Health Reimbursements Arrangements are not for wimps!

Presented by Karen Kirkpatrick
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TODAY'S PRESENTER

Karen Kirkpatrick

- As owner of On Your Mark Consulting, Karen continues a long career of working with insurance brokers, CPAs, TPAs and employers helping them to understand complex regulations and create action items. Previously, she worked at Infinisource for 18 years where she gained a national reputation for being one of the foremost experts on HR Compliance, Payroll, COBRA, HIPAA, FMLA, Consumer Driven Health Plan Options, Health Care Reform and other benefit laws. During her career she has conducted thousands of seminars, webinars and executive briefings on numerous federal insurance laws, human resource compliance, consumer driven health care and health care reform. A nationally recognized speaker, Karen brings the audience intense payroll, HR or benefits (including ACA) regulations in an easy-to-understand format.

OVERVIEW

- *HRAs as they are lovingly called have undergone a major transformation over the last 6 years due to the ACA, but even a few years before that. With all the guidance coming out from different sources, it's hard to keep track let along stay compliant. One day you can use them to reimburse premiums. The next you're told you can't by the IRS, but there are still those in the marketplace that said you could. Then we had to modify how HRAs were "integrated" into our group health plans. Because if they weren't, you might be subject to a penalty for not offering Minimum Essential Coverage. Now in 2016, there are calculations to consider with HRAs regarding Affordability. While all of this "new" guidance is in effect, employers and their advisors are still trying to build compliant plan designs with HRAs, FSAs and HSAs, working together.*

Agenda

- Interplay with FSAs and HSAs
- What is Minimum Essential Coverage and Minimum Value
- Permissible HRAs
- Employer Payment Plans. Again….
- Form 8928
- MMSEA Section 111 HRA Reporting

What is Minimum Essential Coverage

Minimum essential coverage (MEC) is defined by the ACA as most group health plans offered by a large or small employer, or health coverage provided by the government. However, a plan consisting solely of “excepted benefits” is not MEC. (Excepted benefits are certain limited-scope health benefits that are exempt from many requirements under the ACA and HIPAA.) Additionally, guidance designates certain other plans as MEC, such as certain refugee medical assistance and Medicare advantage plans.

-Summary from the Leavitt Group

What is Minimum Value

MV is the 60% Actuarial Value and is met when a plan pays on average at least 60% of the actuarial value of allowed benefits under the plan.

-Summary from the Leavitt Group

Types of HRAs (permissible)

1. Integrated HRAs
   a) Minimum Value not required
   b) Minimum Value required
2. Spousal coverage reimbursement (spin off on Integrated discussion)
3. 2-percent shareholder-employee healthcare arrangement, and
4. Retiree-only reimbursement plans

Not discussed in the webinar is reimbursement related to Medicare and Tricare

Integrated HRAs

1. Minimum Value not required
   a) The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits
   b) 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);
   c) 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 (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse)
   d) The HRA is limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and under the non-HRA group coverage, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits; and
   e) Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out.

   Quick note: **If the HRA is limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and under the non-HRA group coverage, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits – then MV is not required in the non-HRA GHP**

Example 1 Facts

Example (Integration Method: Minimum Value Not Required)

Facts. Employer A sponsors a group health plan and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA group coverage through a family member. Employer A's HRA is limited to reimbursement of co-payments, co-insurance, deductibles, under Employer A's group health plan or other non-HRA group coverage (as applicable), as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Example

- Employer A employs Employee X. Employee X chooses to enroll in non-HRA group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o).
- Employee X attests to Employer A that he is covered by Employer B's non-HRA group coverage.
- When seeking reimbursement under Employer A's HRA, Employee X attests that the expense for which he seeks reimbursement is a co-payment, co-insurance, deductible, or premium under Employer B's non-HRA group coverage or medical care (as defined under Code § 213(d)) that is not an essential health benefit.

Integrated HRAs

2. Minimum Value required
   a) The employer offers a group health plan to the employee that provides minimum value
   b) The employee receiving the HRA is actually enrolled in a group health plan that provides minimum value
   c) The HRA is available only to employees who are actually enrolled in non-HRA MV group coverage, and
   d) Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out

Example 2 Facts

Example (Integration Method: Minimum Value Required)

Facts. Employer A sponsors a group health plan that provides minimum value and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA MV group coverage through a family member. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Example 2

- Employer A employs Employee X. Employee X chooses to enroll in non-HRA MV group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan.
- Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o).
- Employee X attests to Employer A that he is covered by Employer B's non-HRA MV group coverage and that the coverage provides minimum value

Some Relief for Certain Plans

- Notice 2015-87: Treasury and IRS will not treat an HRA available for the expenses of family members not enrolled in the employer's other group health plan for plan years beginning before January 1, 2016, as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2016, nor will they treat an HRA and group health plan that otherwise would be integrated based on the terms of the plan as of December 16, 2015 as failing to be integrated with an employer's other group health plan for plan years beginning before January 1, 2017, solely because the HRA covers expenses of one or more of an employee's family members even if those family members are not also enrolled in the employer's other group health plan.
- To be integrated with the employer's group health plan, however, the HRA must meet all the other requirements of the applicable guidance on integration with a group health plan.
- In addition, the employer will be responsible under § 6055 for reporting the coverage as minimum essential coverage for each individual the medical expenses for whom are reimbursable by the HRA who is not also enrolled in the employer's group health plan.

Exceptions to the Employer Payment Plan Prohibition

An HRA or employer payment plan that, by its terms, reimburses (or pays directly for) premiums for individual market coverage only if that individual market coverage covers only excepted benefits does not fail to comply with the market reforms solely due to the ability to reimburse the employer for that individual market coverage. The market reforms do not apply to a group health plan that is designed to provide solely excepted benefits.

Exceptions to the Employer Payment Plan Prohibition

Spousal Coverage Reimbursement HRAs:

This HRA allows for an employee to be reimbursed for coverage on their spouse's group health plan if that group health plan is ACA compliant.

Example: *The employer reimburses the difference of the cost between covering the employee only and covering herself and her spouse.*

1. *EE only cost is $50 per month.*
2. *EE + Spouse is $290 per month*
3. *Spouse's employer reimburses the $240 difference from the HRA. That is not taxable to the spouse as an employee.*
4. *The EE is paying the $290 pre-tax through a POP plan.*
5. *The employer of the SP is reimbursing them tax-free.*
6. *This is essentially a double tax-free benefit and the spouse's employer should alert their employee to the need to reconcile this at tax time so they don't have any issues.*

Exceptions to the Employer Payment Plan Prohibition

2-percent Shareholder-employee Healthcare Arrangement:

- An S corporation pays for or reimburses premiums for individual health insurance coverage covering a 2-percent shareholder
- Unless and until additional guidance provides otherwise, an S corporation with a 2-percent shareholder-employee healthcare arrangement will not be required to file IRS Form 8928

Exceptions to the Employer Payment Plan Prohibition

Retiree only HRAs:

IRS Notice 2015-17: An employer payment plan that has fewer than two participants who are current employees (for example, a retiree-only plan) on the first day of the plan year is not subject to the market reforms and, therefore, integration is not necessary to satisfy the market reforms.

Speaker's note supported by the IRS on multiple occasions*: All other employer payment plans that reimburse individual premiums either pre-tax or post-tax and reimburse for plans on or off the Marketplace do not meet market reforms per the IRS and would therefore not be compliant ACA plans. The entity that sponsors this type of arrangement would be liable for a 4980(d) excise tax and be required to self-report on IRS Form 8928.

*IRS Technical Release 2013-03, IRS Notice 2013-54, IRS Notice 2015-17,

November 6, 2014 ACA FAQ, March 4, 2016 FAQ

Affordability Determinations for HRAs

- Amounts made available for the current plan year under an HRA
  - That an employee may use to pay premiums for an eligible employer-sponsored plan, or
  - That an employee may use to pay premiums for an eligible employer-sponsored plan
  - May also be used for cost-sharing and/or for other health benefits not covered by that plan in addition to premiums, are counted toward the employee's required contribution
- The employee contribution for health coverage under the major medical group health plan offered by the employer is generally $200 per month. For the current plan year, the employer makes newly available $1,200 under an HRA that the employee may use.
- For purposes of § 4980H(b) and the related reporting under § 6056, the employee's required contribution for the major medical plan is $100 ($200 - $100) per month because 1/12 of the $1,200 HRA amount per month is taken into account as an employer contribution whether or not the employee uses the HRA.

ALE and 1095C Section III

- An ALE Member with a self-insured major medical plan and a health reimbursement arrangement (HRA) is required to report the coverage of an individual enrolled in both types of minimum essential coverage in Part III under only one of the arrangements.
- An ALE Member with an insured major medical plan and an HRA is not required to report in Part III HRA coverage of an individual if the individual is eligible for the HRA because the individual enrolled in the insured major medical plan.
- An ALE Member with an HRA must report coverage under the HRA in Part III for any individual who is not enrolled in a major medical plan of the ALE Member (for example if the individual is enrolled in a group health plan of another employer (such as spousal coverage)).

ALE and 1095C Section III

Part III **Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

ALE and 1095C Section III

- Penalties may be waived under § 6724(a) if the failure is due to reasonable cause and not willful neglect; that is, if a reporting entity demonstrates that it 5 acted in a responsible manner and that the failure is due to significant mitigating factors or events beyond the reporting entity's control.
- A reporting entity, acting in a responsible manner, will make considerable attempts to get a SSN or TIN from a participant. This is not required for someone who is now terminated; however, for active employees, the entity must make:
    1. An initial solicitation when an account is opened or a relationship is established,
    2. A first annual solicitation by December 31 of the year the account is opened (or January 31 if the account is opened in December), or
    3. A second annual solicitation by December 31 of the following year

Form 8928

- Form 8928 is the IRS form where entities that have not complied with certain requirements, including the ACA's reforms for group health plans. Essentially, Code Section 4980D imposes an excise tax for a group health plan's failure to comply with these requirements and this failure may trigger an excise tax of $100 per day per individual.
- If the IRS discovers a compliance failure in an audit, the excise tax is generally a minimum of $2,500. However, if the violations are significant, this could increase to $15,000. The maximum excise tax for unintentional failures is the lesser of 10% of the aggregate amount paid by the employer during the preceding tax year for group health plan coverage or $500,000.

Form **8928**
(Rev. December 2013)
Department of the Treasury
Internal Revenue Service

Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code

(Under sections 4980B, 4980D, 4980E, and 4980G)

► Information about Form 8928 and its separate instructions is at *www.irs.gov/form8928.*

OMB No. 1545-2148

Filer's tax year beginning , and ending ,

A	Name of filer (see instructions)	B Filer's employer identification number (EIN)
	Number, street, and room or suite no. (if a P.O. box, see instructions)	
	City or town, state or province, country, and ZIP or foreign postal code	E Plan sponsor's EIN
C	Name of plan	F Plan year ending (MM/DD/YYYY)
D	Name and address of plan sponsor	G Plan number

Part I Tax on Failure To Satisfy Continuation Coverage Requirements Under Section 4980B

Complete a separate Part I, lines 1 through 6, for failures due to reasonable cause and not to willful neglect, and a separate Part I, lines 12 through 14, for other failures, for each qualifying event for which one or more failures to satisfy continuation coverage requirements that occurred during the reporting period (see instructions).

Section A – Failures Due to Reasonable Cause and Not to Willful Neglect

		For IRS Use Only		
1	Enter the total number of days of noncompliance in the reporting period		1	
2	Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event (2)			
3	If you entered 2 or more on line 2, multiply line 1 by $200. Otherwise, multiply line 1 by $100		3	
4	If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and go to line 5. Otherwise, enter the amount from line 3 on line 6 and go to line 7		4	
5	If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply $2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by $15,000 to the extent the violations were more than *de minimis* for a qualified beneficiary). If the failures were corrected before the date a notice of examination was sent, enter -0-		5	
6	Enter the smaller of line 3 or line 5		6	
7	If there was more than one qualifying event, add the amounts shown on line 6 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 6 above		7	
8	Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care (8)			
9	Multiply line 8 by 10% (.10)		9	
10	Amount from section 4980B(c)(4)		10	500,000
11	Enter the smallest of lines 7, 9, or 10. For a third-party administrator, HMO, or insurance company, the amount you enter on this line filed for all plans you administer during the same tax year cannot exceed $2 million; reduce the amount you would otherwise enter on this line to the extent the amount for all plans would exceed this limit		11	

Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause

12	Enter the total number of days of noncompliance in the reporting period		12	
13	Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event (13)			
14	If you entered 2 or more on line 13, multiply line 12 by $200. Otherwise, multiply line 12 by $100.		14	
15	If there was more than one qualifying event, add the amounts shown on line 14 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 14 above		15	

Section C – Total Tax Due Under Section 4980B

16	Add lines 11 and 15 ►	126	16	

17	Enter the total number of days of noncompliance in the reporting period			17	
18	Enter the number of individuals to whom the failure applies	18			
19	Multiply line 17 by line 18	19			
20	Multiply line 19 by $100			20	
21	If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and go to line 22. Otherwise, enter the amount from line 20 on line 23 and go to line 24			21	
22	If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply $2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by $15,000 to the extent the violations were more than *de minimis* for a qualified beneficiary). If the failures were corrected before the date a notice of examination was sent, enter -0-			22	
23	Enter the smaller of line 20 or line 22			23	
24	If there was more than one failure, add the amounts shown on line 23 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 23 above			24	
25	Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care	25			
26	Multiply line 25 by 10% (.10)			26	
27	Amount from section 4980D(c)(3)			27	500,000
28	Enter the smallest of lines 24, 26, or 27			28	
Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause					
29	Enter the total number of days of noncompliance in the reporting period			29	
30	Enter the number of individuals to whom the failure applies	30			
31	Multiply line 29 by line 30	31			
32	Multiply line 31 by $100			32	
33	If there was more than one failure, add the amounts shown on line 32 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 32 above			33	
Section C – Total Tax Due Under Section 4980D					
34	Add lines 28 and 33 ▶		127	34	
Part III	**Tax on Failure To Make Comparable Archer MSA Contributions Under Section 4980E**				
35	Aggregate amount contributed to Archer MSAs of employees within calendar year			35	
36	Total tax due under section 4980E. Multiply line 35 by 35% (.35) ▶		128	36	
Part IV	**Tax on Failure To Make Comparable HSA Contributions Under Section 4980G**				
37	Aggregate amount contributed to HSAs of employees within calendar year			37	
38	Total tax due under section 4980G. Multiply line 37 by 35% (.35) ▶		137	38	
Part V	**Tax Due or Overpayment**				
39	Add lines 16, 34, 36, and 38			39	
40	Enter amount of tax paid with Form 7004			40	
41	**Tax due.** Subtract line 40 from line 39. If less than zero, enter -0-, and go to line 42. If the result is greater than zero, enter here and attach a check or money order payable to "United States Treasury." Write your name, identifying number, plan number, and "Form 8928" on your payment			41	
42	**Overpayment.** Subtract line 39 from line 40			42	

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Your signature ▶ Telephone number ▶ Date

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN

Firm's name ▶ Firm's EIN ▶

Firm's address ▶ Phone no.

• MMSEA Section 111 HRA Reporting

- Health reimbursement arrangements, also known as "health reimbursement accounts" or "personal care accounts," are a type of health insurance plan that reimburses employees for qualified medical expenses. HRAs consist of funds set aside by employers to reimburse employees for qualified medical expenses, just as an insurance plan will reimburse covered individuals for the cost of services incurred. HRAs are considered to be Group Health Plans (GHPs) and thus HRA coverage is subject to Section 111 Medicare Secondary Payer (MSP) Reporting.

HRA Reporting Requirements
Annual Benefit Value

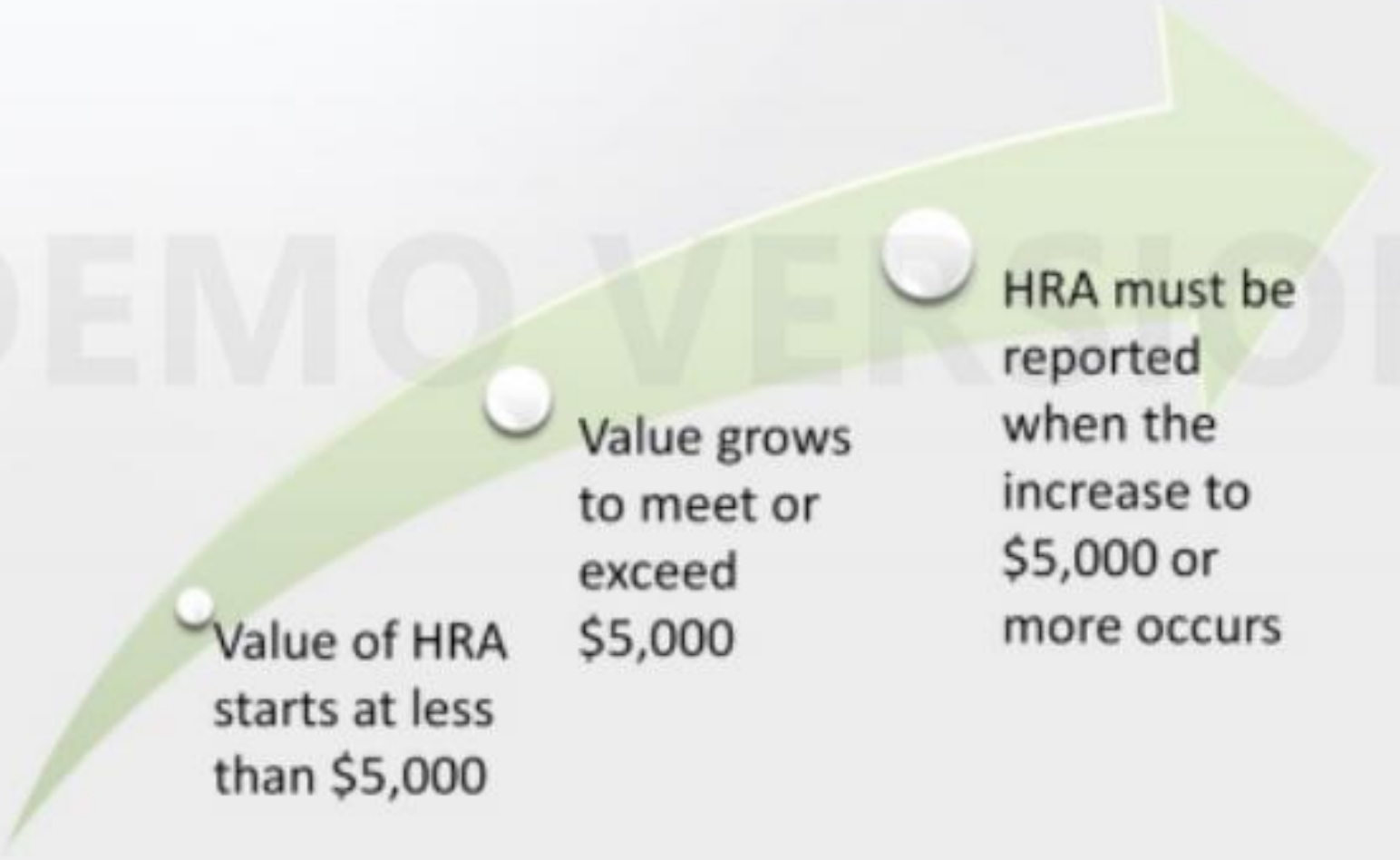
Less than $5,000

- Exempt from reporting

$5,000 or more

- Must be reported

HRA Reporting Requirements
Annual Benefit Value



MMSEA Section 111 HRA Reporting

- Due to carry-over or roll-over options in an HRA, if the value of the HRA starts at less than $5,000 but grows to meet or exceed $5,000, the HRA must be reported when the increase to $5,000 or more occurs.

HRA Reporting Requirements
Annual Benefit Value

Example

- HRA effective 1/1/2011 with a value of $4,750
  - –HRA does not have to be reported in 2011
- During 2011, none of the HRA is used and the full value rolls-over to 2012
- 1/1/2012 another $4,750 added to the HRA
- As of 1/1/2012 the HRA total value = $9,500
  - –HRA must be reported starting 1/1/2012

MMSEA Section 111 HRA Reporting

- In this example, assume an HRA first becomes effective on January 1, 2016. The annual benefit value of the HRA is $4,750. Since the value of the HRA is under $5,000, it does not have to be reported. During 2016, none of the $4,750 is used. As of January 1, 2017, due to a roll-over option, all $4,750 from 2016 becomes available for use in 2017. On January 1, 2017, another $4,750 is added to the HRA. As of January 1, 2017, the total value of the HRA is now $9,500. Since the total value of the HRA now meets or exceeds $5,000, it must be reported.

RESOURCES

https://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements%20

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/GHP-Training-Material/Downloads/Health-Reimbursement-Arrangement-HRA.pdf

https://www.irs.gov/pub/irs-pdf/i8928.pdf

https://www.irs.gov/pub/irs-drop/n-15-87.pdf

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