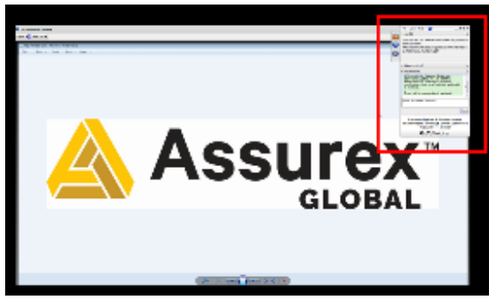
2019

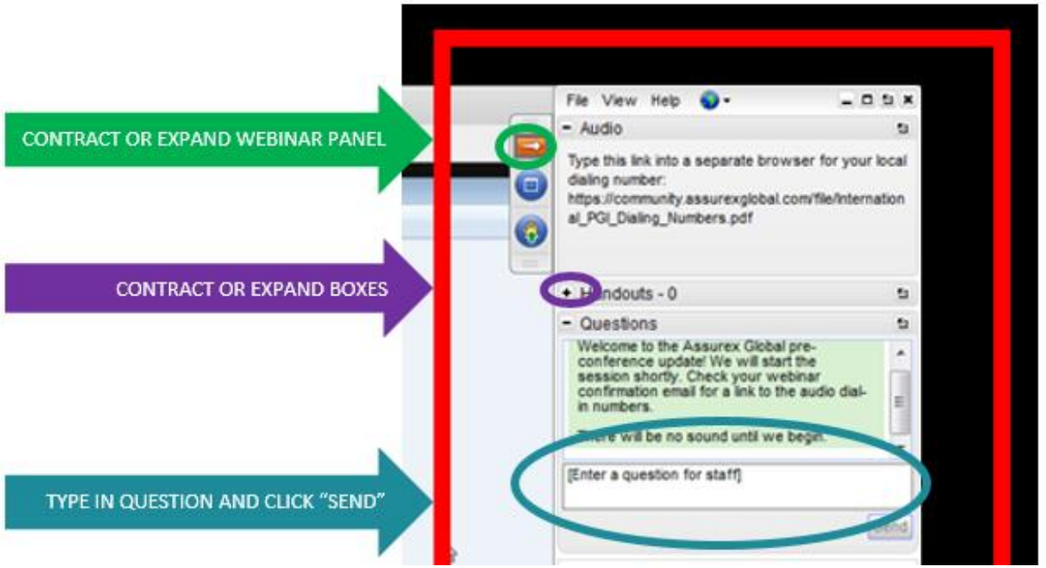
Answers to Your Employee Benefits Questions

Presented by Benefit Comply

Answers to Your Employee Benefits Questions

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” or “Chat” box located on your webinar control panel.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.





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Do FSA and DCAP contribution limits apply on a calendar year basis?

Health FSA Contribution Limits

- Employee Contributions
  - Employee contributions (via salary reductions) are limited annually

2015	2016	2017	2018	2019	2020
$2,550	$2,550	$2,600	$2,650	$2,700	$2,750

  - The contribution limits apply to the employer's health FSA plan year, not necessarily on a calendar-year basis
    - If the employer runs a short plan year, the contribution limit must be adjusted on a pro rata basis
  - Limit applies on a per-employee basis, so family members working for the same employer could each elect up to the annual maximum
    - If an employee works for multiple employers, the employee may elect up to the maximum with each employer unless the employers are part of the same controlled group or affiliated service group
  - Employees may elect up to the full amount for the plan year even if they join mid-plan year
  - Non-elective employer contributions (e.g., matching or seed contributions) do not count toward the limit. However, if employees may elect to receive the employer contributions in cash or as a taxable benefit, then the contributions to the health FSA will count toward the limit

Health FSA Contribution Limits

- Employer Contributions
  - Employer contributions may be made in addition to the maximum employee contributions
  - However, to meet “excepted benefit” status and avoid violating health care reform requirements, the health FSA must satisfy the following two conditions:
    - Maximum Benefit Condition. The maximum benefit payable under the health FSA to any participant cannot exceed the greater of (i) 2x the participant’s salary reduction election; or (ii) the amount of the participant’s salary reduction election plus $500. In other words, the employer could either make a matching contribution (up to $2,750 for 2020) or limit the contribution to $500
    - Availability Condition. Other non-excepted group health plan coverage (e.g., major medical coverage) must be available to those eligible to participate in the health FSA; individuals must be eligible for both a group medical plan and a health FSA, but they do not have to be enrolled in both

DCAP Contribution Limits

- Annual Contribution Limit
  - Contributions, whether made by the employer or employee, are limited to $5,000 annually
    - $2,500 if an individual is married, but filing separately
    - $5,000 limit is shared jointly between spouses if filing together
  - Limit applies on a calendar-year basis, even for a non-calendar year plan
    - Many employers choose to have a calendar year DCAP to avoid potential issues
    - Those with a non-calendar year plan may want to help employees avoid going over the limit
      - Could impose a "pro rata" restriction on DCAP elections for those who join mid-plan year (e.g. new hire)
  - Limit applies per the individual
    - It is not possible to elect more than $5000 under separate DCAPs

Do I have to include employer contributions to a health FSA in the Form W-2 cost of coverage reporting?

Health FSA – W-2 Cost of Coverage Reporting

- W-2 Cost of Coverage Reporting
  - Required only for employers filing 250 or more Form W-2s in the previous calendar year
  - Must report cost of health care coverage (both employer and employee contributions) in Box 12
  - Not all group health benefits are included:
    - Some are excluded (e.g. HSA contributions, long-term care insurance), some are optional (e.g. HRA, dental and vision), and some are required (major medical)
    - A list of types of coverage and IRS guidance on whether the cost should be included can be found here - https://www.irs.gov/affordable-care-act/form-w-2-reporting-of-employer-sponsored-health-coverage

Health FSA – W-2 Cost of Coverage Reporting

- Health FSA Contributions
  - Only employee contributions, no reporting required in Box 12
  - If the employer makes contributions or makes a flex credit available to be used toward the health FSA:
    - If employee's overall salary reductions (for all benefits elected under the cafeteria plan) are ≥ the health FSA amount, the employer contribution is NOT included in the aggregate cost of coverage on Form W-2

EE FSA Contribution	ER FSA Contribution	Total EE Salary Reductions	Reported Cost
$500	$500	$2,000	$0 ($2,000 > $1,000)

    - If employee's overall salary reductions (for all benefits elected under the cafeteria plan) are < the health FSA amount, then the difference between employee's health FSA election and the total amount of the health FSA is included in the aggregate cost of coverage on Form W-2

EE FSA Contribution	ER FSA Contribution	Total EE Salary Reductions	Reported Cost
$1500	$500	$1800	$500 ($1800 < $2000)

When HIPAA special enrollment rights are triggered, what options to special enrollees have?

HIPAA Special Enrollment Rights

- HIPAA Special Enrollment Rights
  - Require the group health plan to allow mid-year enrollment so long as notice of the event is provided within the required time frame
- Triggering Events
  - Loss of other coverage
  - Marriage, birth or adoption
  - Eligibility for Medicaid or CHIP subsidy
- Notice Time Frame
  - General rule: 30 days' notice
  - For loss eligibility for Medicaid or CHIP coverage, or Medicaid/CHIP subsidy eligibility, 60 days' notice
- Effective Date of Coverage:
  - General rule: No later than 1st of the month following notice of the triggering event
  - For the birth or adoption of a child, the effective date is retroactive to the birth/adoption date

HIPAA Special Enrollment Rights

- Special Enrollees
  - Upon a loss of coverage:
    - If the employee loses coverage, the employee and all eligible dependents are special enrollees
    - If a dependent loses coverage, the employee and dependent who lost coverage are special enrollees
  - Upon a marriage, birth or adoption of a child:
    - The employee, spouse and newly acquired dependent(s) are special enrollees
  - Upon eligibility for a Medicaid or CHIP subsidy:
    - The employee and any dependents eligible for the subsidy are special enrollees
- What Coverage Must Be Offered?
  - Likely only medical coverage – HIPAA applies to group health plans, but not excepted benefits (e.g. limited-scope dental or vision, health FSA)
  - However, all the rules appear to require that all medical plan options be available, even if the employee is already enrolled in a medical plan
    - *"Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible." Treas. Reg. §54.9801-6(d)(2)*

HIPAA Special Enrollment Rights

- Examples – Employer offers two medical plan options (PPO & HDHP), dental, vision, and life insurance
  - Example 1 – Employee waives all coverage during open enrollment, but then gets married mid-plan year
    - The marriage triggers HIPAA special enrollment rights for the employee and spouse. The employer must allow them to enroll in the PPO or HDHP but is not required to allow enrollment in any of the other benefits
  - Example 2 – Employee enrolls in single coverage for the HDHP, dental, vision and life insurance during open enrollment, but then has a baby mid-plan year
    - The birth of the child triggers HIPAA special enrollment rights for the employee, spouse and child. The employer must allow them to enroll in the PPO or HDHP but is not required to allow the spouse or child to enroll in any of the other benefits
  - Example 3 – Employee waives all coverage during open enrollment, but then the employee, spouse and child lose coverage mid-plan year under the spouse's plan due to a change in the spouse's employment status
    - The loss of coverage triggers HIPAA special enrollment rights for the employee, spouse and child. The employer must allow them to enroll in the PPO or HDHP but is not required to allow any of them to enroll in any of the other benefits

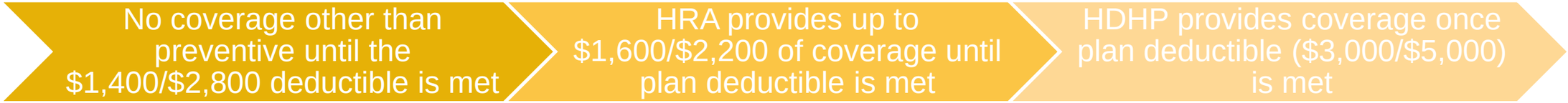
Can employers offer an HRA or FSA alongside an HDHP/HSA plan?

HSA-Eligibility – Limited-Purpose or Post-Deductible FSA/HRA

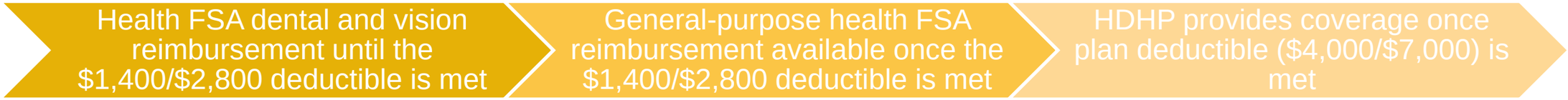
- General-Purpose Health FSA or HRA
  - Coverage under a general-purpose health FSA or HRA makes an individual ineligible to contribute to an HSA (even if it's under a spouse's FSA or HRA plan)
- Limited-Purpose Health FSA or HRA
  - Reimbursement available only for dental, vision or preventive
  - Does not interfere with HSA-eligibility
- Post-Deductible Health FSA or HRA
  - Reimbursement not available until the deductible is satisfied
    - Does not have to be tied to the plan deductible, but instead could be tied to the minimum HDHP deductible ($1,400/$2,800 in 2020), which is often lower
  - Does not interfere with HSA-eligibility

HSA-Eligibility – Limited-Purpose or Post-Deductible FSA/HRA

- Design Options to Offer Alongside an HDHP
  - Offer a limited-purpose health FSA or HRA
    - Regardless of whether the plan deductible is met, the FSA/HRA is available only to reimburse limited-purpose dental or vision expenses
  - Offer a post-deductible health FSA or HRA
    - Example - HDHP with $3,000/$5,000 deductible and a post-deductible HRA



  - Offer a combination limited-purpose and post-deductible health FSA or HRA
    - Example – HDHP with $4,000/$7,000 deductible with a combination health FSA



NOTE: HSA reimbursement would be available as well so long as the claims is not already being reimbursed by the HRA or health FSA (no double-dipping)

What happens when an employee makes excess contributions to an HSA? Is there any way to fix it?

HSA – Excess Contributions

- HSA-Eligibility Requirements
  - Must be enrolled in a qualifying high-deductible health plan (HDHP);
  - May not have any other “disqualifying coverage”, including Medicare; and
  - Cannot be claimed as a tax dependent by another individual
- 2019 Contribution Limits
  - $3,500 for single HDHP coverage
  - $7,000 for family HDHP coverage
  - + $1,000 catch-up contribution for those age 55 or older
- Excess Contributions
  - Individuals may contribute 1/12 of the annual maximum for each month they are HSA-eligible
    - Example – Employee enrolled in single HDHP coverage March – December. Employee may contribute up to $2,916.66 for the year (1/12 x $3,500 x 10)
  - If an individual contributes more than their annual maximum, it is considered “excess contributions”, which should be taxed as additional income and may also require payment of a 6% excise tax

HSA – Excess Contributions

- Remedy - “Curative Distribution"
  - If requested before the tax filing deadline (typically April 15), the 6% excise tax can be avoided
  - Steps for a curative distribution:
    - Employee should notify the HSA trustee/custodian of the excess contribution and request a distribution of the excess amount and attributable earnings (since these will be taxable)
    - Trustee/custodian will report the distribution on Form 1099-SA, coded as an excess contribution
    - If the employer doesn't include the excess contributions as the employee's wages on the W-2, the employee should report this amount as "other income" on their federal income tax return

Can our owners participate in benefits on a tax-favored basis?

Owner Benefits - Taxation

- Participation
  - Employer-sponsored group benefits can be offered to owners, board members and directors
    - Plan eligibility rules should include such individuals (non-employees)
    - Plan should obtain carrier approval
- Owner = sole proprietors, partners in a partnership, and >2% shareholders in an S-Corp
  - Such individuals are not considered employees
  - Directors or board members who are not also providing services as an employee to a corporation are not considered employees either
- Taxation
  - Benefit taxation is handled different for non-employees participating in employer-sponsored benefits
    - Non-employees cannot participate in a cafeteria plan, HRA, or health FSA
    - Contributions made by non-employees should be made on an after-tax basis, and contributions made by the employer should be treated as additional taxable compensation
      - Owners, board members, or directors can likely take tax deductions on their personal returns, but they will vary depending on the structure of the organizations and the nature of the contributions

Owner Benefits - Taxation

- Taxation (continued)
  - Spouses and Dependents of Owners
    - Spouses and dependents of owners who are also employees may participate in benefits on a tax-favored basis. However, spouses and dependents of a >2% S-Corp shareholder are not eligible to participate on a tax-favored basis, even if they are also employees
  - HSA Contributions
    - Owners are permitted to make contributions to HSAs
      - Owner contributions should be made on an after-tax basis, but then may qualify as a deduction when filing the personal tax return
      - Employer HSA contribution taxation varies slightly depending upon the type of owner (IRS Notice 2005-8)
- Nondiscrimination Rules
  - Benefit nondiscrimination rules (e.g. 105(h) for self-funded group health plans and 125 for cafeteria plan benefits) restrict the extent to which employers may favor highly compensated individuals on a tax-favored basis
  - Since owners, board members and directors cannot participate on the same tax-favored basis, they are disregarded for purposes of discrimination testing (and it's okay to treat them differently)

We went over 50 FTEs for the first time this year. When do we have to offer coverage?

Applicable Large Employer (ALE) Status

- ALE Status
  - Employer ***averages*** 50 or more full-time equivalents (FTEs) over the previous calendar year
    - Simply crossing over the 50 threshold for a month or two may not result in ALE status
  - Calculation steps:

    Step 1: Calculate the number employees with 120 or more hours of service for each calendar month

    Step 2: Aggregate hours of service for each month for any other employees and divide the total by 120

    Step 3: Add the numbers obtained in Steps 1 and 2 for each month

    Step 4: Add up the totals from each month from Step 3 and divide the sum by 12
  - Example:

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
FT EEs	43	39	39	40	30	28	28	29	28	38	41	41
Other EEs	1480hrs	1600hrs	1620hrs	1590hrs	1610hrs	1430hrs	1440hrs	1440hrs	1460hrs	1620hrs	1640hrs	1640hrs
FTEs	12.33	13.33	13.5	13.25	13.41	11.91	12	12	12.16	13.5	13.66	13.66
Total FTEs	55.33	52.33	52.5	53.25	43.41	39.91	40	41	40.16	51.5	54.66	54.66
Average FTEs – 48.22												

New Applicable Large Employer (ALE)

- Transition Relief
  - For the first year as an ALE, the employer will not face any penalties under §4980H so long as minimum value, affordable coverage is offered to full-time employees no later than April 1st
  - Example – Employer averages 50 or more FTEs during 2019 for the first time, and is therefore a new ALE in 2020
    - So long as employer offers coverage to at least 95% (or all but 5, if greater) of full-time employees by April 1st, 2020, the employer will not face any penalties under §4890H(a)
      - If using the look-back measurement method, employees must be measured prior to April 1 to determine full-time status
    - If the coverage offered to full-time employees provides minimum value and is affordable by April 1st, 2020, the employer can also avoid penalties under §4890H(b)

How does an employer choose which affordability safe harbor to use?

Affordability Safe Harbors

- Affordable –
  - Affordability is determined by applying the affordability percentage (see below) to an individual's household income
  - Employers are protected from any potential penalties under §4980H(b) so long as the coverage is affordable under 1 of 3 safe harbors:
    - Federal poverty level (FPL) safe harbor;
    - Rate of pay safe harbor; or
    - Form W-2 safe harbor
  - Affordability percentages

2015	2016	2017	2018	2019	2020
9.56%	9.66%	9.69%	9.56%	9.86%	9.78%

    - Percentage adjustments apply for “plan years beginning in…” For example, July – June medical plan year would use 9.86% for the plan year beginning in July 2019, and 9.78% for the plan year beginning July 2020

Affordability Safe Harbors

- Choice of Safe Harbor
  - Employers may apply different safe harbors for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category
  - Employers may switch between safe harbors, but if using the Form W-2 safe harbor, *“it must be used for all months of the calendar year for which the employee is offered health coverage”*
  - Not required to be chosen until reporting is completed for the calendar year, but some employers use them at the beginning of plan year to help set employee contributions

Affordability Safe Harbors

- Choice of Safe Harbor
  - 2-step process
    - Step 1: Start with the federal poverty level (FPL) safe harbor
      - Coverage is affordable if the employee's cost for single coverage does not exceed 9.78% of the FPL for a single individual (approx. $101.79/month for calendar year plan years in 2020)
      - Guarantees affordability for all employees, but also typically requires the largest employer contribution
      - If it applies, use Code 2G when reporting. If it doesn't apply, go to Step 2
    - Step 2: Determine whether the rate of pay or Form W-2 safe harbors apply
      - Coverage is affordable under the rate of pay safe harbor if the monthly cost for single coverage does not exceed 9.78% of the employee's hourly rate of pay x 130 (or the employee's monthly salary)
        - Example – Full-time hourly employees paid $11/hour and up. Employee contributions for the lowest cost minimum value plan cannot exceed $139.85 per month (130 X $11 X 9.78%)
      - Coverage is affordable under the Form W-2 safe harbor if the annual cost for single coverage does not exceed 9.78% of the employee's Box 1 wages
        - Example - Full-time employees have $18,000 or more reported in Box 1. Employee contributions for the lowest cost minimum value plan cannot exceed $146.70 per month ($18,000 X 9.78% / 12)

When do state continuation requirements apply?

State Continuation Rules

- State Continuation Rules
  - Application
    - Generally applicable only to fully-insured plans in the state in which the plan is issued
    - Not tied to where a particular individual resides, or even where the employer may be operating
    - Example – Policy issued by a carrier in Texas would be subject to Texas continuation rules only, even if employer has a location outside of Texas or employees who reside outside of Texas
  - Coverage Requirements Vary By State
    - Length of continuation coverage varies
      - Some require continuation coverage beyond the maximum coverage period required under federal COBRA continuation rules (e.g. COBRA maximum coverage period + 6 months)
    - Employer and plan application varies
      - Some require continuation coverage only when the employer is NOT subject to federal COBRA (e.g. less than 20 employees)
      - Some require continuation coverage for all group health coverage while others require it only for medical
    - Qualifying events triggering continuation coverage vary
    - Employer notice requirements and individual application time frames vary

State Continuation Rules

- State Comparison

	California	Illinois	Texas	Connecticut	Florida
Applicable Employers	All employers who offer group health insurance	All employers who offer group health insurance	All employers who offer group health insurance	All employers who offer group health insurance	Employers with <20 employees
Length of Coverage	36 months Extends continuation if federal COBRA is less than 36 months	12 months for employees, 9 for spouse/dependents 2 years for spouses/dependents for special circumstances	9 months, generally Extends continuation an additional 6 months after federal COBRA	18 months, generally 36 months for employee's death or divorce	18 months, generally 29 months for a disability extension
Employer Notice Time Frame	15 days	10 days	5 days	14 days	14 days
Application Time Frame	31 days after group plan ends; 30 days after COBRA ends	30 days	60 days	60 days	30 days

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