January 28, 2016

IRS Provides Guidance on HRAs, FSAs, Pay-or-Play and Other Issues

The IRS recently released Notice 2015-87, which contains guidance on a broad range of topics under the Affordable Care Act ("ACA"), including:

- Health Reimbursement Arrangements ("HRAs")
- Application of COBRA to health FSAs with a carryover feature
- Impact of certain employer payments on calculation of employee health coverage cost
  - Treatment of employer provided flex-credits, opt-out payments and HRA contributions
  - Treatment of cash-in-lieu payments under Service Contract Act "SCA") or Davis Bacon Act ("DBA")
- Penalty relief for "good faith" reporting
- Section 4980H employer mandate (pay-or-play)
  - Increases to "affordability" safe harbors
  - Increased pay-or-play penalties starting in 2015
  - Hours of service for employees on short-term or long-term disability

Set forth below are key pieces of guidance found in the Notice.

HRAs AND OTHER ARRANGEMENTS THAT REIMBURSE HEALTH INSURANCE PREMIUMS

The Notice confirms prior guidance that prohibits employers from reimbursing employees for the cost of individual market health coverage, whether on a pre-tax or after-tax basis. The following is a summary of guidance provided on HRAs, which breaks little new ground:

- Retiree-only HRAs (fewer than 2 participants who are current employees) may reimburse individual market premiums (including premiums for Medicare and Medicare

supplement plans) and can be stand-alone plans not integrated with a group health plan.
- Employers may allow employees to use HRA funds remaining after group coverage terminates as long as they are not used to reimburse individual market premiums.
- As of plan years beginning in 2017, HRAs covering family members cannot be integrated with employee-only coverage – spouses and dependents must be enrolled in group health plan coverage for a current employee HRA to reimburse their claims.
- HRAs for active employees may reimburse premiums for individual market coverage that solely provides excepted benefits, such as dental or vision coverage.

- Amounts credited to a stand-alone HRA before 2014 may reimburse medical expenses pursuant to the terms in effect before 2014 without violating the ACA market reforms.

APPLICATION OF COBRA TO HEALTH FSAs WITH A CARRYOVER FEATURE

COBRA rules do not require a health FSA to offer continuation coverage upon a qualifying event unless the amount remaining in the FSA exceeds the premium that could be charged to the employee for COBRA for the remainder of the plan year. In other words, the health FSA must be "underspent" at the time of termination in order for COBRA to apply.

The Notice clarifies that when determining if COBRA applies (i.e., if the FSA is underspent at the time of termination), carryover amounts must be included when determining if the amount that the employee is entitled to receive during the remainder of the plan year exceeds the amount the employee must pay for COBRA. However, the cost of COBRA does not include the amount of the carryover as the employee has already paid for the carryover in a prior year.

Example: An employee elects to contribute $2,500 to a health FSA in the current year and carries over $500 from the prior year ($3,000 total). The employee terminates employment June 30, after being reimbursed for $1,600 in medical expenses. The employee is entitled to COBRA under the health FSA because the amount remaining ($1,400) is greater than the COBRA premium that could be charged for the remainder of the year ($1,250, based on a June 30 termination of employment).

The Notice also clarifies that carryover amounts are available to COBRA participants to the same extent as active employees, but that employers may limit the carryover to employees who elect to contribute to the FSA in the following year, thus effectively negating the possibility that COBRA coverage could extend beyond the end of the current plan year. The Notice further provides that employers may limit carryovers to a maximum period (e.g., one or more years).

Example: At the end of the plan year, a COBRA qualified beneficiary has $500 remaining in a health FSA with a carryover feature. The qualified beneficiary is entitled to carry over $500 for the remainder of the COBRA duration, unless the terms of the plan limit carryovers to individuals who have elected to make a salary reduction election to the health FSA for that next plan year.

EMPLOYEE HEALTH CARE COST – 4980H AND SECTION 6056 REPORTING

The Notice clarifies several issues regarding how to treat various forms of employer contributions, such as amounts available under HRAs, as cafeteria plan flex-credits, and cash opt-out payments, for the purposes of "affordability" under the employer mandate ("4980H(b)")

and ACA reporting regarding employer offers of coverage ("6056 reporting").

HRA Contributions

Most employers do not allow employees to use HRA funds to reimburse premiums under the employer's group health plan. However, if an employee can use funds in an HRA to pay for coverage under the employer's group health plan, the amounts available under an HRA are treated as an employer contribution to coverage. To be treated as an employer contribution, employees must be informed of the amount available under the HRA within a reasonable amount of time before the employee must decide whether to enroll in health coverage.

Example: An employer offers employee-only medical coverage at an employee cost of $200 per month. The employer also makes available $1,200 in an integrated HRA each year that employees can use to pay for the cost of medical, dental or vision coverage available under the employer's plan. The HRA contribution is treated as reducing the employee's cost of coverage for the purposes of 4980H(b) and 6056 reporting. The cost of coverage reported on line 15 of Form 1095-C would be $100 per month (the $200 monthly employee cost is reduced by $100 per month based on the $1,200 annual HRA contribution that is available to reimburse the plan's premiums).

In general, HRAs (including retiree-only HRAs) are subject to the ACA's provider reporting requirements (section 6055) unless they are integrated with the employer's fully insured group health plan or another exception applies (e.g., the plan is supplemental to Medicare).

Cafeteria Plan Flex Credits

The Notice clarifies that employer contributions include cafeteria plan flex credits when they can be used solely to pay for medical care (e.g., used as a health FSA contribution) or the employer's group health plan premiums. These are referred to as "health flex credits."

Example: An employer offers employee-only medical coverage at an employee cost of $200 per month. The employer also offers flex contributions of $600 per year that may only be applied toward the employee cost for medical, dental or vision coverage under the employer's plan or contributed to a health FSA. The $600 is a health flex credit and is treated as reducing the employee's cost of coverage for the purposes of 4980H(b) and 6056 reporting. The cost of coverage reported on line 15 of Form 1095-C would be $150 per month (the $200 monthly employee cost is reduced by $50 per month based on the $600 annual health flex credit).

Employer contributions do not include cafeteria plan flex credits when they can also be used to pay for benefits not related to health or may be received as cash. These are referred to as "non-health flex credits."

Example: An employer offers employee-only medical coverage at an employee cost of $200 per month. The employer also offers flex contributions of $600 per year that may be applied toward the employee cost for health care coverage, health FSA, dependent care FSA and group life insurance coverage or may be received as cash. The $600 is a non-health flex credit and is not treated as reducing the employee's cost of coverage for the purposes of 4980H(b) and 6056 reporting. The cost of coverage reported on line 15 of Form 1095-C would be $200 per month.

However, for plan years beginning before 2017, the Notice provides transition relief wherein non-health flex contributions will be treated as reducing an employee's cost of coverage for the

purposes of 4980H(b), provided the arrangement was adopted by December 16, 2015 and was not substantially increased thereafter. Because it can affect an employee's eligibility for the premium tax credit, for the purposes of 6056 reporting, the IRS encourages employers not to reduce the cost of coverage reported on Line 15 of Form 1095-C by the amount of a non-health flex credit and to claim relief under the Notice if later contacted by the IRS regarding an assessable payment.

Opt-Out Payments – Unconditional

A cash opt-out payment is "unconditional" when employees may receive it without having to show proof of other coverage, such as enrollment in a spouse's plan. Unconditional opt-out payments are treated as increasing an employee's cost of coverage. With unconditional opt-out payments, an employee must make the regular employee contribution and forgo the opt-out payment to enroll in coverage. Therefore, unconditional opt-out payments are added to the employee's cost of coverage for ACA reporting purposes.

Example: An employer offers employee-only coverage at an employee cost of $125 per month but pays employees $25 each month if they decline coverage. The opt-out payment is treated as increasing the employee's cost of coverage for the purposes of 4980H(b) and 6056 reporting because the employee must forgo the opt-out benefit in addition to making the regular contribution to obtain coverage. The cost of coverage reported on line 15 of Form 1095-C would be $150 per month.

However, for plan years beginning in 2015 and 2016 and until formal regulations are issued, the Notice provides transition relief wherein unconditional opt-out payments will not be treated as increasing an employee's cost of coverage for the purposes of 4980H(b) and 6056 reporting, provided the arrangement was adopted by December 16, 2015.

Opt-Out Payments – Conditional

A cash opt-out payment is "conditional" when made only to employees who show proof of enrollment in other coverage, such as that of a spouse's employer. It does not increase the employee's cost of coverage. In these situations, the opt-out payment is conditioned on an employee satisfying a meaningful requirement related to the provision of health care to employees. In other words, an employee is not entitled to the opt-out benefit simply by declining the employer's health coverage.

Example: An employer offers employee-only coverage at an employee cost of $125 per month but pays employees $25 per month if they opt-out in favor of a spouse's plan. The opt-out payment is not treated as increasing the employee's cost of coverage for the purposes of 4980H(b) and 6056 reporting because it is subject to a meaningful condition related to the provision of health care to employees. The cost of coverage reported on line 15 of Form 1095-C would be $125 per month.

Employers that offer a conditional opt-out benefit should ensure that they only recognize group health plan coverage and not individual market coverage or Medicare as "other coverage." Doing otherwise raises ACA market reform and Medicare Secondary Payer issues (for employers with 20 or more employees), and may not qualify as a conditional opt-out payment because the condition is not related to the provision of health care "to employees."

Service Contract Act ("SCA") and Davis Bacon Act ("DBA") Employees

The Notice provides much-needed transition relief to employers with SCA and DBA employees. For plan years beginning in 2015 and 2016 and until further guidance is provided, such employers may treat “cash-in-lieu” payments as employer contributions toward the cost of health coverage, to the extent the amount of the payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBA. If not for this guidance, employers would have been required to treat “cash-in-lieu” payments as employee contributions for ACA purposes.

Example: An employer offers SCA or DBA employees the choice of employee-only coverage under a group health plan at no employee cost or a cash payment of $500 per month. For the employee, $500 per month does not exceed the amount required to satisfy the employer’s fringe benefit requirements. For the purposes of 4980H(b) and 6056 reporting, the cost of coverage reported on line 15 of Form 1095-C would be $0 per month.

Because it can affect an employee’s eligibility for the premium tax credit, for the purposes of 6056 reporting, the IRS encourages employers not to reduce the cost of coverage reported on Line 15 of Form 1095-C by the amount of a cash-in-lieu payment and to claim relief under the Notice if later contacted by the IRS regarding an assessable payment.

6055 AND 6056 REPORTING – PENALTY RELIEF FOR GOOD FAITH REPORTING

The Notice confirms that the IRS will not impose penalties on employers who file incomplete or incorrect returns for calendar year 2015 if they can show that they have made good faith efforts to comply. This relief does not apply to timeliness failures. However, employers that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that there was reasonable cause for the timeliness failure.

Note: Based on the statutory inflationary adjustment applicable starting with reporting year 2015, filing penalties for 2015 returns (due in 2016) are increased as follows:

Penalty Description	**2015 Penalty**
Failure to file an IRS information return or provide a payee statement	$260 per return or statement
- Annual penalty limit for non-willful failures	$3,178,500
- Lower limit for entities with gross receipts < $5M	$1,059,500
Failures corrected within 30 days of required filing date	$50 per return or statement
- Annual penalty limit for non-willful failures	$529,500
- Lower limit for entities with gross receipts <$5M	$185,000
Failures corrected by August 1	$100 per return or statement
- Annual penalty limit for non-willful failures	$1,589,000
- Lower limit for entities with gross receipts <$5M	$529,500
Failures due to intentional disregard (no cap)	$520 per return or statement

SECTION 4980H – PAY-OR-PLAY

Increases to Affordability Safe Harbors

Under the ACA, an offer of employer-sponsored health coverage is “affordable” if the cost of employee-only coverage does not exceed 9.5% (indexed for inflation) of an employee’s household income. For 2015 and 2016, the indexed numbers are 9.56% and 9.66%, respectively.

When it comes to determining "affordability" of health coverage, using an employee's household income would be difficult, if not impossible. Therefore, IRS regulations permit employers to use one of three safe harbors to determine affordability based on whether the applicable premium exceeds 9.5% of W-2 income, an employee's Rate of Pay or a measure of the Federal Poverty Level. That is, an employer using one of the safe harbors would not need to ask about an employee's household income to determine whether the insurance is affordable for purposes of the ACA; it would simply take the applicable safe harbor, multiply by 9.5% and measure the result against the premium for self-only coverage.

Prior guidance indicated that although the percentage of household income an employee may be charged may change each year, the three safe harbors are "hard-wired" at 9.5%. The Notice clarifies that the three affordability safe harbors are adjusted retroactively to match the indexed thresholds that apply to household income for 2015 and 2016. The Notice also confirms that the increased thresholds apply when determining if coverage is affordable under the interim guidance for multiemployer plans and whether a "qualifying offer" has been made for Section 6056 reporting purposes.

Increased Pay-or-Play Penalties

The Notice officially confirms that penalties under the employer mandate increase each year starting with 2015.

Penalty Description	**2014**	**2015**	**2016**
Section 4980H(a) – Failure to offer coverage to at least 95% of full-time employees (n/a in 2014 and 70% in 2015)	$2,000	$2,080	$2,160
Section 4980H(b) – Failure to offer coverage that is affordable and minimum value (n/a in 2014)	$3,000	$3,120	$3,240

Crediting "Hours of Service" during STD and LTD

The Notice provides new guidance for employers regarding crediting hours of service for employees on leave. In general, any hours for which an employee is paid or entitled to pay are treated as "hours of service" for ACA purposes. The Notice reiterates this concept and also provides confirmation that hours of service do include hours for which an employee is paid under an employer's short-term or long-term disability program (regardless of whether paid by the employer directly or by a third party), unless the cost of coverage that was paid by the employee, if any, was paid on an after-tax basis and the cost of coverage that was paid by the employer, if any, was treated as income to the employee. The Notice also confirms that hours for which an employee is paid under workmen's compensation, unemployment or state disability programs are not hours of service for ACA purposes.

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Your Trion Strategic Account Managers are here to answer any questions you might have as you prepare to comply with upcoming ACA requirements. If you are not currently a Trion client and would like assistance navigating the changes required by health care reform, please contact us today by emailing trionsales@trion-mma.com.

ACA Regulations & Guidance Issued In the Last Two Months

Dec. 2015: IRS Issues Notice 2016-4 Extension of 2015 Annual Reporting Deadlines
Dec. 2015: IRS Issues Final Regulations on Minimum Value of Employer Plans & Other Rules on Premium Tax Credits
Dec. 2015: IRS Issues Notice 2015-87 Market Reforms, Affordability Safe Harbors & Other Misc.

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