TRUCKER ✦ HUSS

Benefits Report

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In this issue…

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COBRA Compliance and the Health Flexible Spending Account Carryover

ELIZABETH L. LOH

In Internal Revenue Service ("IRS") Notice 2013-71, the IRS issued guidance allowing Health Flexible Spending Accounts ("Health FSAs") to offer carryovers of unused balances of up to $500 remaining at the end of a plan year to be used for qualified medical expenses in a subsequent plan year (See our November 2013 Special Alert for an overview of the Notice). Offering this Health FSA carryover is optional, but if an employer wants to add the feature, the employer must amend its Health FSA plan document on or before the last day of the plan year from which amounts may be carried over. While the Health FSA carryover feature may reduce potential Health FSA forfeitures, there are several COBRA administrative and compliance issues that an employer must consider before deciding whether to implement the Health FSA carryover feature.

How COBRA Applies to Health FSAs

Health FSAs are group health plans that generally are subject to the COBRA rules. If a participant in a Health FSA providing excepted benefits experiences a COBRA qualifying event (*e.g.,* termination of employment) and has an underspent account, the Health FSA must offer such participant COBRA continuation coverage up through the end of the plan year. Further, the Health FSA may charge the COBRA qualifying beneficiary up to 102% of total plan premiums for COBRA coverage. For example, assume Employee A elects $2,400 in Health FSA coverage for the plan year and terminates employment on April 30th. The maximum COBRA premium that can be charged for the remaining eight months in the year is $1,632 (*i.e.,* $1,600 (8 months x $200) x 102%).

How the Health FSA Carryover Feature Interacts with COBRA

If a Health FSA participant terminates employment, the participant forfeits any remaining Health FSA amounts (including any unused carryover amounts at the time of termination). However, if the Health FSA participant properly elects COBRA continuation coverage, the participant may take advantage of the Health FSA plan's carryover feature and carry over up to $500 in unused Health FSA amounts to the

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next plan year. Although the IRS has not provided formal guidance on this issue, IRS officials have informally commented that the COBRA qualifying beneficiary must be provided the Health FSA carryover option if the option is provided to active Health FSA plan participants — even if this would result in the COBRA qualifying beneficiary having coverage beyond the end of the plan year. However, the Health FSA carryover cannot last beyond the end of the applicable maximum COBRA coverage period (*e.g.,* 18 months from the date of the COBRA qualifying event). This is a departure from the normal Health FSA COBRA rules, which provide that a Health FSA participant's maximum COBRA continuation coverage period is exhausted at the end of the plan year in which the COBRA qualifying event occurs.

Carryover Amount is not Taken Into Account When Determining COBRA Premium

An employer should disregard any Health FSA carryover amounts when calculating the Health FSA COBRA qualifying beneficiary's COBRA premium. An IRS official has informally explained that including these amounts would cause the Health FSA COBRA qualifying beneficiary to pay twice for the carryover amount. In other words, the Health FSA COBRA qualifying beneficiary would pay for the carryover amount once in the prior year when he or she made salary reductions to his or her Health FSA, and again in the carryover year.

Re-enrollment Rights Do Not Have to be Offered

Although a COBRA qualifying beneficiary may continue to participate in the Health FSA as long as he or she has amounts to carry over (up to his or her maximum COBRA coverage period), the Health FSA is not required to provide the qualifying beneficiary with open enrollment rights. For example, the qualifying beneficiary does not have the right to re-enroll in the Health FSA plan *(i.e.,* increase his or her Health FSA election amounts) at open enrollment.

Carryover Impact on Health Savings Account Eligibility

If a COBRA qualifying beneficiary's general purpose Health FSA amounts carry over to a subsequent year, this carryover will prevent such individual from making or receiving Health Savings Account ("HSA") contributions in that year. Under the Internal Revenue Code's HSA rules, an individual who is covered by a non-High Deductible Health Plan *(e.g.,* a general purpose Health FSA) is HSA-ineligible. It is important to note that even an individual covered by a general purpose Health FSA solely as a result of Health FSA carryover amounts is HSA-ineligible for the entire plan year — even for the months in the plan year that the individual's Health FSA no longer has any amounts available to pay or reimburse medical expenses. Accordingly, if an individual elects COBRA for his or her Health FSA, and any amounts carry over to a subsequent year, the

individual will be HSA-ineligible for that year. For example, the COBRA qualifying beneficiary will not be able to make or receive HSA contributions to an HSA offered through the individual's new employer for the year that any Health FSA amounts carry over. To avoid this result, an employer may amend its Health FSA plan to provide participants the opportunity to either (1) opt out of the Health FSA carryover feature, or (2) carry over any unused amounts from a general purpose Health FSA to an HSA-compatible Health FSA (*e.g.,* a limited purpose Health FSA) for the following year.

Action Items

An employer wanting to permit Health FSA participants to carry over any unused Health FSA amounts from the 2014 plan year will need to amend its Health FSA plan by December 31, 2014 to include the carryover feature. Further, the employer will need to coordinate with its Health FSA third party administrator and/or COBRA administrator to ensure that these vendors can properly administer this new carryover feature. The employer also will need to carefully communicate the Health FSA carryover feature to its employees and COBRA qualifying beneficiaries (including how the Health FSA carryover will impact HSA eligibility). Ideally, the employer should explain the Health FSA carryover feature prior to the end of the election period for the plan year in which the Health FSA carryover will apply so that participants can account for this new feature when making their elections. Contact the author of this article or the attorney with whom you normally work for questions or assistance in amending your Health FSA plan.

New FAQs Issued on ACA's Cost-Sharing Limitations for Plans Using Reference-Based Pricing

ERIC J. SCHILLINGER

On October 10, 2014, the Department of the Treasury, Department of Labor and Department of Health and Human Services (collectively the "Departments") jointly issued FAQs Part XXI ("FAQs"). The FAQs address compliance with the annual cost-sharing limitations under the Patient Protection and Affordable Care Act (the "ACA") for non-grandfathered health plans using reference-based pricing.

For plan years beginning on and after January 1, 2014, the ACA requires non-grandfathered health plans to ensure that any annual cost-sharing amounts for covered essential health benefits do not exceed certain maximum out-of-pocket limits ("MOOPs"). Under the Section 2707(b) of the Public Health Service Act, as added by the ACA, if a non-grandfathered plan imposes cost-sharing (*i.e.,* deductibles, coinsurance, copayments, or other similar charges), such cost-sharing may not exceed the limits provided under Section 1302(c)(1) of the ACA. For plan years beginning in 2015, those limits for in-network charges are $6,600 for self-only coverage and $13,200 for all other levels of coverage. The new FAQs clarify that a plan using reference-based pricing will not violate the ACA's MOOP rules if the plan design includes a reasonable method to ensure that participants have sufficient access to quality providers at the reference-based price.

What is reference-based pricing?

To help control costs, some plans have entered into pricing arrangements with certain service providers ("reference-price providers"), in which a plan negotiates with a provider to pay a fixed amount for certain services (*e.g.*, knee replacements) as payment in full. Under this plan design, a participant who uses a reference-price provider for such services would not be required to pay any additional costs for that procedure, but a participant who does not use a reference-price provider would be responsible for any difference in cost between the reference-based price and the health care provider's charges.

Guidance

To address the Departments' concern that a health plan could use reference-based pricing as a "subterfuge for the imposition of otherwise prohibited limitations on coverage," the FAQs set forth the factors for determining whether the plan design provides "a reasonable method" to ensure that participants have sufficient access to quality providers.

Type of Service. To ensure that the plan's provider network includes services from high-quality providers at reduced costs, the reference-based pricing structure should only apply to services for which a participant has enough time to make an informed choice of provider. For example, excluding a participant's out-of-pocket costs for emergency services from the MOOP for providers who do not accept the reference-based price — which is independently prohibited by the ACA — would be unreasonable.

Reasonable Access. The plan should ensure that participants and beneficiaries have access to an adequate number of reference-price providers, taking into consideration adequacy measures developed by the states, a provider's geographic location, and wait times.

Quality Standards. The plan should ensure that a sufficient number of reference-price providers meet reasonable quality standards.

Exceptions Process. The plan should develop a process for treating services rendered by a provider that does not accept the reference-based price as if those services were provided by a reference-price provider in cases where participants cannot access a reference-price provider or using the reference-price provider would compromise the quality of services received.

Disclosure. The plan should automatically provide participants with information regarding the plan's reference-based pricing structure, including a list of applicable services and the exceptions process. Upon request, the plan should also provide participants with a list of reference-price providers and providers that will accept a price above the reference-based price for each service, as well as information on the reference-price process and underlying data used to ensure that an adequate number of reference-price providers meet reasonable quality standards.

We note that the FAQs state that the Departments will continue to evaluate the use of reference-based pricing and may issue additional guidance. If you have any questions regarding the foregoing, please contact the attorney with whom you normally work or the author of this article.

IRS Closes Minimum Value Loophole and Kills Skinny Plans for Employers Subject to Play or Pay Mandate

CALLAN CARTER

On November 4, 2014, the Internal Revenue Service (IRS) and the Department of Health and Human Services (HHS) issued Notice 2014-69, disapproving employers' use of "skinny" health plans that limit coverage for inpatient hospitalization services and/or physician services for the purpose of meeting the "minimum value" requirement of Internal Revenue Code (the "Code") section 4980H (the "play or pay" mandate). Until the Departments publish further regulations regarding the minimum value requirement, the guidance states that a plan that fails to provide "substantial coverage" for inpatient hospitalization services and/or physician services will fail to meet that requirement.

While the guidance is effective immediately and shuts down the promotion of skinny plans to employers subject

to the play or pay mandate, the Notice provides short-term relief for an employer that entered into a binding written commitment to adopt a skinny plan or had begun enrolling employees in such a plan *prior* to November 4, 2014. For these employers, the upcoming regulations will not apply until after the end of the plan year beginning before March 1, 2015. Such employers must also notify employees that such plan coverage will not affect employee eligibility for a possible premium tax credit under Code section 36B to purchase State or Federal Marketplace/Exchange coverage.

Minimum Value Requirement

Beginning in 2015, applicable large employers (as defined in Code section 4980H(c)(2), generally employers with 50 or full-time employees, taking into account full-time equivalent employees) must offer health plan coverage that provides minimum value to their full-time employees or be subject to an excise tax if a full-time employee obtains federally subsidized coverage offered through a federal or State Marketplace or Exchange. Under Code section 36B(c)(2)(C)(ii), "minimum value" is defined as a plan that pays at least 60% of covered claims.

Minimum Value Loophole

The agencies set forth the ways in which a plan could test its design to determine if it met the 60% threshold in 45 CFR 156.145. One methodology allows a plan to use the MV Calculator, an online calculator provided on the HHS website. Soon after its introduction, however, a flaw was discovered in the calculator, in that it did not require an employer to input of any plan benefit limits, allowing a plan that limited coverage for hospitalization services or physician services to still earn a score of 60%. These plans became known as "minimum value plans" or "skinny" plans, which were promoted to employers as a way to satisfy the ACA's play or pay requirement at a low cost.

IRS Guidance

In the Notice, the IRS stated that such plans "do not provide the minimum value intended by the minimum value requirement." Acknowledging the concern over the flaw in the MV Calculator, the Notice states that "the IRS, Treasury and HHS are considering whether the continuance tables underlying the Minimum Value Calculator produce valid actuarial results for plans with these designs."

Plan Notice Requirement for Skinny Plans

Because an individual whose coverage does not provide minimum value can qualify for a premium tax credit to purchase State or Federal Marketplace/Exchange coverage, the Notice also requires employers that offer skinny plan coverage to provide a written disclosure to employees that the coverage will not preclude the employee from obtaining a premium tax credit. This notice requirement applies to any skinny plan sponsor, including those that qualify for the short-term relief, small employers (*i.e.,* those not subject to Section 4980H) and employers that cover only part-time employees.

OTHER DEVELOPMENTS IN EMPLOYEE BENEFITS

IRS Releases Rev. Proc. 2014-61 Addressing FSA and Transportation Benefit Limits for 2015

On October 30, the Internal Revenue Service ("IRS") released its annual inflation adjustment guidance for over 40 federal tax provisions, including annual contribution limits for tax-qualified health flexible spending arrangements ("Health FSAs") and monthly limits for qualified transportation benefits. These and the other tax adjustment limits were covered in IRS Revenue Procedure 2014-61 and a companion news release (IR-2014-104).

Under Revenue Procedure 2014-61, a participant's annual contribution limit for a Health FSA will increase to $2,550 in 2015 (from $2,500 in 2014). By contrast, transportation benefit limits will remain at 2014 levels, *i.e.,* a $130 monthly limit for transportation in a commuter highway vehicle and/or transit pass and a $250 monthly limit for qualified parking benefits.

— SONYA M. GORDON

FIRM NEWS

On November 18, **Brad Huss** and **Nick White** will be speaking on *Internal Controls and Best Practices for the Plan Committee and Top Audit Issues* for the Western Pension & Benefits Council Los Angeles chapter.

On November 14, **Mary Powell** will be giving a presentation at the JCEB's Executive Compensation National Institute in Chicago entitled, *Revisiting Severance: 409A Pitfalls, ERISA Considerations, FICA, and Recent Case Law*.

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