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Employee Benefits | Life Insurance | Risk Management

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INSURANCE BRIEF

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Health FSA Carryovers and HSA Eligibility

The Internal Revenue Service released a Chief Counsel Advice (CCA) memo which answers questions on how health FSA carryovers affect HSA eligibility.

Background: To be eligible to contribute to an HSA, an individual must be enrolled in a high-deductible health plan (HDHP) and have no other first dollar medical coverage. If either the individual or their spouse is enrolled in a health FSA then neither is HSA-eligible. Then the IRS changed the use-it-or-lose-it rule for Sec. 125 plans to allow health FSAs to offer a carryover of up to $500 (see our SML Update dated November 1, 2013). This raised questions about what employers and employees could do to maintain HSA eligibility.

Key Provisions: Not surprisingly, participation in a full purpose FSA solely as the result of a carryover of unused money makes the individual ineligible to contribute to an HSA. This is true for the entire plan year into which the money was carried, regardless of whether the individual later has a zero balance in that plan year. This is different than the rules under a grace period where once the balance goes to zero, at the end of the grace period you are now HSA-eligible.

The IRS will allow a participant to decline/waive the carryover in order to become HSA-eligible the following year. The waiver must be made prior to the beginning of the next plan year. Alternatively, they can elect to have their balance carried over to a limited purpose FSA.

A Sec. 125 plan can be amended to allow for the employer to automatically enroll an employee electing a HDHP into the limited purpose FSA and carrying over any full purpose FSA balance into the limited purpose FSA. This option requires the employer to offer both a full and limited purpose FSA.

Under the uniform coverage rule the entire election amount must be available for reimbursement at the beginning of the plan year. How does this apply during the run-out period where there is carryover from a full into a limited purpose FSA? The IRS has said that during the run-out, any claims submitted to the limited purpose FSA are reimbursed only up to that year's election. Any amount in excess of the limited purpose election may be reimbursed after the full purpose FSA run-out period when the final amount of any carryover is determined.

What's Next?

If you would like additional information about implementing a carryover provision please contact your SML Account Team.

Bay Area Transit Law

Governor Brown has signed into law the Commuter Benefits Program. This law requires employers with 50 or more full-time employees working within the jurisdiction of the Bay Area Air Quality Management District (Air District) to offer one of four commuter-benefit options to employees working at least 20 hours per week.

- Option 1 - Pre-Tax Option: The employer allows employees to exclude their transit or vanpool costs from taxable income, to the maximum amount allowed by federal law;
- Option 2 - Employer-Provided Subsidy: The employer provides a transit or vanpool subsidy to reduce or cover the employees' monthly transit or vanpool costs;
- Option 3 - Employer-Provided Transit: The employer provides a free or low-cost bus, shuttle or vanpool service for employees (operated by or for the employer); or
- Option 4 - Alternative Commuter Benefit: The employer proposes an alternative commuter benefit method that would be as effective as the other options in reducing single-occupant vehicle trips (and/or vehicle emissions).

Effective Date: Employers must have an option in place by September 30, 2014. This means that if an employer wishes to set up a Sec. 132 pre-tax option their Plan must be effective September 1st.

The Air District consists of the following counties in their entirety: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo and Santa Clara. It also includes the southern portion of Sonoma and the southwestern portion of Solano.

What's Next? The Air District and the Metropolitan Transportation Commission will notify employers and provide guidelines and employer assistance materials. Once an employer selects an option they will register with the agencies. More information can be found at this Air District web page.

Your SML Account Team can assist in implementing a Sec. 132 transit plan.

Annual Deductible Limit Repealed

The Protecting Access to Medicare Act of 2014 was passed on April 1st (no fooling!) to again postpone changes in the amounts Medicare pays physicians. Although Medicare is the main focus of this law, it also contained a provision to eliminate the health care reform limitation on annual deductibles.

Background: As of 2014 plan years the maximum deductible allowed for individual and small group market fully-insured policies was $2,000 for individual and $4,000 for family.

Effective Date: The amendments made by this Act "shall be effective as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148)." In other words, it is as if the limits never existed.

This will allow small employers in the fully-insured market to return to higher-deductible health plans.

What's Next? We will have to wait and see how the carriers respond. Since they have all already filed their plan designs with the states and received approval for 2014 it may be many months before we see higher deductible options available. We will keep you posted as we hear more.

Special Enrollment Rules in Exchanges

Many employers may be asked by employees when they can move from their plan to an Exchange plan. When planning severance packages employers should be aware of these rules as well. For your reference we are providing the rules for CoveredCA and the Federal Exchanges.

CoveredCA Special Enrollment Rules: Consumers have 60 calendar days from the date of the qualifying event to take advantage of the special enrollment period. Qualified individuals can enroll in a Covered California Health Plan or change their Covered California Health Plan when any of these events happen:

- A qualified individual or dependent loses Minimum Essential Coverage (MEC) (this is defined in greater detail below);
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual who was not previously a citizen, a national or a lawfully present individual gains such status which makes them newly eligible for coverage;
- A qualified individual's enrollment or non-enrollment in a Covered California Health Plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of anyone involved with Covered California or the Department of Health and Human Services;
- An enrollee adequately demonstrates to Covered California that the Covered California Health Plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for premium assistance or has a change in eligibility for cost-sharing reductions, regardless of whether the individual is already enrolled in a Covered California Health Plan;
- An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value; and
- A qualified individual or enrollee gains access to Covered California Health Plans as a result of a permanent move.

Special Enrollment Circumstances:

- Federally recognized American Indians and Alaska Natives may enroll in or change existing coverage in Covered California Health Plans one time per month.

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SF HCSO Annual Reporting

The HCSO Annual Reporting Form is now available for on-line submission! To avoid penalties of $500 per quarter, "covered employers" must submit the Form by April 30, 2014. We recommend you review the instructions prior to beginning the form.

As a reminder: you are not a "covered employer" under the HCSO and you should not submit the Form if (1) you are a private employer and you employed fewer than 20 persons, (including those employed outside of San Francisco) in each of the four calendar quarters of 2013; or (2) ; you are a non-profit corporation and you employed fewer than 50 persons (including those employed outside of San Francisco) in each of the four calendar quarters of 2013; or (3) if you did not have any employees in San Francisco in 2013. If you are not required to submit the Form, no further action is required.

If you have any questions please visit the Office of Labor Standards Enforcement's HCSO website to access the text of the HCSO, the implementing regulations, answers to "Frequently Asked Questions," and other helpful forms and notices. You can also contact the OLSE by phone at (415) 554-7892 or by email at hcso@sfgov.org.

Special Enrollment Rules in Exchanges *(cont'd from page 3)*

- Individuals who are income eligible for Medi-Cal may apply at any time during the year and are not limited to Open Enrollment periods. When people have income changes that would qualify them for Medi-Cal, they can apply for Medi-Cal any time.

Enrollment date based on Special QE	Coverage Effective
1st and 15th of the month	First day of the following month
16 and last day of month	First day of the second following month
Birth, adoption or placement of adoption	On the date of the birth, adoption or placement Note: any premium assistance and CSRs are effective the first day of the following month
Marriage	First day of the following month
Loss of Minimum Essential Coverage (MEC)	First day of the following month

Federally Facilitated Exchange Special Enrollment rules: If you have a qualifying life event, you get a special enrollment period. This means you can enroll in or change your health insurance plan outside the open enrollment period. Most special enrollment periods last 60 days from the date of the qualifying life event.

You can apply for Medicaid or the Children's Health Insurance Program (CHIP) any time. If you're qualified you can enroll right away.

Qualifying life events that create a special enrollment period include:

- Getting married
- Having, adopting, or placement of a child
- Permanently moving to a new area that offers different health plan options
- Losing other health coverage (for example due to a job loss, divorce, loss of eligibility for Medicaid or CHIP, expiration of COBRA coverage, or a health plan being decertified). **Note:** Voluntarily quitting other health coverage or being terminated for not paying your premiums are not considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage.)
- For people already enrolled in Marketplace coverage, having a change in income or household status that affects eligibility for tax credits or cost-sharing reductions

What if I'm losing job-based insurance? If you lose your job-based health insurance, you have 2 primary options for health insurance coverage: a Marketplace plan or COBRA continuation coverage.

Option 1: Get an individual Marketplace plan. If you leave your job for any reason and lose your job-based coverage, you can choose to buy coverage from the Marketplace. This is true even if you leave your job outside the Marketplace open enrollment period. By using the Marketplace, you'll learn if you qualify for lower costs on your monthly premiums on private insurance. You could also qualify for lower out-of-pocket costs. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Option 2: Get COBRA coverage. You may also be able to keep your job-based plan through COBRA continuation coverage. COBRA is a federal law that may let you pay to keep you and your family on your employee health insurance for a limited time (usually 18 months) after your employment ends or you otherwise lose coverage.

If you buy COBRA continuation coverage, you won't be able to get any of the lower costs on premiums and out-of-pocket costs that people may get using the Marketplace. You'd also have to pay the full monthly premium, including any part of the premium that your employer had contributed.