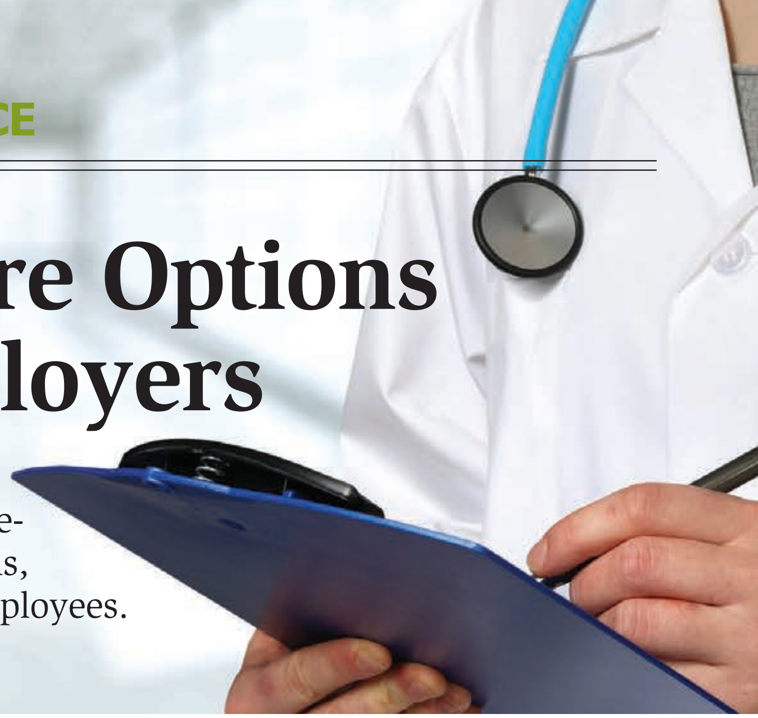

New Healthcare Options for Small Employers

Here's the skinny on qualified small employer health reimbursement arrangements (QSEHRA), hardship distributions, and HIPAA penalties for terminated employees.

BY GAYLE M. MEADORS, PC

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New Medical Expense Reimbursement Arrangement

In December 2016, Congress passed the 21st Century Cures Act (CCA), designed, among other things, to assist small employers that are not providing group health insurance to employees. Section 9831 of the Internal Revenue Code, which describes exceptions to the requirements for group health plans, was amended by CCA by adding a new subparagraph (d). The new amendment took effect as of January 1, 2017.

The purpose of the change in the law is to permit eligible small employers to reimburse employees for individual health insurance premiums or other qualifying medical expenses. Such reimbursement was not permitted under the provisions of the Affordable Care Act, because a reimbursement account was deemed to be an employer group plan that did not meet the ACA requirements and, therefore, would result in a penalty to an employer under Internal Revenue Code section 4980D. (See IRS Notice 2013-54.)

This newly enacted type of health expense reimbursement plan is called a qualified small employer health reimbursement arrangement (QSEHRA). A QSEHRA can only be offered by an eligible employer. Under CCA, an eligible employer is defined as an employer (1) with fewer than 50 full-time employees (2) that is not offering group health insurance to any of its employees.

The following rules apply to the operation of the QSEHRA:

- All contributions must be made by the employer. No salary reduction contributions by employees are permitted.
- All employees must be covered except: (1) new hires (less than 90 days); (2) employees under age 25; or (3) part-time or seasonal employees. Part-time and seasonal employees are defined in Internal Revenue Code Section 105(h)(3)(B).
- All employees must be treated the same, with limited exceptions. The employer can find out the costs of an insurance policy in the individual market where that employer is located and can vary the reimbursement based on such policy based only on either the age of the employee or, if applicable, family members, and based on the number of family members covered. The same policy must be the benchmark for reimbursement, even though the employee may be purchasing a different insurance policy from a different insurer.
- The arrangement can either pay premiums or medical expenses directly or can reimburse the employee for medical expenses incurred. (The term medical expense is defined in Internal Revenue Code Section 213(d).)
- The maximum reimbursement for the calendar year is $4950 for an employee alone or $10,000 if the arrangement also covers family members. Such numbers are indexed for inflation.

The purpose of the change in the law is to permit eligible small employers to reimburse employees for individual health insurance premiums or other qualifying medical expenses.

As has traditionally been the position of the IRS with regard to reimbursement of medical expenses, if the employer is reimbursing the employee for an expense already incurred, the employee must provide proof the expense has already been incurred. If the employer issues a reimbursement payment without substantiation, the IRS views the funds as being available for any purpose and therefore taxable.

With regard to the individual health insurance policies for which reimbursement can be sought, it does not matter whether or not a policy is purchased on the ACA exchange.

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However, the policy, whether purchased on the ACA Exchange or not, must cover "minimum essential benefits" as defined in the ACA.

If the policy does not cover minimum essential benefits, then any QSEHRA reimbursement is fully taxable to the employee. If insurance is purchased on the ACA Exchange, any QSEHRA amount is looked at to determine if it allows the purchase of affordable coverage under ACA rules. If the QSEHRA amount is not considered sufficient for the insurance to be affordable, any subsidy available under the exchange is reduced to account for the QSEHRA amount.

Finally, the employer must provide a notice of the features of the QSEHRA 90 days before the beginning of the plan year in which the QSEHRA commences. This notice requirement does not take effect until the IRS issues a model amendment. See IRS Notice 2017-20.

Although there are administrative complexities involved when employees are eligible for a subsidy under the ACA exchange, for those employers whose employees do not have group health insurance and whose employees are unlikely to be purchasing a policy through the ACA exchange with a subsidy, this new reimbursement arrangement is an attractive new option.

New Guidance on Hardship Distributions from 401(K) Plans

Code Section 401(k) imposes several restrictions on distributions to plan participants. In general, an in-service distribution is not permitted until age 59 1/2, but an exception is made in the case of a financial hardship. Amounts can be withdrawn to satisfy the hardship if other options are not available (such as a plan loan), but the rules are strict as to what constitutes a financial hardship and what documentation is required.

There has been an ongoing concern by plan sponsors as to what information is required and who needs to retain it in case of an audit in the future by the IRS. The IRS addressed this in the Internal Revenue Manual, Section 4.72.2, on February 23, 2017. See TE/GE-04-0217-0008. The discussion focused on what documentation is required to prove that the hardship is due to medical expenses, the purchase of a primary residence, tuition, avoidance of eviction, funeral expenses, or casualty home repairs. See § 1.401(k)-1(d)(3)(iii)(B).

The IRS stated in its guidance the following information must be retained to prove the hardship safe harbor has been met:

A. Medical Care: • Who incurred the medical expenses (name)? • What is the relationship to the participant (self, spouse, dependent, or primary beneficiary under the plan)? • What was the purpose of the medical care (not the actual condition but the general category of expense, for example, diagnosis, treatment, prevention, associated transportation, long-term care)? • Name and address of the service provider (hospital, doctor/dentist/podiatrist/other, pharmacy) • Amount of medical expenses not covered by insurance

B. Purchase of Principal Residence: • Will this be the participant's principal residence? • Address of the residence • Purchase price of the principal residence • Types of costs and expenses covered (down-payment, closing costs and/or title fees) • Name and address of the lender • Date of the purchase/sale agreement • Expected date of closing

C. Educational Payments: • Who are the educational payments for (name)? • What is the relationship to the participant (self, spouse, child, dependent, or primary beneficiary under the plan)? • Name and address of the educational institution • Categories of educational payments involved (post-high school tuition, related fees, room and board) • Period covered by the educational payments (beginning/end dates of up to 12 months)

D. Foreclosure/Eviction from Your Principal Residence: • Is this the participant's principal residence? • Address of the residence • Type of event (foreclosure or eviction) • Name and address of the party that issued the foreclosure or eviction notice • Date of the notice of foreclosure or eviction • Due date of the payment to avoid foreclosure or eviction

E. Funeral and Burial Expenses: • Name of the deceased • Relationship to the participant (parent, spouse, child, dependent, or primary beneficiary under the plan) • Date of death • Name and address of the service provider (cemetery, funeral home, etc.)

F. Repairs for Damage to Principal Residence: • Is this the participant's principal residence? • Address of the residence that sustained damage • Briefly describe the cause of the casualty loss (fire, flooding, type of weather-related damage, etc.), including the date of the casualty loss • Briefly describe the repairs, including the date(s) of repair (in process or completed)

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The IRS gives two options regarding retention of the documents described above. Either the plan sponsor or its record-keeper needs to review and retain all the above documents, or else it can provide a notice to the participant who is requesting the hardship distribution that the participant must retain all the relevant documents and must make them available upon request.

Hefty Penalty Imposed Due to Improper Handling of HIPAA Information

An announced penalty assessed through settlement dated February 14, 2017, between the Department of Health and Human Services Office for Civil Rights and a healthcare system is a stark reminder of the importance of health providers keeping patient health information secure. Under HIPAA, healthcare providers

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must protect the privacy of patients' protected health information (PHI).

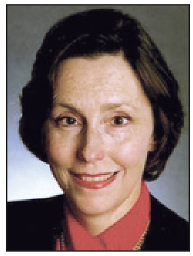
In this case, Memorial Healthcare System, a healthcare system in Florida, operated six hospitals and related facilities and also was affiliated with many physician offices. The system had HIPAA safeguards in place regarding policies. However, it was discovered that PHI had been improperly accessed by former employees of the hospital system or affiliated physician offices. There was a breach of PHI patients by 14 individuals who should not have had access. Of the 14 individuals, 12 were employed by affiliated physician offices, and those 12 breached the PHI of 115,000 patients.

HHS determined that there was no systematic review of the need for individuals to have access to PHI, no monitoring of log-in activity, and, in particular, no protocol for automatically terminating log-in privileges for terminated employees. Due to these violations, the healthcare system agreed to the \$5.5 million fine. A copy of the settlement agreement and required corrective actions is available at www.hhs.gov/sites/default/files/memorial-ra-cap.pdf.

Make certain that terminated employees are prevented from accessing patient data.

The magnitude of the fine serves as an important reminder to all healthcare providers to make certain that terminated employees are prevented from accessing patient data through credential cancellation, and PHI access for current employees is monitored to make sure that only appropriate access by persons with a need to know is occurring. **PM**

The above discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.



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