TIKIA CONSULTING GROUP, INC.
EMPLOYEE BENEFITS

HEALTH FSAS AND HRAS UNDER THE AFFORDABLE CARE ACT

PENALTIES INCREASED FOR VIOLATIONS OF HIPAA'S ADMINISTRATIVE SIMPLIFICATION RULES

IRS RELEASES FINAL 2016 FORMS 1094 AND 1095

HEALTHCARE ALERT

Understanding the Rules on Health FSAs Under the Affordable Care Act

Health FSAs Exempt From Market Reforms Under Certain Circumstances

A health flexible spending arrangement (health FSA) is a popular benefit that employers offer to reimburse employees for certain medical expenses. As part of the implementation of the Affordable Care Act (ACA), new rules apply to health FSAs. The summary

In general, a health FSA is designed to reimburse employees for qualified medical care expenses (other than premiums).

below is intended to help employers understand these new rules and remain compliant with the ACA.

Health FSAs Explained
In general, a health FSA is a benefit designed to reimburse employees for qualified medical care expenses **(other than premiums)** incurred by the employee, or the employee's spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27. Contributions to a health FSA offered through a section 125 cafeteria plan do not result in gross income to the employee. Employees electing coverage under a health FSA typically choose to enter into a salary reduction agreement in order to make contributions to the health FSA. For taxable years beginning in 2016, salary reduction contributions to a health FSA are limited to **$2,550.**

In general, health FSAs are considered group health plans under the ACA, and thus are subject to the ACA market reforms explained below.

ACA Market Reforms
The ACA contains certain market reforms that apply to group health plans, including

- **Annual Dollar Limit Prohibition:** A prohibition on any annual limit on the dollar amount of benefits for any individual; and
- **Preventative Services Requirement:** A requirement that non-grandfathered plans provide certain preventative services without imposing any cost-sharing requirements for these services.

These market reforms, however, do not apply to a group health plan **in relation to its provision of "excepted benefits".** Excepted benefits include, among other things, accident only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and **certain health FSAs.**

Health FSAs as "Excepted Benefits"
Although a health FSA is generally considered a group health plan, a health FSA may be considered to provide **only** excepted benefits if:

- Other group health plan coverage not limited to excepted benefits is made available for the year to employees by the employer; and

The ACA contains certain "market reforms" that apply to group health plans, including the **Annual Dollar Limit Prohibition** and the **Preventative Services Requirement.**

- The health FSA is structured so that the maximum benefit payable to any participant cannot exceed **two times** the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed **$500 plus the amount of the participant's salary reduction election**).

If an employer provides a health FSA that does not qualify as excepted benefits, the health FSA is generally subject to market reforms. Furthermore, a health FSA that is **not offered through a section 125 cafeteria plan** is subject to the annual dollar limit prohibition and **will fail to comply with the annual dollar limit prohibition.**

For more information on the ACA rules that apply to health FSAs, please read IRS Notice 2013-54.

Understanding the Rules on HRAs Under the Affordable Care Act

HRAs Satisfy Market Reforms Under Certain Circumstances
A health reimbursement arrangement (HRA) is a popular benefit that employers offer to reimburse employees for certain medical expenses. As part of the implementation of the Affordable Care Act (ACA), new rules apply to HRAs. The summary below is intended to help employers understand these new rules and remain compliant with the ACA.

HRAs Explained
An HRA is an arrangement that is **funded solely by an employer** and that reimburses an employee for qualified medical care expenses incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. This reimbursement is excludable from the employee's income, and amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. In general, **HRAs are considered to be group health plans under the ACA.**

ACA Market Reforms
The ACA contains certain "market reforms" that apply to group health plans, including the:

- **Annual Dollar Limit Prohibition:** A prohibition on any annual limit on the dollar amount of benefits for any individual; and
- **Preventative Services Requirement:** A requirement that non-grandfathered plans provide certain preventative services without imposing any cost-sharing requirements for these services.

Application of the Market Reforms to HRAs
In order to comply with the ACA market reforms, an HRA must be **"integrated"** with other coverage **as part of a group health plan** that alone complies with the market reforms. An HRA is integrated with a group health plan for purposes of the market

reforms if it meets the requirements under one of two integration methods. Under the first method, the market reforms are satisfied if:

- The employer offers a group health plan (other than the HRA) to the employee that **does not consist solely of excepted benefits** (such as limited-scope dental and vision benefits);
- The employee receiving the HRA is **actually enrolled** in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage);
- The HRA is available **only to employees who are enrolled in non-HRA group coverage**, regardless of whether the employer sponsors the non-HRA group coverage;
- The HRA is **limited to reimbursement** of one or more of the following - copayments, coinsurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute essential health benefits; and
- Under the terms of the HRA, an employee (or former employee) is **permitted to permanently opt out of and waive future reimbursements** from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

Alternatively, the market reforms are also satisfied if:

- The employer offers a group health plan to the employee that provides minimum value (MV);
- The employee receiving the HRA is **actually enrolled** in a group health plan that provides minimum value, regardless of whether the employer sponsors the plan (non-HRA MV group coverage);
- The HRA is available **only to employees who are actually enrolled in non-HRA MV group coverage**, regardless of whether the employer sponsors the non-HRA MV group coverage; and
- Under the terms of the HRA, an employee (or former employee) is permitted to **permanently opt out of and waive future reimbursements** from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

Note: A group health plan, **including an HRA**, used to purchase coverage on the individual market is **not integrated** with that individual market coverage for purposes of the market reforms.

For more information on the ACA rules that apply to HRAs, please read IRS Notices 2013-54 and 2015-87.

Penalties Increased for Violations of HIPAA's Administrative Simplification Rules

Increases Generally Apply to Civil Penalties Assessed After August 1, 2016
The US Department of Health and Human Services (HHS) has published an interim final rule adjusting for inflation the **civil monetary penalties** assessed for violations of the Administrative Simplification Rules under the Health Insurance Portability and Accountability Act (HIPAA). The increases generally apply to civil penalties assessed **after August 1, 2016**, whose associated violations occurred after November 2, 2015.

Background
HIPAA requires national standards to be established for electronic health care transactions, as well as "code sets", unique health identifiers, and security. These standards - called the **Administrative Simplification Rules** - apply to health care providers, clearinghouses, and covered health plans with **50 or more participants** that are **not self-administered.**

Increased Penalties
The interim final rule imposes the following penalty increases for violations of the Administrative Simplification Rules:

- For a covered entity that **did not know** of the violation and, by exercising reasonable diligence, would not have known of the violation, the minimum penalty is **$110** per violation (formerly $100);
- For a violation **due to reasonable cause and not willful neglect**, the minimum penalty is **$1,100** per violation (formerly $1,000);
- For a violation due to **willful neglect and corrected during the 30-day period** beginning on the first date the covered entity or business associate knew, or, by exercising reasonable diligence, would have known that the violation occurred, the minimum penalty is **$11,002** per violation (formerly $10,000); and
- For a violation due to **willful neglect and not corrected during the 30-day period** beginning on the first date the covered entity or business associate knew, or by exercising reasonable diligence would have known that the violation occurred, the minimum penalty is **$55,010** per violation (formerly $50,000).

Violations occurring on or before November 2, 2015, and assessments made prior to August 1, 2016, whose associated violations occurred after November 2, 2015, will

continue to be subject to the civil monetary penalty amounts set forth in existing regulations or statues if the amount has not yet been adjusted by regulation.

Note: HHS is expected to publish annual adjustments to these penalties not later than January 15 of every year.

Click here to read the interim final rule in its entirety.

Open Enrollment for 2017 Individual Marketplace Coverage Begins November 1

Six Special Enrollment Periods Available Outside of Open Enrollment
Open enrollment for 2017 health plans on the Individual Health Insurance Exchange (Marketplace) begins **November 1, 2016** and ends **January 31, 2017.** After that date, an individual can enroll or change plans **only** if he or she qualifies for a Special Enrollment Period. Please note that the last day to enroll in or change plans for coverage to start January 1, 2017 is **December 15, 2016.**

Special Enrollment Periods
Federal agencies previously announced that Special Enrollment Periods for the Individual Marketplace are limited to **six defined types of circumstances:**
1. Loss of other qualifying coverage (eg, employer-based coverage);
2. Change in household size (eg, due to marriage or birth);
3. Change in residency (Note: Beginning July 2016, individuals requesting a Special Enrollment Period as a result of a change in his or her residence generally must have minimum essential coverage for **one or more days in the 60 days preceding the change in residence**);
4. Change in eligibility for Marketplace coverage or for financial help to purchase such coverage;
5. Enrollment errors made by the Marketplace or a health plan; or
6. Other special circumstances which apply to, among others, victims of domestic abuse or natural disasters.

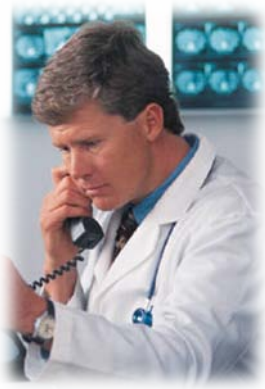
For information on how to enroll in the Individual Marketplace, please visit HealthCare.gov.

Understanding the Rules on "Employer Payment Plans" Under the Affordable Care Act

"Employer Payment Plans" Violate Market Reforms
An employer payment plan is an arrangement under which an employer reimburses an employee for **some or all of the premium expenses** incurred for an individual health insurance policy or uses its funds to **directly pay the premium** for an individual health insurance policy covering the employee. As part of the implementation of the Affordable Care Act (ACA), new rules apply to employer payment plans. The summary below is intended to help employers understand these new rules and remain compliant with the ACA.

The ACA contains certain "market reforms" that apply to group health plans, including the:

- **Annual Dollar Limit Prohibition:** A prohibition on any annual limit on the dollar amount of benefits for an individual; and
- **Preventative Services Requirement:** A requirement that non-grandfathered plans provide certain preventative services without imposing any cost-sharing requirements for these services.



Application of the ACA Market Reforms to Employer Payment Plans
An arrangement under which an employer provides reimbursements or payments that are dedicated to providing medical care, such as cash reimbursements for the purchase of an individual market policy, is itself a group health plan under the ACA. Accordingly, **the arrangement is subject to the ACA market reforms without regard to whether the employer treats the money as pre-tax or post-tax to the employee.**

If a group health plan does not itself comply with the market reforms, the plan must be **integrated** with a group health plan that is in compliance. However, the Internal Revenue Service (IRS) has stated that **an employer payment plan cannot be integrated with an individual market policy to satisfy the market reforms.** Consequently, employer payment plans may be subject to an excise tax penalty of **$100 per day per applicable employee** ($36,500 per year, per employee) under the Internal Revenue Code.

Alternative to Employer Payment Plans
According to IRS Notice 2015-17, if an employer increases an employee's compensation, but **does not condition** the payment of the additional compensation on the purchase of health coverage (or otherwise endorse a particular policy, form, or issuer of health insurance), this arrangement is **not an employer payment plan.**

IRS Releases Final 2016 Forms 1094 and 1095

The Internal Revenue Service (IRS) has released the final forms and instructions for Forms 1094 and 1095 for calendar year 2016 reporting. **Employers are required to report in early 2017 for calendar year 2016.**

Who is Required to Report
Applicable large employers (ALEs) - generally those with **50 or more full-time employees**, including full-time equivalents (FTEs) - must use **Forms 1094-C and 1095-C** to report information to the IRS and to their full-time employees about their compliance with the employer shared responsibility provisions ("pay or play") and the health care coverage they have (or have not) offered in a calendar year. **Forms 1094-B and 1095-B** are used by insurers, self-insuring employers, and other parties that provide minimum essential health coverage (**regardless of size, except for large self-insuring employers**) to report information on this coverage to the IRS and to covered individuals.

Employers subject to **both** reporting provisions (generally **self-insured employers with 50 or more full-time employees**, including FTEs) will satisfy their reporting obligations using Forms 1094-C and 1095-C.

2016 Forms and Instructions
The following calendar year 2016 reporting forms and instructions are now available:

- Form 1094-C (transmittal)
- Form 1095-C
  - 2016 Instructions for Forms 1094-C and 1095-C
- Form 1094-B (transmittal)
- Form 1095-B
  - 2016 Instructions for Forms 1094-B and 1095-B

Information Reporting Deadlines
ALEs must furnish a Form 1095-C to each of its full-time employees by **January 31, 2017.** Forms 1094-C and 1095-C are also required to be filed with the IRS by **February 28, 2017** (or March 31, 2017, if filing electronically).

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