Tikia Consulting Group, Inc.
Employee Benefits

Newsletter

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As we approach mid-year, we need to be cognizant of the ACA deadlines and regulations that impact employers for not only 2014 but also 2015 and 2016. Examples are the "look-back provision", Cadillac plans, Transitional Reinsurance/PCORI fees, compliance with Wrap documents, FSA, HSA and COBRA regulations.

In This Issue:

"It is amazing what you can accomplish if you do not care who gets the credit."
- Harry Truman

Congress Eliminates Cap on Deductibles

The deductible cap for small group health plans under the Affordable Care Act has been permanently removed. Originally, the Affordable Care Act (ACA) had a provision that capped the deductible for individual and small group health plans at $2,000 for individuals and $4,000 for families. Last year, when it became evident that it would be difficult for many plans to comply with this requirement, the Health and Human Services Department issued a waiver for 2014. Now, through a bipartisan effort, this provision has been eliminated entirely in an effort to help issuers design plans that work well for small business owners. It also allows small businesses to continue trending towards High-Deductible Health Plans coupled with Health Savings Accounts. However, there are many other plan design requirements delineated in the ACA that still apply to small employers, including the limit on out-of-pocket maximums for essential health benefits.

Marketplace Enrollment – Special Enrollment Period

Now that the first Open Enrollment period has ended, coverage will only be allowed before the next open enrollment beginning November 15, 2014, or if you have a qualifying life event or a complex situation related to applying in the Marketplace.

Examples of qualifying life events:

- Marriage
- Birth of a Child
- Child Adoption
- Moving outside your insurer's coverage area
- Losing other health coverage—due to losing job-based coverage, divorce, the end of an individual policy plan year in 2014, COBRA expiration, aging off a parent's plan, losing eligibility for Medicaid or CHIP, and similar circumstances.
- Gaining citizenship
- Release from incarceration
- Gaining status as member of an Indian tribe.
- Having a change in income or household status that affects eligibility for premium tax credits or cost-sharing reductions ***only*** if you already enrolled in Marketplace coverage

If you voluntarily end coverage or if you lose coverage because your current plan does not qualify as minimum essential coverage, you are not eligible for the Special Enrollment Period.

New Model COBRA Forms Available

The Department of Labor (DOL) has proposed new regulations that would revise the COBRA requirements in an effort to increase visibility of the options available in the Health Insurance Marketplace. While the proposed regulations will only become effective after a comment period and final review, the DOL has already released an amended Model General Notice and a revised Model Election Notice. The updated forms contain more information than the previous documents regarding the Health Insurance Marketplace including a statement that insurance coverage through the exchange may be less expensive than COBRA coverage and that COBRA-eligible individuals may qualify for a special enrollment period under the parameters of the exchange.

Q: As an employer, what can I do to stop employees from using e-cigarettes in the office? Is there a law against this activity?

A: Electronic cigarettes and other vapor products have been on the rise in the past several years. While there is continued debate regarding the safety of vapor products, no federal law prohibiting the use of e-cigarettes or vapor products has been passed to date. Some municipalities have passed laws prohibiting the use of vapor products indoors or common areas.

That said, if you would like to prohibit your employees from using vapor products or smoking e-cigarettes in the workplace, we recommend that you update your non-smoking policy to include these products and enforce the policy in a non-discriminatory and consistent manner.

"Invalid Contribution" Rollovers (Retirement Plan)

Recently the IRS issued Revenue Ruling 2014-9 which gives guidance on how "Invalid Contributions" to a Qualified Plan should be treated. The ruling builds on the concept to "reasonably conclude" that the contribution is a valid rollover contribution at the time of acceptance into the plan.

There are several steps for the Plan Administrator (commonly the employer) to use to satisfy the "reasonably conclude" requirement:

- The most recent Form 5500 for the plan that is transferring the funds should be reviewed to verify the plan administrator's certification that the transferring plan is a qualified retirement plan;
- The rollover check which is issued should be reviewed to be sure of the accuracy of the transfer-in plan name as well as the indication of "For The Benefit Of" employee name;
- Review any evidence that may contradict the treatment of the rollover as being rollover eligible

If the administrator of the accepting plan determines that the rollover should be considered invalid, it must distribute the invalid amount, plus any earnings, to the employee. This distribution of the invalid amount must occur within a reasonable time frame following the determination.

With these new guidelines, employers should consider a review of its rollover forms and procedures to ensure that these steps are currently being followed by the plan's record keeper. A review of the actual forms and procedures, along with any administrative service agreement with the plan's record keeper should also be undertaken. It is suggested that this project should be with the assistance of legal counsel and any other advisors to the plan.

How does FSA carryover affect eligibility for HSA's

Recently, the IRS issued guidance on how the issue of FSA carryovers will affect the eligibility for an HSA.

1. Individuals covered by a health FSA that pays or reimburses all qualified medical expenses may not contribute to an HSA. This also includes an individual who has coverage solely as the result of a carryover of unused funds from the prior year.

2. Individuals covered by a health FSA that pays or reimburses all qualified medical expenses may not contribute to an HSA during the entire plan year of the health FSA. Further, an individual covered by a health FSA solely as the result of a carryover of unused funds may not contribute to an HSA, even after the health FSA is completely used.

3. When participating in both a health FSA and an HSA-compatible health FSA, an individual may carry over to the HSA-compatible health FSA any unused health FSA funds. Conversely, the carryover may not be transferred to a non-health FSA or other type of cafeteria plan.

4. Participants in both a health FSA and an HSA-compatible health FSA—with unused health FSA funds carried over to the HSA-compatible health FSA—may contribute to an HSA the following year.

5. If a cafeteria plan offers both a health FSA and an HSA-compatible health FSA, an individual with coverage in an HDHP (a) may be automatically enrolled in the HSA-compatible health FSA, and (b) may carry over any unused health FSA funds to the HSA-compatible health FSA.

6. If you participate in a health FSA that provides for a carryover of unused funds, you may decline or waive the carryover for the following year. If you waive the carryover, you may contribute to an HSA during the following year.

7. When an individual carries over unused health FSA funds to a HSA-compatible health FSA, the uniform coverage rules may be applied during the run-out period, as follows: ***(a)*** During run-out, the unused health FSA funds may be used to reimburse any allowed Sec. 213(d) medical expenses incurred prior to the end of the plan year. ***(b)*** Any claims covered by the HSA-compatible health FSA must be (timely) reimbursed up to the amount elected for the HSA-compatible health FSA plan year. ***(c)*** Any claims exceeding the elected amount may be reimbursed after the run-out period (at which time the amount of any carryover is determined).

IRS announces 2015 HSA limits

Maximum contributions to health savings accounts will jump slightly next year, the Internal Revenue Service announced. It will increase by $50 for individuals and $100 for families.

The agency announced that the maximum 2015 HSA contribution will be $3,350 for individuals with self-only coverage, up from $3,300 this year. For those with family coverage, the maximum contribution will be $6,650, up from $6,550.

HSA contribution limits are updated annually to reflect cost-of-living adjustments.

The annual limitation on deductions for an individual with family coverage under a high-deductible health plan will be $6,650 for 2015.

The maximum out-of-pocket employee expense will increase next year to $6,450 for single coverage from $6,350, and to $12,900, from $12,700, for family coverage.

The increases are detailed in Revenue Procedure 2014-30, and take effect in January.

Source: BenefitsPro

Did You Know?

It is estimated that an average employee working in the U.S. spends 53 working hours resolving family-related matters. This staggering figure supports the reasoning behind employer-sponsored Employee Assistance Programs (EAPs). Such programs help employees effectively manage their personal matters as well as boost workplace productivity. EAPs are relatively inexpensive to administer and provide employees with a variety of valuable benefits. All contact made between an employee and an EAP is strictly confidential.

Employer Health Care Arrangements

On May 13th, the IRS issued a set of Frequently Asked Questions (FAQs) addressing the subject of Employer Health Care Arrangements. Although brief, this latest publication – in particular the entry below – seems to have sparked quite a buzz in the marketplace:

Q1. What are the consequences to the employer if the employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance (either through a qualified health plan in the Marketplace or outside the Marketplace)?

Under IRS Notice 2013-54, such arrangements are described as employer payment plans. An employer payment plan, as the term is used in this notice, generally does not include an arrangement under which an employee may have an after-tax amount applied toward health coverage or take that amount in cash compensation. As explained in Notice 2013-54, these employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits and the requirement to provide certain preventive care without cost sharing. Notice 2013-54 clarifies that such arrangements cannot be integrated with individual policies to satisfy the market reforms. Consequently, such an arrangement fails to satisfy the market reforms and may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee) under section 4980D of the Internal Revenue Code.

Q2. Where can I get more information?

On Sept. 13, 2013, the IRS issued Notice 2013-54, which explains how the Affordable Care Act's market reforms apply to certain types of group health plans, including health reimbursement arrangements (HRAs), health flexible spending arrangements (health FSAs) and certain other employer healthcare arrangements, including arrangements under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy.

DOL has issued a notice in substantially identical form to Notice 2013-54, DOL Technical Release 2013-03, and HHS will shortly issue guidance to reflect that it concurs with Notice 2013-54. On Jan. 24, 2013, DOL and HHS issued FAQs that addressed the application of the Affordable Care Act to HRAs.

Source: TASC©

Remember ...

The deadline for submitting **PCORI Fees** is July 31, 2014

Dependent Definition Defined

To be compliant with the Affordable Care Act's employer "shared responsibility" provisions, large employers (currently defined as having 50 or more full-time employees) are mandated to offer their full-time employees and their dependents with affordable health coverage.

For insurance purposes, "Dependents" are defined as an employee's natural or adopted children under age 26. This definition excludes foster children, stepchildren and children who are not U.S. citizens.

Employers have the freedom to allow employees to cover their residential stepchildren and foster children so long as they are income tax dependents and it would not result in duplicative coverage. Legally, they can also decide to exclude them without the fear of potential "pay-or-play" penalties.

Because foster children typically are covered by government agencies and stepchildren's biological parents typically include them under their own employer's group health coverage, there would be no reason for these dependent individuals to be without health coverage.

Employers that do not currently have group plans that offer 1) dependent coverage, 2) dependent coverage that meets the minimum essential coverage, or 3) dependent coverage for adopted children, have until their 2016 plan year to expand their group health plan and should begin taking steps to expand their coverage in their 2015 plan year.

Qualified Retirement Plans Must Recognize Same-Sex Marriages Retroactively to June 26, 2013

The IRS has recently issued guidance on how qualified retirement plans (such as 401K plans, profit sharing plans, defined benefit pension plans and 403B plans) should apply the Supreme Court's 2013 Windsor decision, which ruled that same-sex marriages must be recognized for all federal tax purposes. While the IRS had already issued guidance indicating that all qualified retirement plans would need to prospectively recognize all same-sex marriages, it had not addressed whether plans would need to be retroactively amended to either the date of the Windsor ruling or to another date. This guidance clarifies that qualified retirement plans that have sections that would not comply with the Windsor ruling (for example, plans that refer to opposite-sex couples) must be retroactively amended to recognize same-sex spouses effective June 26, 2013. The deadline to adopt a plan amendment to this effect is the later of: 1) December 31, 2014 or 2) the cyclical remedial plan amendment period under section 5.05 of Rev. Proc. 2007-44.

Does My Coverage Meet the Minimum Value Standard?

The Affordable Care Act (ACA) establishes a minimum value (MV) standard of benefits, which is 60% (actuarial value).

The MV standard is important to determine because individuals are not eligible for a subsidy in the Health Insurance Marketplace if they are eligible under an affordable employer sponsored plan that meets MV.

Do note that, under the employer mandate, employers who do not offer an affordable plan option that meets MV may be subject to a penalty fee beginning in 2015.

How do you determine if your coverage meets MV standards?

The U.S. Department of Health and Human Services has created a minimum value calculator that you can use. You simply enter your plan information into the calculator and it will assist you in determining if the plan covers at least 60% of the total allowed costs of benefits, thus meeting the MV standard.

We hope that you find the information presented helpful, and we welcome any feedback.

Please feel free to visit our website at www.tikiaconsultinggroup.com and provide us with comments.

Thank you!