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CONTACTS

Lisa R. Nelson, Esq.
Director
Compliance & Regulatory Affairs
lisan@barneyandbarney.com 858.875.3017

Christopher K. Bao, Esq.
Compliance Manager, Orange County
Compliance & Regulatory Affairs
chris.bao@barneyandbarney.com 949.540.6924

CA Insurance LIC: 0H18131

www.barneyandbarney.com

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CONGRESS REPEALS SMALL GROUP ANNUAL DEDUCTIBLE LIMIT

On March 31, 2014, Congress passed (and the President signed into law) legislation that repeals the maximum annual deductible limit imposed on small employer group health plans pursuant to the Affordable Care Act (ACA).

Set to take effect January 1, 2014, the ACA originally imposed a limit on annual deductibles, $2,000 for individual plans and $4,000 for family plans. This new legislation retroactively repeals the provision to the date of the ACA enactment (March 23, 2010), effectively eliminating this provision from the ACA entirely.

Unaffected provisions include the annual out-of-pocket maximum limits under ACA. This provision puts a limit on the maximum that a plan participant can spend, including deductibles, co-insurance, co-payments or similar charges for essential health benefits provided in-network only. The maximum out of pocket limit for 2014 is $6,350 for an individual plan and $12,700 for a family plan. This provision applies only to non-grandfathered plans.

Action Required

Employers in the small group market (under 50 lives) will no longer be required to limit the deductibles for their plans. The repeal follows concerns that the limits would impair the ability to use High Deductible Health Plans (HDHP) with employer contributions into a Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or health Flexible Spending Account (FSA), since the Department of Health and Human Services (HHS) did not plan to decrease the deductible limits considering such employer contributions.

For more information regarding Public Law No. 113-93, go to:

http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf

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HIPAA SECURITY RISK ASSESSMENT TOOL NOW AVAILABLE

Recently, the Department of Health and Human Services (HHS) released an interactive Security Risk Assessment (SRA) Tool to assist those subject to HIPAA in performing the required HIPAA security risk assessment. The Office of the National Coordinator for Health Information Technology (ONC) within HHS developed this tool.

The HIPAA Security Rule requires most Covered Entities (including self-funded group health plans) and business associates of Covered Entities to conduct a thorough assessment of potential security risks in order to ensure the confidentiality, integrity and availability of electronic Protected Health Information (ePHI). The SRA Tool will assist plan sponsors of self-funded plans to download and use the tool to run the required Security Risk Assessment free of charge. The Security Risk Assessment contains 156 questions addressing administrative, technical and physical safeguards. An explanation of potential risks, definitions and examples are also included in the SRA Tool.

Action Required

Employers sponsoring a self-funded plan (including Flexible Spending Accounts (FSA), Employee Assistance Programs (EAP), Health Reimbursement Arrangements (HRA) and self-funded medical and dental plans) are required to be HIPAA compliant. Step one of HIPAA compliance is to conduct a risk assessment. Barney & Barney has available a HIPAA Guidance Manual. This manual includes a risk assessment. If your company has already conducted this risk assessment, a new one is not required. The SRA Tool is another option for conducting the risk assessment with many examples and helpful guidance throughout the risk assessment. Please consult with your legal counsel regarding all HIPAA and other security requirements applicable to your plans.

For more information regarding the SRA Tool, go to:

http://www.healthit.gov/providers-professionals/security-risk-assessment-tool

GUIDANCE RELEASED ON CORRECTING CERTAIN HEALTH FLEXIBLE SPENDING ACCOUNT ERRORS

Recently, the Internal Revenue Service (IRS) released a Chief Counsel Advice Memorandum that provides **informal guidance** on how to correct errors relating to health Flexible Spending Account (FSA) payments for unsubstantiated expenses or improper payments later deemed an ineligible expense. Although the written advice contained in the memo cannot be cited or used as precedent, it offers helpful insight into how the IRS would treat certain situations. Highlights from the memo are as follows:

- Permissible Debit Card Corrections
  1) Deactivate the card
  2) Demand repayment
  3) Withhold the payment from compensation (to the extent allowed by law)
  4) Apply a claims substitution or offset, and
  5) Treat the payment as any other business indebtedness (i.e., take the same steps the employer would take to collect an equivalent business debt)
- A Third Party Administrator (TPA) may apply corrective procedures on behalf of the plan sponsor
- Corrective procedures may be in any order so long as applied consistently, with the exception of 5 which must be applied only after the employer has pursued all other correction methods
- Treating an improper payment as uncollectible should be rare and not part of the routine process

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Guidance Released on Correcting Certain Health Flexible Spending Account Errors (Continued)

- Procedures 2-4 should be used in the plan year in which the improper payment was made. When not possible, proceed to procedure 5
- When using procedure 5 the employer must first request payment consistent with its collection procedures for all other business debts. If payment is not recovered, the debt may be forgiven and the payment may be reported as wages on the employee's Form W-2 (subject to income tax, FUTA and FICA withholdings) for the year in which the payment was made and subsequently forgiven

No Action Required

Employers should be aware of the rules for correcting health FSA payments where the payment was improper or unsubstantiated, in order to properly address the error.

For more information regarding the IRS Chief Counsel Advice Memorandum, go to:

http://www.irs.gov/pub/irs-wd/1413006.pdf

EXPATRIATE PLANS PROVIDED SOME RELIEF FROM HEALTH INSURER FEES

Recently, the Internal Revenue Service (IRS) released IRS Notice 2014-24 (scheduled to be published formally on April 14, 2014) which provides a temporary safe harbor for some expatriate health insurance plans. For the 2014 and 2015 plan years, the health insurer fee for direct premiums written for expatriate plans will be reduced by 50% when reporting to the IRS the total direct premiums written. The health insurer fee became effective for the 2014 year and imposes a fee on health insurers using a calculation that considers the total premiums paid to the carrier. A carrier with a larger market share will pay a higher fee.

Keep in mind, previous guidance provides that expatriate plans are not required to comply with ACA requirements prior to 2016 as long as they comply with applicable federal health plan mandates pre-ACA, ERISA, IRC and other applicable law. In addition, an expatriate plan will be considered Minimum Essential Coverage (MEC) for purposes of the individual mandate and the employer mandate.

For purposes of this temporary transitional relief, the Expat Frequently Asked Questions (FAQ) defines an expatriate health plan as "an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage." The Expat FAQ confirms that the definition of expatriate health coverage also applies for purposes of the Health Insurer Issuer Standards related to the Transitional Reinsurance Program of 45 CFR 153.400(a)(1)(iii) for plans with plan years ending on or before December 31, 2015.

No Action Required

Employers with employees outside of the country for which an expatriate plan is provided should be aware of the expatriate plan ACA rules. Employers are encouraged to work with their expatriate plan provider to review compliance with the ACA, where required, as well as discuss any health insurer fees their plans may be subject to.

For more information regarding IRS Notice 2014-24, please go to:

http://www.irs.gov/pub/irs-drop/n-14-24.pdf

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BAY AREA EMPLOYERS MUST SOON OFFER EMPLOYEES A COMMUTER BENEFIT PLAN

Bay Area employers with 50 or more full-time employees in the jurisdiction of the Metropolitan Air District (listed below) are now required to register for the Bay Area Commuter Benefits Program. Through this program, employers must offer their employees one of the four Commuter Benefit options listed below in order to comply with CA Senate Bill 1339, signed into law in October 2012 with regulations effective March 26, 2014.

- Option 1 — allow employees to exclude their transit or vanpool costs from taxable income, to the maximum amount, as allowed by federal law (currently $130 per month) pursuant to Internal Revenue Code (IRC) 132(f)
- Option 2 — employer-provided transit or vanpool subsidy up to $75 per month
- Option 3 — employer-provided free or low cost bus, shuttle or vanpool service operated by or for the employer
- Option 4 — an alternative employer-provided commuter benefit that is as effective in reducing single occupant vehicles as options 1-3

Bay Area counties subject to the mandate include:

- Alameda County, Contra Costa County, Marin County, Napa County, San Francisco County, San Mateo County, Santa Clara County, Solano County, and Sonoma County

In addition to offering a commuter benefit, employers must:

- Designate a commuter benefits coordinator (typically an employee already handling payroll/benefits)
- Submit an online registration form to the Air District/ Metropolitan Transportation Commission (MTC) and update their registration information on an annual basis
- Notify employees of the commuter benefit option and make that option available
- Maintain records to document implementation of the commuter benefit

Employers may also be requested to provide information by the Air District/MTC for program evaluation purposes.

The commuter benefits program must be offered to employees who work at least 20 hours per week. Seasonal or temporary employees working 120 or fewer days are not included. The employee count for purposes of application of the mandate to the employer is based on 50 or more employees for all Bay Area worksites combined.

Action Required

Employers with employees working in any of the nine-counties listed above must implement commuter benefits by September 30, 2014. Employers are not required to contribute to an employee's commuter benefit but must offer one of the options listed above. The employer must register their plan with 511.org in order to report and verify compliance with this mandate.

For more information regarding the Bay Area Commuter Mandate, please go to:

https://commuterbenefits.511.org/#options; and, https://commuterbenefits.511.org/docs/employer_guide.pdf

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IRS RELEASES MEMORANDUM ON HEALTH FSAs AND CONTRIBUTIONS TO HSAs

Background

- Only "eligible individuals" may contribute to a Health Savings Account (HSA). An eligible individual is defined as an individual who, in addition to other requirements, is covered under a High Deductible Health Plan (HDHP), and who is **not** covered under "other coverage" that is a non-HDHP that provides coverage for a benefit covered under the HDHP
- A health Flexible Spending Account (FSA) that reimburses qualified medical expenses without other restrictions (i.e., general purpose health FSA) is considered "other coverage" and therefore a health plan that would make an individual ineligible to contribute to an HSA
- Notice 2013-71 permits cafeteria plans to provide for the use of up to $500 of any unused amount remaining in an individual's health FSA, to be carried over to the following year

Flexible Spending Accounts and Health Savings Accounts: Frequently Asked Questions (FAQs)

On March 28, 2014, the Internal Revenue Service (IRS) released a Memorandum detailing the interaction between FSAs, FSA carryovers, and HSA contributions. The informal guidance was released in an FAQ format, and the below FAQs are merely a summary of the unofficial guidance. **Note: This advice may not be considered precedent and, therefore, is not considered official guidance**. **Use of the following FAQs should be done with caution.**

Question 1

May an otherwise eligible individual contribute to an HSA if he/she participates in a general purpose health FSA that is solely funded with carryover funds from the previous year?

Answer 1

No. An individual who participates in a general purpose health FSA is not an eligible individual that can contribute to an HSA. This includes an individual who participates in a general purpose health FSA that is purely funded with carryover funds.

Question 2

May an otherwise eligible individual contribute to an HSA if he/she has fully exhausted all of the FSA funds (including carryover amounts) in their general purpose health FSA, prior to the end of the plan year?

Answer 2

No. An individual who participates in a general purpose health FSA is not an eligible individual that can contribute to an HSA. This includes an individual who no longer has amounts in their general purpose health FSA to pay or reimburse his/her medical expenses.

Question 3

May an individual who participates in a general purpose health FSA have funds carryover to an HSA compatible health FSA (e.g., limited purpose health FSA, a post-deductible health FSA, or a combination of both) in the following plan year?

Answer 3

Yes. An individual who participates in a general purpose health FSA may elect to have any unused amounts carried over to the HSA compatible health FSA in the following year. However, the carryover amounts may not be carried over to a **non-health** FSA or another type of cafeteria plan benefit.

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IRS Releases Memorandum on Health FSAs and Contributions to HSAs (Continued)

Flexible Spending Accounts and Health Savings Accounts: Frequently Asked Questions (FAQs) (Continued)

Question 4

May an otherwise eligible individual contribute to an HSA in the current year if he/she has carried over funds from a prior year general purpose health FSA to a current year HSA compatible health FSA (e.g., limited purpose health FSA, a post-deductible health FSA, or a combination of both)?

Answer 4

Yes. An individual who is otherwise eligible to participate in an HSA may contribute to an HSA in the current year, so long as amounts carried over from a prior year general purpose health FSA are carried over to an HSA compatible health FSA in the current year.

Question 5

May a cafeteria plan that offers both a general purpose health FSA and an HSA compatible health FSA automatically convert carry-over amounts from a previous general purpose health FSA to an HSA compatible health FSA upon an individual's enrollment into an HDHP for the following year?

Answer 5

Yes. A cafeteria plan that offers both types of health FSAs (general purpose and HSA compatible) may automatically convert a general purpose health FSA into an HSA compatible health FSA upon an individual's enrollment into a HDHP.

Question 6

If a cafeteria plan provides that individuals who participate in a general purpose health FSA have the ability to decline the carryover to the following year, may an individual who declines the carryover contribute to an HSA in the following plan year?

Answer 6

Yes. An individual who declines the carryover from a general purpose health FSA has the ability to contribute to an HSA in the following plan year.

Question 7

If an individual elects to carry-over unused amounts from a general purpose health FSA to an HSA-compatible health FSA, how do the uniform coverage rules (maximum reimbursement at the beginning of the plan year) impact the annual run-out period of the general purpose health FSA?

Answer 7

The uniform coverage rules may be applied in the following manner:

During the run-out period of the general purpose health FSA, any unused amounts in it may be used to reimburse any expenses that were incurred during that plan year. Thereafter, any claims incurred in the following year, which are covered by the HSA- compatible health FSA, must be timely reimbursed up to the amount elected. Any claims that are in excess of the amount elected would be reimbursed after the run-out period, from the carry-over amounts.

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IRS Releases Memorandum on Health FSAs and Contributions to HSAs (Continued)

Flexible Spending Accounts and Health Savings Accounts: Frequently Asked Questions (FAQs) (Continued)

Answer 7 (Continued)

Example: Employer A offers a calendar year general purpose health FSA, along with a calendar year HSA-compatible health FSA plan. Both FSAs provide for a carryover of $500, and do not have a grace period. Employee B has an unused amount of $600 remaining in her general purpose health FSA on December 31 of Year 1. Employee B elects the maximum amount of $2,500 to be contributed to her HSA compatible health FSA for Year 2, in addition to electing the carryover amount from Year 1. On January 15 of Year 2, Employee B submits $2,700 of expenses for dental work incurred on January 10 of Year 2. The HSA-compatible health FSA reimburses $2,500 to Employee B (her elected amount), for the dental expenses incurred in Year 2. On February 15 of Year 2, Employee B submits expenses in the amount of $300, seeking reimbursement from the general purpose health FSA established in Year 1. Since Employee B still had $600 remaining in her general purpose health FSA from Year 1, the $300 of general medical expense incurred in Year 1 and submitted on February 15 of Year 2, reduced the $600 amount to only $300 remaining to be carried over to Year 2. That $300 carryover balance from Year 1, would be used to reimburse the remaining balance for Employee B's dental work incurred on January 10 of Year 2, for any amounts greater than the $2,500 she was already reimbursed. Therefore, since the difference between the amount incurred for dental work on January 15 of Year 2 ($2,700) and the amount reimbursed to Employee B already from the HSA-compatible health FSA ($2,500) was $200, this would reduce the $300 dollar carryover from the general purpose health FSA in Year 1 to a $100 carryover to Year 2 ($300 carryover - $200 remaining dental balance = $100 carryover into Year 2). Also, Employee B could contribute to her HSA as of January 1 of Year 2.

Action Required

Although this is informal guidance from the IRS, employers with general purpose health FSAs, HSA-compatible FSAs, and HSAs should consult with their legal counsel regarding this informal guidance and implement a strategy, taking into consideration the above FAQs.

For more information regarding the informal guidance contained in the IRS Memorandum, go to:

http://www.irs.gov/pub/irs-wd/1413005.pdf

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QUESTION OF THE MONTH

Q1: Our company maintains both a medical plan and an employee assistance program (EAP). One of the EAP benefits is a limited number of mental health or substance use disorder counseling sessions. Can we design our medical plan so that participants must exhaust these EAP counseling sessions in order to receive mental health or substance use disorder benefits under the medical plan?

A1: Assuming your medical plan is subject to the federal mental health parity rules, the design you propose is not allowed unless the medical plan has a comparable exhaustion requirement for medical/surgical benefits. By way of background, if a group health plan that provides medical/surgical benefits also provides either mental health or substance use disorder benefits, the plan generally will be subject to mental health parity requirements under the federal Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA). One of these requirements is parity as to "non-quantitative treatment limitations," which are limits on the scope or duration of treatment that are not expressed numerically. More specifically, under the terms of the plan (as written and operated), any processes, strategies, evidentiary standards, or other factors used to apply a non-quantitative treatment limitation to mental health or substance use disorder benefits must be comparable to (and applied no more stringently than) the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical surgical/benefits.

Requiring participants to exhaust their EAP counseling benefits before being eligible for mental health or substance use disorder benefits under the medical plan—which would effectively make the EAP a gatekeeper—is a non-quantitative treatment limitation subject to the parity requirements. (This limitation is non-quantitative because the medical plan is not imposing a quantity limit by requiring the limited number of EAP sessions be used first.) Consequently, if gatekeeping processes with similar exhaustion requirements (whether or not involving the EAP) are not applied to medical/surgical benefits in your medical plan, the requirement to exhaust EAP counseling benefits would violate the rule that non-quantitative treatment limitations must be applied comparably to mental health and substance use disorder benefits.

Source: EBIA Thomson Reuters

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