ACA Updates #2 Q&A – the following questions were asked during the two webinar sessions in November 2017.

Please note that although we do not provide any continuing education credits for our webinars, we can provide a statement of your attendance for you to independently submit for credit.

Q: Does the new tax bill address dependent care?

A: As introduced, the tax bill contains a provision to remove the exclusion of a dependent care flexible spending account (FSA) from income tax after December 31, 2017. However, there was an amendment put forward on November 6, 2017 that would postpone the elimination of the dependent care FSA until tax years after December 31, 2022. It is important to remember that this is only the House version of the bill and it will yet need to be reconciled with the Senate version. It is possible, however, that if the bill is passed in the current form (without the amendment), there would no longer be any incentive for employers to offer a dependent care FSA in the future. Much debate is still expected on the bill, however, so it is by no means a certainty that this provision will be included in the final version of the tax bill that may be signed into law.

Q: Please explain how PCOR Fees apply to a health care FSA.

A: If a health care FSA is non-excepted, then the PCOR Fee must cover every employee who participated in that non-excepted health FSA. The PCOR Fee must be calculated using one of the three PCOR Fee calculation methods - actual, snapshot or Form 5500. Most employers sponsor excepted (as opposed to non-excepted) health FSAs and are therefore not required to pay a PCOR Fee for their health FSAs. For example, a health FSA that is funded purely by employee dollars is an excepted health FSA and would not be subject to the PCOR Fee.

Q: Where can I find information on what medical expenses are covered by a health care FSA?

A. To be able to be reimbursed from a health care FSA, an expense must fall within the legal definition of "medical care," as defined in Internal Revenue Code §213(d) and related regulations. The expense must be primarily for a medical purpose (not a cosmetic purpose), and if the item is dual-purpose in nature (medical/non-medical), it can only be reimbursed if specifically required by a letter of medical necessity. In addition, the expense must be for the employee, his or her spouse, a tax dependent for health coverage purposes, or an employee's child through the calendar year in which the child turns age 26. In addition, the expense must be incurred within the plan year, and the amount of the expense must be within the plan limits ($2,600 for 2017, indexed annually). The plan limit for 2018 will be $2,650 per plan year.

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If the health care FSA is a limited health care FSA, the expense must be specifically for a dental or vision expense.

The IRS issues Publication 502 each year for taxpayers to use while itemizing medical expenses on their income tax return. Some of the items listed in this Publication may be eligible under a health FSA; however, it should be noted that not all items listed will be considered eligible under the cafeteria plan rules. For example, premiums and long term care insurance may be deductible on your income tax return, but they would not be eligible for reimbursement under the health FSA.

Employee Benefits Corporation provides a quick resource on our website that lists common medical expenses. Click here to download the flyer: http://www.ebcflex.com/Portals/8/PDF/quick-forms/eligibleExpenses.pdf.

Q: If we have retired employees that are still on our health insurance but not yet 65, do we need to provide them with a 1095-B, 1095-C or neither?

A: It depends on whether the individual is covered by an insured or self-insured plan and when they retired. If he or she is covered by a self-insured plan, then the individual would have to be provided with a Form 1095-B and the 1095-C if the retired employee was a full-time employee at any point during the calendar year. In the following calendar year, the employer would just be providing the Form 1095-B for the self-funded plan.

If the individual is covered by an insured plan for any month during the calendar year, then he or she would have to be provided with a Form 1095-C for that year by the employer. Going forward, they would not get the Form 1095-C from the employer, because they would no longer be full-time employees. However, the insurance carrier would continue to provide the 1095-B for proof of insurance coverage.

Q: Please discuss available measures that ALEs can use to determine whether the coverage they offer to FTEs is "affordable."

A: For plan years beginning in 2017, employer-sponsored coverage was considered "affordable" under both the pay-or-play rules and the eligibility rules for the premium tax credit if an employee's required contribution for self-only coverage did not exceed 9.69% of the employee's household income for the year. For plan years beginning in 2018, the percentage will drop from 9.69% to 9.56% of employee household income.

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Since it can be challenging for employers to know what an employee's "household income" might be, the IRS allows employers to use any of the following three safe-harbor methods:

• An employee's required share of premium for the lowest-cost, self-only coverage that provides minimum value may not exceed 9.5%* of the employee's W-2 taxable (Box 1) income. Notably, this calculation excludes any employer contribution made to an employee's health savings account, 401(k) plan or other non-taxable Section 125 (cafeteria plan) benefits. In addition, the cost of dependent coverage is not included in the calculation when determining whether the employer is offering affordable coverage. Employers may also elect to use the hourly rate or salary rate of pay to do the calculation. (*9.69% for 2017)

• An employee's required share of premium for the lowest-cost, self-only coverage that provides minimum value may not exceed 9.5%* of the employee's rate of pay as of the first day of the coverage period, which is usually the first day of the plan year. (*9.69% for 2017)

• An employee's required share of premium for the lowest-cost, self-only coverage that provides minimum value may not exceed 9.5% of the federal poverty level for a single individual. (*9.69% for 2017)

A health insurance plan is considered to provide "minimum value" if it covers at least, on average, 60% of an employee's total allowed cost of medical benefits expected to be incurred under the plan (generally determined using an actuarial value method of calculation).

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