Why Simply Establishing a Code of Conduct and a Response Process is Not Enough

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Dr. Right throws open the door of the operating suite, barking orders and cutting off the head nurse as she begins the preoperative check. "Let's go! I have a full schedule today and you're wasting my time. I have patients to see and lives to save." Dr. Right glances at the surgical tray and shouts at the scrub tech, "Why can't you ever get it straight?! I always use the right-handed changle clamp and you never have it ready. I have it on my preference card for Pete's sake!" Dr. Right snatches the scalpel from the tech and plunges into the six hour case. The OR staff collectively roll their eyes and sigh—another

day, another blow up.

Nearly everyone who has worked in or around hospitals has a similar war story involving an out of line physician and long suffering staff. However, disruptive physician behavior is not limited to such stereotypical outbursts—it encompasses verbal abuse, combative behavior, physical threats and attacks, intimidation, inappropriate communication, and sexual harassment. Disruptive behavior may be most simply described as any inappropriate behavior that interferes with the delivery of quality care, in other words, "you know it when you see it." Not only does disruptive behavior impact quality of care however, it also has the potential to erode staff morale, impugn the hospital's reputation, threaten efficient operation of the hospital, and increase litigation risk.

Hospitals can help to reduce or avoid disruptive behavior and its corrosive effects by setting clear expectations for professional behavior and establishing a consistent response process. Indeed, the Joint Commission requires hospital leaders to "develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety," and to "create and implement a process for managing behaviors that undermine a culture of safety."

A code of conduct lays the foundation for professional behavior. It should be accessible and transparent, and for that reason the code of conduct is often incorporated into the medical staff bylaws. Requiring physicians to acknowledge that they have reviewed and understand the code of conduct as part of the membership or credentialing process helps to emphasize the seriousness with which the medical staff and hospital take expectations of professionalism.

The code of conduct should clearly link appropriate professional conduct to patient care. The code of conduct should also include the types of behavior deemed unacceptable and intolerable (the list should be illustrative rather than exhaustive), together with an explanation that such behavior erodes the quality of patient care, contributes to an inhospitable work environment, and leads to patient dissatisfaction. In short, the code of conduct should reflect a culture of professionalism, with an emphasis on collegiality, honesty, integrity and respect.

After drawing the parameters for acceptable behavior, it is equally important to develop and maintain a response process by which to address unacceptable behavior. This process should again be readily accessible and transparent. Most importantly the response process should be regularly and consistently applied so as to avoid claims of unfairness or discrimination.

The details of the response process will necessarily vary depending on the size, composition and resources of the medical staff, however it should set forth steps for reporting disruptive behavior, evaluating reported behavior, and efficiently remediating disruptive behavior. Documentation throughout the response process is essential. Keep in mind that the response process will necessarily overlap, and should be compatible with, the medical staff's peer review and fair hearing processes. Human resources may also play a role when physicians are employed.

In addition to the procedural aspects of addressing disruptive behavior, the response process should allow for consideration of variables that necessarily weigh in determining what action to take in a particular situation: the degree of egregiousness, whether disruptive behavior is isolated or chronic, whether previous remedial steps have been taken, and perhaps most significant, the physician's willingness to take responsibility for his or her actions. If disruptive behavior may stem from impairment, the wellness committee should be involved. There is no one size fits all template for responding. The range of potential actions in any given case is wide, and action may be escalated in the event poor behavior continues or is not improved.

For example, an isolated outburst might be addressed over a cup of coffee or by way of a candid committee discussion with the physician, perhaps followed by a letter of rebuke or warning. Behavior attributable to mental health or substance abuse may best be referred to a state or privately operated wellness program. More egregious or repetitive behavior might warrant a written apology, a behavior contract or participation in an intensive behavior program directed at the type of behavior at issue. The most serious incidents or chronic behavior might trigger reduction or limitation in privileges, summary suspension, or even termination.

Simply establishing a code of conduct and a response process is not enough however. Once action has been enacted, implementation, monitoring and follow through are critical to the integrity of the code of conduct and response process. Accountability is essential. If improved behavior is not maintained or stated objectives are not met, then there must be consequences, otherwise the code of conduct loses its value and effectiveness and leadership may be perceived as weak, ineffective and indifferent towards disruptive behavior.

Disruptive behavior is complex and can have far reaching effects. A code of conduct and response process that establish clear expectations and predictability are important tools for successfully curbing and addressing disruptive behavior. These tools are made more powerful when hospital and medical staff leadership model professionalism, and they may be further enhanced by way of training and education opportunities. The bottom line is that avoidance and half measures are not an option.

How the PRIME Act Impacts Providers

How SGR Legislation Attempts to Curb Medicare and Medicaid Fraud Increases Cost and Compliance Burdens

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On April 16, 2015, the Medicare Access and CHIP Reauthorization Act (Public Law 114-010), which repealed the Medicare sustainable growth rate, improved Medicare payments for physicians, and extended the Children's Health Insurance Program by 2 years, became law. The Medicare Access Act also incorporated amendments to the Social Security Act originally proposed in the Preventing and Reducing Improper Medicare and Medicaid Expenditures (PRIME) Act. A bipartisan group of U.S. Senators had reintroduced the PRIME Act in March 2015, following the lead of the U.S. House of Representatives, which tapped the bill for reconsideration in February. The initiatives proposed in the PRIME Act, and subsequently enacted in the Medicare Access Act, stiffen protections against Medicare and Medicaid fraud and abuse and to increase fraud detection measures. At the same time, however, the relevant provisions place heightened requirements and restrictions on health care entities, increasing regulatory pressure on those who provide care to Medicare and Medicaid beneficiaries.

The PRIME Act had been introduced twice in the Senate, once in 2011 and again in 2013, but died in committee relatively quickly both times. However, despite its repeated failure, the provisions of the PRIME Act changed little and were incorporated nearly wholesale into the Medicare Access Act.

All health care providers should be aware that the Medicare and Medicaid fraud prevention provisions in the Medicare Access Act impose additional cost and compliance burdens on the entire health care industry. Health care providers should carefully analyze these provisions to determine how to comply with the new law and how such compliance will impact administrative costs and the care delivery structure.

Medicare Access Provisions Relevant to Providers

Sponsors of both the PRIME Act and the Medicare Access Act sought to increase oversight of billing procedures, recovery audit contractors, and transfers of personally identifiable information, and certain provisions of these acts significantly impact health care providers. Specifically, these provisions would:

- Prohibit prescription drug plan sponsors from paying Medicare or Medicaid claims for prescription drugs without a valid national provider number (NPI);
- Prohibit reimbursement on a claim for medical services under Medicaid without a valid beneficiary identification number, as determined by a state Medicaid agency;
- Require the Centers for Medicare & Medicaid Services (CMS) to establish new procedures for verifying NPIs;
- Provide bonuses for Medicare administrative contractors (MACs) that reduce improper payment errors to certain levels and penalties for MACs that reach an upper-end error threshold; and
- Increase penalties for intentional fraud relating to Medicare, Medicaid, or Children's Health Insurance Plan (CHIP) beneficiary identification numbers or billing privileges to imprisonment for not more than 10 years and/or a monetary fine of not more than $500,000.

However, the Medicare Access Act also benefits hospitals and physician groups by limiting the civil monetary penalty (CMPs) for inducements to reduce or limit Medicare services specified in 42 U.S.C. § 1320a-7a(b)(1). The Act amended the CMP provision to apply only to inducements to limit medically necessary Medicare services. This significant change removes a major obstacle for hospital and physician groups that are in the process of developing gainsharing programs.

Effect on Providers

The Medicare and Medicaid fraud prevention provisions of the Medicare Access Act increase scrutiny on billing practices, creating additional administrative burdens that will raise costs for pharmacies and other health care providers and lengthen the time for providers to receive reimbursement. For example, before Congress passed the Act, pharmacies were not required to provide the prescriber's NPI when submitting a claim. However, under the Medicare Access Act, verified NPIs must be submitted with each claim, placing added administrative burdens on both the prescribing physician (to provide the NPI) and the pharmacy (to ensure that the prescribing physician provides the NPI) so that Medicare and Medicaid pharmaceutical benefit claims are submitted with proper NPIs in order to avoid rejection. Even if proper

identification numbers are provided for all claims, the Medicare Access Act requires that CMS and state Medicaid agencies verify the identification numbers—an additional step that may cause significant delays in reimbursement for pharmacies.

In addition, the Medicare Access Act creates incentives for MACs that significantly reduce improper payment error rates, as well as penalties for those MACs that allow such error rates to rise. Offering quality incentives for MAC oversight may encourage MACs to creating additional compliance requirements and standards applicable to health care providers in an attempt to lower error rates and capture a portion of the new incentive payments. Thus, health care providers will likely need to adjust administrative and practice policies and procedures in order to comply with the MACs.

Although the full extent of the additional administrative burdens the Medicare Access Act imposes on health care providers may not be immediately apparent, certain procedural changes, such as the NPI inclusion and verification requirements for pharmacy claims, will likely have a sudden impact on reimbursement from federal health care programs. To minimize the effect of this requirement, all pharmacies should consider storing (whether electronically or otherwise) physician NPIs for reference on subsequent claims, as well as implementing policies and procedures to ensure NPIs are included in outgoing claims.

An Update for Providers on the IRS's "Pay or Play" Rules

What Large Employers Must Know Regarding Shared Responsibility Requirements and Penalties

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DISCLAIMER: Potential Impact of Pending Supreme Court Decision on Employer Shared Responsibility Rule and Reporting and Disclosure Requirements

The United States Supreme Court will soon decide the validity of the Internal Revenue Service (IRS) regulation implementing section 36B of the Internal Revenue Code. Code section 36B is the component of the Patient Protection and Affordable Care Act (ACA) that provides a refundable individual tax credit/premium subsidy for coverage under a qualified health plan. There is no question that the premium subsidy is available to individuals who purchase health insurance on one of the 13 state-run insurance "Exchanges" established pursuant to the ACA. The IRS regulation, however, provides that Code section 36B also provides the tax credit/subsidy to individuals who purchase health insurance on the federally facilitated Exchange created and operated by the Department of Health and Human Services.

The Court's decision on the availability of the individual tax credit will also decide the future of the employer shared responsibility rule (sometimes called the "pay or play" rule) with respect to employers that have employees who reside in any of the 37 states that do not have state-run Exchanges. This is because the ACA, like a structure made of LEGOs™, is made up of many interlocking pieces. The employer shared responsibility rule imposes a penalty on an applicable large employer (ALE), defined below, if: 1) the ALE has not made available to its full-time employees affordable minimum essential coverage that provides a "minimum value" of health coverage, as defined in the statue and regulations, and 2) at least one of the ALE's full-time employees receives subsidized coverage on an Exchange. If the Supreme Court decides that individuals who receive health insurance through the federal Exchange do not qualify for a premium subsidy under Code section 36B, the Court will also be deciding, in effect, that employers of those individuals are not subject to the employer shared responsibility penalty.

This article focuses on the reporting obligations of ALEs that are at the heart of the IRS's administration of the health premium tax credit and enforcement of the employer shared responsibility rule. If the Supreme Court finds that those rules do not apply in the 37 states that do not have state-run Exchanges, then the reporting requirements for ALEs whose employees reside in those states could be greatly curtailed, if not eliminated.

Applicability of Employer Shared Responsibility Requirements

Generally, an ALE is an employer with at least 50 full-time or full-time equivalent employees. As noted above, the employer shared responsibility rule applies with respect to an ALE's full-time employees. For purposes of the rule, a full-time employee is, generally, one who works at least 30 hours per week. With respect to ALEs with at least 100 full-time or full-time equivalent employees, the employer shared responsibility rule has been in effect since January 1 of this year. The rule is scheduled to go into effect on January 1, 2016 for ALEs that have fewer than 100, but at least 50, full-time or full-time equivalent employees.

ALE Reporting and Disclosure Requirements

For years beginning with 2015, Code section 6056 requires that an ALE that is subject to the employer shared

responsibility provisions annually report to the IRS certain identifying information about itself and its full-time employees, and information regarding the health care coverage, if any, that the ALE offered to its full-time employees during each month of the year. ALEs must also annually furnish a statement to full-time employees regarding the health care coverage, if any, provided to the employee and his or her family members during each month of the year. Employees and their family members may use this information to determine whether they may claim the premium tax credit on their individual income tax returns. The employer shared responsibility rule and the reporting and disclosure rules apply to all ALEs, including tax-exempt entities, federal, state and government entities and Indian tribal governments.

An ALE will use Form 1095-C to satisfy both the IRS reporting requirement and the employee disclosure requirement of Code section 6056. An ALE will use Form 1094-C to transmit the 1095-C forms for its employees to the IRS. ALEs that file 250 or more 1095-C forms with the IRS during a year must file the forms electronically. The regulations permit, but do not require, the electronic furnishing of Form 1095-C to full-time employees if certain requirements are met. For information regarding electronic filing, see IRS Publication 5165, Guide for Electronically Filing Affordable Care Act (ACA) Information Returns.

Similar to the deadline for furnishing W-2 forms, the date by which an ALE must furnish 1095-C forms to its full-time employees for a calendar year is January 31 of the following year. ALEs must file the 1094-C transmittal form and the 1095-C forms for its full-time employees with the IRS no later than February 28 (March 31 if filed electronically) of the year immediately following the calendar year to which the return relates. If an ALE is also subject to the rules under Code section 6055 (which are beyond the scope of this article) that apply to employer sponsors of self-funded group health plans (included HRAs), the Forms 1094-C and 1095-C that the ALE uses to satisfy the reporting and disclosure requirements under Code section 6056 must also include the information needed to satisfy the requirements of Code section 6055. The ALE must use a single Form 1095-C to satisfy the reporting and disclosure requirements of Code section 6055, if applicable, and Code section 6056 with respect to any individual full-time employee or family member.

For more information regarding the ALE reporting and disclosure requirements, see the Instructions for Forms 1094-C and 1095-C, IRS Publication 5196, Understanding Employer Reporting Requirements of the Health Care Law, and the following IRS websites: http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Applicable-Large-Employers and http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056.

Penalties

Generally, the penalty for failing to file a correct information return is $100 for each such failure, not to exceed $1,500,000 per year. Similarly, the penalty for failing to provide a correct statement to an employee is, generally, $100 for each such failure, not to exceed $1,500,000 per year. The IRS has announced, however, that it will not impose penalties with respect to reports and statements for 2015 that are due in 2016 if the reporting entity can show that it has made a good faith effort to comply with the reporting requirements.

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