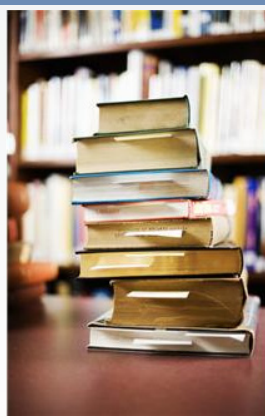
Legal and financial information for the
Community Action network

FALL 2014

# CAPLAW*update*



## Affordable Care Act Employer Mandate Q&A

By Eleanor A. Evans, Esq. and Graham Rogers, CAPLAW

After a one-year delay, the so-called "employer mandate" provisions of the federal health care reform law are set to take effect January 1, 2015. These rules require employers with 50 or more full-time employees and full-time equivalent employees to offer health insurance coverage to substantially all of their full-time employees and their dependents. The coverage offered must provide "minimum value" and be "affordable."[1] The employer mandate rules (which are sometimes referred to as the employer "pay or play" rules or employer "shared responsibility" rules) apply not only to for-profit employers but also to tax-exempt organizations and federal, state, local and Indian tribal governmental entities.

This Q&A is intended to help employers in the Community Services Block Grant (CSBG) network better understand, in light of final employer mandate regulations issued earlier this year, how the employer mandate rules affect them and to help them comply with those rules. Ultimately, however, each employer should consult with a qualified professional to determine whether it is subject to the employer mandate rules and, if so, the best way for it to comply.

To determine whether it is subject to the employer mandate rules, an employer converts the total hours of its part-time

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## Why It's Important for Your Organization to Use Custom Business Email Addresses

By Jean Carr, Esq., CAPLAW

Some CSBG network organizations may not use custom business email addresses but instead may permit employees to use individual accounts, such as *janedoe@yahoo.com* or *johndoe3@sbcglobal.net*, for work purposes. A custom business email address is one that reflects the company domain name, such as *janedoe@yourorganization.org*. Employee email accounts used for business purposes

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employees into full-time equivalent employees (FTEs) and adds that number to the number of its actual full-time employees. If the result is equal to or greater than 50, the employer is considered an "applicable large employer" that must comply with the employer mandate.[2] (See "Determining Whether Your Organization Is a Large Employer," Spring 2013 CAPLAW Legal Update, p. 4.)

> "...an applicable large employer that fails to offer affordable coverage providing minimum value to substantially all of its full-time employees will be required to make one of two types of payments to the IRS."

Starting in 2015, an applicable large employer that fails to offer affordable coverage providing minimum value to substantially all of its full-time employees will be required to make one of two types of payments to the IRS. The first type of payment (the "no offer payment") will apply to those applicable large employers that fail to offer coverage to substantially all of their full-time employees and their dependent children up to age 26. This payment, which is calculated on a monthly basis, is $2,000 per year for every full-time employee, excluding the first 30 full-time employees and not counting FTEs. The second type of payment (the "inadequate coverage payment") applies to those employers that offer coverage, but that coverage is not "affordable" or does not provide "minimum value" (see discussion of what it means for coverage to be affordable and to provide minimum value in Q&As 15 and 16 below). In this case, the payment, which is calculated on a monthly basis, is the lesser of: (1) $3,000 per year for each full-time employee receiving subsidized coverage on a state health insurance exchange, or (2) $2,000 per year for each full-time employee, excluding the first 30 full-time employees and not counting FTEs. An employer will not be required to make either type of payment unless at least one of its full-time employees applies for and receives subsidized coverage through a state health insurance exchange.[3]

As noted in Q&A 1 below, applicable large employers that have at least 50 but fewer than 100 full-time employees and FTEs in 2014 and that meet certain additional criteria will not be subject to employer mandate payments until 2016.

> "...applicable large employers that have at least 50 but fewer than 100 full-time employees... will not be subject to employer mandate payments until 2016."

Congress passed the health reform law, formally known as the Patient Protection and Affordable Care Act (ACA) in 2010. The IRS issued proposed employer mandate regulations in January 2013 (see "Health Care Reform 'Pay or Play' Q&A," Spring 2013 CAPLAW Update, p. 3). In July 2013, the IRS issued Notice 2013-45 delaying enforcement of the employer mandate from January 1, 2014 to January 1, 2015. On February 10, 2014, the IRS issued final employer mandate regulations. Among other things, the final regulations provide a number of transition rules intended to aid employers as they prepare for compliance in the coming months.

## Transition Rules

1. ***When will the employer mandate begin to apply to our organization, which has 50 or more full-time employees (including FTEs) in 2014?***

Starting in 2015, the employer mandate rules will apply to employers that had 100 or more full-time employees and FTEs in 2014. An applicable large employer with at least 50 but fewer than 100 full-time employees and FTEs in 2014 will not be subject to the employer mandate rules until 2016, as long as it meets three requirements. First, it must not reduce the size of its workforce or overall hours of service of its employees between February 9, 2014 and December 31, 2014 in order to delay application of the employer mandate until 2016. (It may, however, reduce its workforce or overall hours of employees' service during that time for a bona fide business reason unrelated to qualifying for this transition rule.) Second, during the period between February 9, 2014 and December 31, 2015 (or, for a non-calendar year plan, the last day of the plan year that began in 2015), it must not drop or materially reduce the level of health insurance coverage it offered to its employees as of February 9, 2014. Third, it must certify its eligibility for this relief to the IRS.[4]

2. ***How do the final employer mandate regulations affect our organization's determination of whether it is an "applicable large employer" for 2015?***

Whether an employer is considered an "applicable large employer" subject to the employer mandate rules depends

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on whether it had 50 or more full-time employees and FTEs in the prior calendar year. Usually, this calculation is to be made based on the entire prior calendar year. However, a special transition rule applies for purposes of determining applicable large employer status for 2015. Instead of basing its calculation on the full 2014 calendar year, an employer may choose any period of at least six consecutive months in the 2014 calendar year on which to base its calculation.[5] (See "Determining Whether Your Organization Is a Large Employer," Spring 2013 CAPLAW Legal Update, p. 4.)

*The transition rules described in questions 3-7 apply only to those employers subject to the employer mandate rules in 2015. These rules will be effective only for the 2015 calendar year (or, if the employer's plan year does not coincide with the calendar year, for the plan year beginning in 2015). These rules will not apply to those applicable large employers with fewer than 100 full-time employees and FTEs that meet the requirements discussed in Q&A 2 above which delay the application of the employer mandate until 2016.*

### 3. *Because of the way our organization's pay periods fall, offering coverage to employees on January 1, 2015 would be administratively difficult. Do we have to offer coverage on that exact date?*

No. If an employer offers coverage to a full-time employee effective no later than the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for the entire month. Note that this rule applies to January 2015 only.[6]

### 4. *Our organization, which employs more than 100 full-time employees, has a non-calendar year plan. When will the employer mandate rules take effect for us?*

The final regulations include transition relief from employer mandate payments for non-calendar year plans during the period in 2015 before the start of the 2015 plan year. This relief gives employers with non-calendar year plans additional time to expand eligibility for coverage in those plans. If eligible for the relief, the employer will not be subject to employer mandate payments with respect to any full-time employees who are offered affordable coverage that provides minimum value effective by the first day of the 2015 plan year.

To qualify for the relief, the non-calendar year plan in question must not have been modified after December 27, 2012 to begin at a later calendar date. The relief applies to non-calendar year plans in the following circumstances, either or both of which may apply to a particular plan. First, a non-calendar year plan will be eligible for this relief if full-time employees who are eligible for coverage on the first day of the 2015 plan year under the terms of the plan as in effect on February 9, 2014 are offered affordable coverage that provides minimum value effective by the first day of the 2015 plan year. Second, a non-calendar year plan will be eligible for relief if: (1) it covered at least ¼ of all the employer's employees (or 1/3 of its full-time employees) as of any date in the 12 months ending on February 9, 2014 or (2) the employer offered coverage to at least 1/3 of all of its employees (or half of its full-time employees) during the open enrollment period ending closest to and before February 9, 2014.[7]

### 5. *How should our organization determine whether it offers coverage to "substantially all" its employees in 2015?*

To avoid the no offer payment, an employer must offer affordable coverage that provides minimum value to substantially all of its full-time employees and their dependents. For an employer subject to the employer mandate rules in 2015, this means offering health insurance coverage to at least 70% of its full-time employees and their dependents (unless transition relief for dependent coverage applies as described in Q&A 7 below). This number will rise to 95% of full-time employees in 2016 and future years.[8]

### 6. *Will there be any temporary changes to how employer mandate payments are calculated?*

"An employer subject to the 'pay or play' rules in 2015 will be permitted to disregard 80 of its full-time employees when calculating the no offer payment…"

Yes. An employer subject to the "pay or play" rules in 2015 will be permitted to disregard 80 of its full-time employees when calculating the no offer payment or the cap on the inadequate coverage payment for any month in 2015 (or, for non-calendar year plans any month in the 2015 plan year). For all subsequent years, employers will only be permitted to disregard 30 full-time employees.[9]

### 7. *Does our organization need to offer coverage to dependents of full-time employees starting in the 2015 plan year?*

The final regulations state that an employer will not be subject to an employer mandate payment for failing to offer coverage to dependents of its full-time employees in the 2015 plan year, as long as it takes steps in its 2014 or 2015 plan years (or both) to extend coverage to dependents starting with the 2016 plan year. If an employer offered coverage to dependents in its 2013 or 2014 plan years, it may not subsequently reduce or drop that coverage. The term "dependent" means a full-time employee's natural or adopted child or a child placed with the employee for adoption through the calendar month that the child turns age 26. Note that the term "dependent" does not include the employee's spouse.[10]

## Determining Which Employees Qualify as Full-Time and When Those that Do Must Be Offered Coverage

*An employer needs to know the number of full-time employees it has to determine: (1) whether it is subject to the employer mandate rules as an applicable large employer; and (2) whether it may owe an employer mandate payment for failing to offer coverage to an eligible full-time employee and the amount of any such payments.*

### 8. *How is the term "full-time employee" defined?*

An employee is considered to work full-time for a calendar month if he or she averages at least 30 hours of service per week or 130 hours of service per month.[11]

### 9. *What counts as an hour of service?*

Generally, an 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 an employee is paid, or entitled to payment, 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.[12]

### 10. *Our organization has a number of volunteers and students in work-study jobs. Do we need to track their hours of service?*

No. The final regulations exclude several categories of work from the definition of hours of service. Of particular relevance to CSBG network organizations is work performed by bona-fide volunteers and students participating in federal, state, or locally-funded work-study programs.[13]

For these purposes, a "bona-fide volunteer" is an individual who volunteers for a government entity or tax-exempt organization and whose only compensation from that entity or organization is in the form of (1) reimbursement (or reasonable allowance) for reasonable expenses incurred in the performance of volunteer services, or (2) reasonable benefits (including length of service awards) and nominal fees customarily paid by similar entities in connection with the performance of services by volunteers.[14]

Note that, with respect to student employees, hours of work that a student performs for an employer outside of a work-study program must be counted toward the student employee's full-time status. This includes work performed by students working in paid internships or externships.[15]

### 11. *What about participants in job training programs or paid interns employed on a short-term basis? Do we need to count their hours?*

Yes; if a participant in a job training program or an intern employed on a short-term basis performs services for an employer and is paid or entitled to payment for those services, his or her hours worked count as "hours of service" for purposes of the employer mandate rules and must be tracked. However, the employer need not offer coverage to a job training participant or paid intern if he or she has left the organization before the date on which the employer mandate rules specify that the employer must offer coverage to avoid employer mandate penalties (see Q&As 12 and 13 below). Because of the fact-specific nature of these situations, a CSBG network organization with questions about application of these rules to job training participants, paid interns and other short-term employees should consult with an attorney or other qualified professional.

### 12. *How do we determine whether an employee is a full-time employee?*

There are two methods employers may use to determine which employees are full-time employees: the monthly method and the look-back method. The final employer mandate regulations provide a detailed explanation of these different methods. An employer may choose to apply one of these methods to all of its employees or to apply a different method to salaried vs. hourly employees or to collectively bargained vs. non-collectively bargained employees. For example, an employer might choose to apply the monthly method to all salaried employees and the look-back method to all hourly employees. Alternatively, the employer could choose to apply one method (either the monthly method or the look-back method) to all employees, whether they are salaried or hourly.[16] Whichever method an employer uses with respect to a particular employee, it must generally offer the employee coverage for an entire month to avoid employer mandate payments for that month (however, note the special exception to this rule for January 2015 discussed in Q&A 3).[17]

*Monthly Method*

Under the monthly method, the employer tracks an employee's hours of service for each calendar month to determine if the employee is full-time and must be offered coverage for that month. An employer will not be subject to employer mandate payments for failing to offer coverage to new full-time employees on the date they first meet the plan's eligibility requirements (other than the completion

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of a waiting period) if it offers them coverage effective by the first day of the fourth full calendar month after that date.[18] Employers using the monthly method may choose to measure hours of service on a weekly basis over a four- or five-week period (depending on the length of the month), rather than by calendar month, to correspond with the employer's payroll periods.[19]

*Look-back Method*

"Under the look-back method, an employer determines an employee's status as a full-time employee during a future period... based upon the employee's hours of service in a prior period..."

Under the look-back method, an employer determines an employee's status as a full-time employee during a future period (referred to as the stability period), based upon the employee's hours of service in a prior period (referred to as the measurement period). An employee who is credited with enough hours of service during the measurement period to be considered a full-time employee during the stability period must be offered coverage effective for the entire duration of the stability period regardless of the number of hours the employee actually works during the stability period, as long as he or she remains employed by the employer. The measurement period may last anywhere from three to 12 consecutive months. The stability period must last for six consecutive months or the length of the measurement period, whichever is longer. An administrative period of up to 90 days can be scheduled between the end of the measurement period and the beginning of the stability period to give the employer time to determine which employees qualified as full-time during the measurement period and to enroll employees in coverage for the stability period.[20]

The final regulations include a transition rule permitting employers to adopt a measurement period as short as six consecutive months for the stability period beginning in 2015. This is true even if the stability period is 12 months, which would normally require a 12-month measurement period. However, the measurement period must begin no later than July 1, 2014, and must end no earlier than 90 days before the first day of the 2015 plan year.[21]

The look-back method may be used to determine the status of both new hires and ongoing employees (i.e., those who have worked a full measurement period); complex rules apply to the transition of a new employee to an ongoing employee. Although the employer sets the length of the initial measurement period, the start date of each new employee's initial measurement is based on his or her first day of employment. After a new employee becomes an ongoing employee, he or she will be subject to standard measurement, administrative and stability periods that the employer applies uniformly to ongoing employees. For example, an employer with a calendar year plan might choose to use a standard 12-month measurement period that starts on November 1 of Year A and continues through October 31 of Year B; followed by a standard two-month administrative period from November 1 through December 31 of Year B, during which it determines which employees qualified as full-time based on their hours of service in the preceding measurement period and conducts open enrollment; followed by a standard 12-month stability period that runs from January 1 through the following December 31 of Year C.[22]

An employer initially must categorize each new hire either as an employee who, as of his or her start date: (1) is reasonably expected to work full-time; or (2) for whom it cannot be determined whether he or she is reasonably expected to work full-time (i.e., a variable hour, seasonal or part-time employee).[23] An employer will not be subject to employer mandate penalties for failing to offer coverage immediately to a new employee it reasonably expects to be full-time upon hire if it offers him or her coverage no later than the first day of his or her fourth full calendar month of employment. Whether the employer's determination that a new hire is a full-time employee is reasonable is based on the facts and circumstances. Factors to be considered include: whether the employee is replacing an employee who was or was not a full-time employee; the extent to which employees in the same or comparable positions are or are not full-time employees; and whether the job was advertised, or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description), as requiring more or less than 30 hours of service per week.)[24]

A different rule applies with respect to new employees who the employer cannot determine are reasonably expected to work full-time, but who are later determined to work full-time during their initial measurement period. For such an employee, an employer will not be subject to employer mandate penalties during the employee's initial measurement period (and any associated administrative period) if it offers coverage to the employee that will become effective no later than the first of the month following the 13-month anniversary of the employee's start date.[25]

### *13. May our organization's plan impose a waiting period?*

Generally speaking, group health plans are not permitted to impose a waiting period longer than 90 days. This rule is separate from the employer mandate rules and applies regardless of the size of the employer sponsoring the plan.[26] A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being eligible for coverage means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's

"Eligibility conditions based solely on the passage of time cannot exceed 90 days..."

terms).[27] Eligibility conditions based solely on the passage of time cannot exceed 90 days (note that 90 days means 90 calendar days, including weekends and holidays, and not three months). However, requiring employees to complete a certain number of hours of service before becoming eligible for coverage is also generally allowed under the waiting period regulations as long as the number of required hours of service is capped at 1,200.[28]

The waiting period regulations also explain that the measurement period used in the look-back method under the employer mandate rules (i.e., the time period for determining whether a variable-hour employee meets the plan's hours of service per period eligibility condition) will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee's start date (plus any time remaining until the first day of the next calendar month if the employee's start date is not the first day of a calendar month).[29]

### 14. *If an individual previously employed at our organization has recently been rehired, must he or she be offered coverage upon his or her return to work?*

"A break in service is a period in which an employee is not credited with any hours of service for the employer."

For purposes of the employer mandate rules, under both the monthly and look-back measurement methods, a full-time employee returning to a previous employer after a break in service lasting less than 13 consecutive weeks is treated as a continuing employee and must generally be offered coverage as of the first day he or she is credited with an hour of service upon returning to work or as soon as administratively practicable thereafter (i.e., by the first day of the calendar month after returning to work) . A break in service is a period during which an employee is not credited with any hours of service for the employer. The employer may treat an employee experiencing a break in service of 13 weeks or longer as a new hire. Additionally, an employer may choose to treat an employee as a new hire even if he or she experiences a break in service shorter than 13 consecutive weeks, if the break is at least four consecutive weeks and is longer than the employee's period of employment immediately preceding the break.[30]

Under these rules, for example, if a Community Action Agency lays off Head Start staff for 10 weeks in the summer, those staff will be generally be considered continuing employees who must be offered coverage upon or shortly after their return to work at the end of the summer.

## Definitions of Affordability and Minimum Value

### 15. *How will we know if the coverage offered under our organization's plan is "affordable" to employees?*

An employer's coverage is considered "affordable" if an employee's required premium contribution for the lowest cost employee-only coverage offered by the employer is equal to no more than 9.5 percent of the employee's household income. Because employers generally will not have access to data on their employees' household incomes, employers have three possible optional "safe harbor" methods for determining affordability. Under these rules, coverage is affordable if a full-time employee's premium contribution for the lowest cost individual coverage providing minimum value does not exceed either: (1) 9.5 percent of the employee's wages reported on Form W-2 for the year in question; (2) 9.5 percent of the employee's rate of pay at the beginning of the coverage period (generally the plan year); or (3) 9.5 percent of the federal poverty line for a single individual; (for this purpose, an employer may use any of the federal poverty guidelines in effect within six months before the first day of the plan year). The Form W-2 safe harbor is applied on a yearly basis after the end of the calendar year but its application may be pro-rated if an employee is only offered coverage for part of the year. The rate of pay and federal poverty line safe harbors are applied on a monthly basis. An employer may choose to apply any one of these safe harbors for any reasonable category of employees, as long as it does so on a uniform and consistent basis for all employees in a particular category. Reasonable categories generally include specified job categories, nature of compensation (hourly or salaried), geographic location, and similar bona fide business criteria.[31]

### 16. *What does it mean for a health plan to provide "minimum value"?*

"A plan provides minimum value if it covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan."

A plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.[32] The Department of Health and Human Services (HHS) and the IRS have produced a minimum value calculator. By entering certain information about the plan, such as deductibles and co-pays, into the calculator employers can obtain a determination as to whether the plan provides minimum value.

## Allowability of Employer Mandate Payments under OMB Cost Principles

### 17. *Will our organization be able to charge employer mandate payments to its federal grants?*

To date, no guidance specifically addresses whether employer mandate payments will be allowable costs under the federal cost principles that apply to employers receiving federal grant funds.

On the one hand, the payments could be construed as penalties, which are unallowable costs under the cost principles. Costs of fines and penalties resulting from

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violations of, or failure of a federal grantee to comply with federal, state, and local laws and regulations are unallowable except when incurred as a result of compliance with specific provisions of an award or instructions in writing from the awarding agency.[33] The Affordable Care Act, however, gives large employers a choice of whether to "play" or to "pay." Only if an employer neither plays nor pays will it be violating or failing to comply with the Act. Therefore, it seems unlikely that employer mandate payments would be considered unallowable fines or penalties under this provision.

On the other hand, the payments could be construed as taxes. Taxes that a federal grantee is required to pay are generally allowable, except for taxes from which an exemption is available to the grantee.[34]

Although the treatment of employer mandate payments under the federal cost principles is not clear, the cost principles clearly state that costs of providing health insurance to employees are allowable.[35]

## More Information

For more information about the rules discussed in this Q&A, see the following publications:

- The IRS's "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act"
- The Federal Register notices containing the final employer mandate regulations, the final 90-day waiting period regulations, and the final regulations regarding orientation periods
- Health care reform articles for large employers from the Leavitt Group, a multistate insurance brokerage
- Deciding Whether to Play or Pay Under the Affordable Care Act – 2014 Updates from the law firm Jones Day
- A series of alerts for employers from the national employment law firm Seyfarth Shaw on selected health care reform topics. See, in particular, Issues 77 (final employer mandate regulations), 79 (final regulations on the 90-day waiting period limitation) 80 (employer reporting requirements) and 82 (final 90-day waiting period regulations on orientation periods).
- The Health Care Reform Dashboard, created and maintained by the law firm Ballard Spahr LLP, contains information and alerts on various aspects of the Affordable Care Act, including the employer mandate. The site also includes "The ACA Tracker," which tracks and includes links to regulations and other guidance issued by federal agencies on the ACA.

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# Custom Business Email Addresses
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contain data that must be protected, preserved, and readily accessible by the organization at all times. Using customized business emails will enable your organization to fully control, access and store information in employees' email accounts, thereby protecting the organization from legal liability of various kinds. It will also project a more professional image and enable recipients to readily identify emails as being sent in connection with the official business of your organization. Establishing custom business emails is not difficult or expensive to do; some "how-to" tips are provided later in this article.

## Risks of Using Individual Email Accounts for Business Purposes

There are a number of legal risks associated with using individual email accounts for business purposes. Following are some examples of those risks:

- **Safeguarding Confidential Information:** A variety of state and federal privacy laws require organizations to protect certain sensitive information, such as social security numbers, driver's license or passport numbers, health information, and financial account information. Email messages exchanged in the conduct of the organization's business may contain information that requires protection under these laws. Without the ability to fully control and safeguard its employees' email accounts, an organization will not be able to protect confidential information in those accounts to the extent required by law.
- **Securing Data:** Email sent or received from personal accounts is unlikely to be protected by the organization's data backup systems, firewalls, encryption or other data protection procedures,

# Article End Notes

## Affordable Care Act Employer Mandate Q&A

1. 26 C.F.R. § 54.4980H.

2. 26 C.F.R. § 54.4980H-1(a)(4), -1(a)(21), -1(a)(22) and -2.

3. 26 C.F.R. § 54.4980H-4 and -5.

4. 26 C.F.R. § 54.4980H-6(b) and 79 Fed. Reg. 8543, 8574 (Feb. 12, 2014).

5. 79 Fed. Reg. 8543, 8574.

6. 79 Fed. Reg. 8543, 8573.

7. 79 Fed. Reg. 8543, 8570-8571.

8. 79 Fed. Reg. 8543, 8575.

9. 79 Fed. Reg. 8543, 8576.

10. 79 Fed. Reg. 8543, 8574-8575 and 26 C.F.R. § 54.4980H-1(a)(12).

11. 26 C.F.R. § 54.4980H-1(a)(21).

12. 26 C.F.R. § 54.4980H-1(a)(24).

13. 26 C.F.R. § 54.4980H-1(a)(24)(ii).

14. 26 C.F.R. § 54.4980H-1(a)(7).

15. 79 Fed. Reg. 8543, 8550-8551.

16. 26 C.F.R. § 54.4980H-3(e).

17. 26 C.F.R. § 54.4980H-5(c).

18. 26 C.F.R. § 54.4980H-3(c)(2).

19. 26 C.F.R. § 54.4980H-3(c)(3).

21. 26 C.F.R. § 54.4980H-5(c).

20. 26 C.F.R. § 54.4980H-3(d).

21. 79 Fed. Reg. 8543, 8573.

22. 26 C.F.R. § 54.4980H-3(d).

23. 26 C. F. R. § 54.4980H-3(d)(2)-(3).

24. 26 C.F.R. § 54.4980H-3(d)(2).

25. 26 C.F.R. § 54.4980H-3(d)(3).

26. 26 C.R.R. § 54.9815-2708.

27. 26 C.F.R.§ 54.9815–2708(b)-(c)(1).

28 26 C.F.R. § 54.9815-2708(c).

29. 26 C.F.R.§ 54.9815–2708(c)(3)(i).

30. 26 C.F.R. § 54.4980H-3(c)(4) and -3(d)(6) (in the case of an "educational organization," the relevant break in service period is 26 weeks rather than 13 weeks. However, CSBG network organizations are generally not likely to qualify as educational organizations.)

31. 26 C.F.R. § 54.4980H-5(e).

32. 26 C.F.R. § 54.4980H-1(28) and 26 U.S.C. § 36B(c)(2)(C)(ii) and 45 C.F.R. § 156.145.

33. 2 C.F.R. Part 230, App. B, ¶16 (O.M.B. Circular A-122, which applies to nonprofit grantees); see similar provision in 2 C.F.R. Part 225, App. B, ¶16 (O.M.B. Circular A-87, which applies to state and local government grantees). See also 2 C.F.R. § 200.441 (O.M.B. "Super Circular" cost principle rules, which when effective, will apply to both nonprofit and state and local government grantees).

34. 2 C.F.R. Part 230, App. B, ¶47.a. (O.M.B. Circular A-122, which applies to nonprofit grantees); see similar provision in 2 C.F.R. Part 225, App. B, ¶40 (O.M.B. Circular A-87, which applies to state and local government grantees). See also 2 C.F.R. § 200.470 (O.M.B. "Super Circular" cost principle rules, which when effective, will apply to both nonprofit and state and local government grantees).

35. 2 C.F.R. Part 230, App. B, ¶8.g. (O.M.B. Circular A-122, which applies to nonprofit grantees); see similar provision in 2 C.F.R. Part 225, App. B, ¶8.d. (O.M.B. Circular A-87, which applies to state and local government grantees). See also 2 C.F.R. § 200.431 (O.M.B. "Super Circular" cost principle rules, which when effective, will apply to both nonprofit and state and local government grantees).

## Why It's Important for Your Organization to Use Custom Business Email Addresses

1. When using this link, note that the pdf will automatically open in the Download folder.

## How Does a CAA Minimize Liability Arising from Completed WAP Units?

1. 10 C.F.R. § 440.18(e)(2).

2. OMB Circular A-122; OMB Circular A-87.

3. 2 C.F.R. Part 200.

4. See OMB Circular A-122, Attachment B, ¶ 22.a(1), (2); OMB Circular A-87, Attachment B, ¶ 22.a, b; 2 C.F.R. § 200.447(a), (b).

5. See OMB Circular A-122, Attachment B, ¶ 22.a(3); OMB