



Health Reimbursement Arrangement Frequently Asked Questions

What is a Health Reimbursement Arrangement (HRA)?

The HRA is an employer-funded health care reimbursement account. The employee incurs eligible expenses – and then submits a claim form and documentation of the expenses, as required, prior to receiving reimbursement from the account. Eligible expenses are defined within the plan document and can include all out-of-pocket medical, dental and vision expenses (not paid by insurance or by any other qualified health plan; such as a Flexible Benefit Plan or Health Savings Account) and/or eligible premiums.

Expenses can be incurred and claimed for all eligible persons within the plan as defined within the plan document. An eligible person can include the employee (participant), former participant, spouse and dependents. Eligible expenses must be incurred while the participant or eligible family member is active in the plan, as defined within the plan document.

When an eligible COBRA qualifying event occurs, the employer is required to give the eligible participant, spouse and/or dependents the option to continue coverage in the HRA as a COBRA beneficiary. COBRA continuation for the HRA is offered under the same rules as any other qualified health insurance plan.

What procedures must be followed when offering an HRA?

When you introduce a new Health Reimbursement Plan (HRA) for your company certain items must be completed prior to the implementation of the Plan including:

- Review the design of your HRA to ensure it will meet your company's benefit objectives;
- Establish plan administration procedures (internal or third-party);
- Train staff responsible for the operation of your HRA; and
- Educate eligible employees on the availability of the plan prior to the start of your HRA plan year.

The options available to you within an HRA are listed below. You can choose one or all options to be included as eligible options within your HRA design. You can redesign your HRA Plan each year to keep up with changing employer or employee needs.

Insurance Options

Group Health Insurance

Employer-paid tax-free HRA dollars can be used to pay for group health insurance premiums such as: health, dental, vision, accident, cancer, hospital income and critical illness. The employee share of most of these premiums can be paid with tax-free dollars through a Flexible Benefit Plan.

Long Term Care Insurance

Long term care insurance premiums paid by the employer either directly as a company-paid benefit or through the HRA are paid with tax-free dollars. Payment of long term care insurance premiums by the employee through salary reduction must be paid with after-tax dollars. After-tax payroll deduction of these premiums may be an option.

Individual Health Insurance Premiums

While individual health insurance premiums are not specifically restricted from being paid with HRA dollars there are several cautions to be considered when offering individual policy coverage through an HRA or Flex Plan. Are you sponsoring the individual products as an employer-sponsored group plan when premiums are paid with employer HRA dollars? ERISA rules may then apply and HIPAA rules may conflict. Individual state mandates may also cause a problem. The law is still evolving on these issues and we do not have clear guidance.

Out-of-Pocket Medical Expenses

Eligible out-of-pocket medical expenses can include all Code 213 medical expenses as outlined in IRS Publication 502. Certain over-the-counter drugs and medications may also be included.

The employer determines what will be eligible for tax-free reimbursement under the HRA Plan design as specified in the individual plan adoption agreement and plan document.

What should be done to educate employees regarding the HRA?

The HRA Coordinator is the person in charge of the day-to-day operation of the plan. This person needs to be educated on how the company HRA Plan will work and convey this information to all eligible employees.

We recommend the Plan Coordinator do the following before the employee meeting date:

- Review the Plan Design and read the Plan Document;
- Read the Information & Rules Page and other Customized Materials;
- Copy the Information & Rules Page and Enrollment/Verification Memo for employees; and
- Copy the Reimbursement Instructions, Claim Form and HIPAA Privacy Notice.

Whatever design you adopt under your plan document (e.g. dollar amounts allowed, eligibility requirements, reimbursement schedule etc.) determines the rules for the entire HRA plan year. Each year you may re-evaluate the HRA and redesign it to fit the changing needs of your company and its employees. You are now ready to hold your employee meeting and review the plan with your employees.

What needs to be completed at the employee meeting?

The employee meeting is important to the success and understanding of your HRA. The function of the meeting is to explain the HRA to the employees and to encourage them to utilize the plan when appropriate.

Each plan year it should be mandatory for each eligible employee to sign an Enrollment/Verification Memo demonstrating he/she was informed of the availability of the HRA Plan. It also shows that the employee understands how to use the plan and provides the required Medicare Secondary Payer information, as appropriate. All eligible employees and new hires should also be provided the HRA Summary Plan Description, as this is a qualified Health Plan. The plan document and supporting materials constitute the Summary Plan Description.

At the employee meeting the Plan Coordinator will:

- Distribute the Information & Rules Page along with the Enrollment/Verification Memo to all eligible employees;
- Review the rules of your HRA Plan as stated on the Information & Rules Page;

- Distribute a Claim Form, Reimbursement Instructions and HIPAA Privacy Notice Form to all eligible employees;
- Review the Reimbursement Procedures and Reimbursement Schedule; and
- Allow time for Questions & Answers.

(If you cannot answer certain questions call or e-mail us. We are always here to support you and your Plan.)

Are any payroll taxes required on HRA dollars?

Under an HRA the following taxes are exempted on all dollars paid through the HRA as tax-free employer-paid medical benefit:

1. Social Security contribution
2. Medicare contribution
3. Federal Withholding Taxes
4. Federal Unemployment Taxes
5. State Withholding Taxes (varies per state – exempt in Colorado)
6. State Unemployment Taxes (varies per state – exempt in Colorado)

What options for administration are available?

The "administration" of an HRA plan refers to the tax-free reimbursement of eligible expenses to the employee (participant) with employer-provided HRA dollars. Administration includes the proper adjudication of claims (including review of the required documentation) plus tracking and reporting of the participant account reimbursements and balances. Under recent legislation the administrator of the plan is also responsible for electronic Medicare Secondary Payer Reporting to be completed on a quarterly basis.

There are two options available to you for administration. One option involves internal administration by you and the second involves an outside administrator performing this service for you. Due to the new Medicare Secondary Payer Reporting and the strict HIPAA Privacy rules it is recommended to have an outside administrator; like FlexMagic Consulting administer and report your plan.

Does the Company have to set up any special banking arrangements?

HRA dollars can be held in your general fund account. No special bank account is required. However, if a separate account is established, it should be under the company name, not under the plan name. (Example, ABC Company, not ABC Health Reimbursement Arrangement). If a trust account is established the plan is considered to be a funded plan and an audited opinion may be required. Your tax counsel and accountant can help you determine what is most appropriate in your company's situation.

How often should status reports be provided to participants?

Reports are recommended at least once a year, but preferably twice a year or even quarterly. Both a calendar year-end and a plan year end report are recommended.

How are claims processed?

All claims must be adjudicated before reimbursement and only copies of provider statements, or insurer's Explanation of Benefits (EOB) are required as documentation of a claim. Your claim's administrator has both the right and the obligation to deny a claim if all required documentation is not provided or if the claim is ineligible.

A claim is never paid without the signed claim form and the attached copies of proper documentation as this could possibly result in plan disqualification in the event of an audit.

What Claims are Accepted?

Eligible expenses must be incurred while the employee or eligible family member was an active participant in the plan. Medical expenses incurred prior to the plan year, but paid during the plan year, are **NOT** eligible expenses. Eligible expenses cannot be paid by insurance or another company reimbursement plan; and dollars reimbursed through the plan cannot be claimed as a deduction on a tax return.

Claim Substantiation must include the following information:

- The receipt must include the date of service, family member for whom the service was provided, provider of the service and documentation that the expense was not paid by an insurance plan. A copy of the Explanation of Benefits (EOB) from the insurance carrier may document that the expense was not paid by insurance;
- Eligible expenses cannot be paid by insurance or any other plan;
- Services must be incurred after the employee's effective date and while the employee is an active participant in the Plan. (Some plans allow expenses to be carried forward into the next Plan Year and even to be claimed after retirement – follow your plan design and plan document specifications carefully). An employee or eligible COBRA beneficiary is active in the plan if COBRA coverage is elected after the qualifying event, within the COBRA guidelines, and if premiums are paid timely each month for continued participation in the HRA.
- Mileage reimbursement is indexed each year for medical services. To be eligible for this reimbursement the employee must keep a mileage log of the trip with vehicle odometer readings, date of visit, reason for visit and family member name. Check with your tax accountant for eligibility (check HRA design to see if this option is an eligible expense).
- Certain over-the-counter drugs and medications may also be eligible with proper documentation and a doctor's prescription

If a claim is denied, or the employee claim substantiation is not complete, the participant is provided with a written claim denial (explanation of why the claim is being denied).

Reimbursements are processed on an immediate, weekly, monthly or even quarterly basis (based on plan design).

Where Can I Find a List of Eligible Expenses?

Eligible Health Care expenses are listed and explained under IRS Publication 502, however, eligible expenses may be limited within the HRA based on plan design. You can also call us at 1-800-888-9084 or via e-mail info@flexmagic.com.

Note: All participant claims for reimbursement that are unusual and/or unclear should be referred through the participant to his/her own tax advisor for advice. If the expense is eligible as a deduction item on a tax return, it may be eligible within the HRA Plan (based on the HRA design).

In the event of an audit, it is the participant who must provide proof to the IRS that the expense reimbursed was a valid medical expense eligible for reimbursement. Therefore, his/her own tax advisor's opinion is important. Participants have the right to appeal a denied claim (see Reimbursement Instructions).

How do Premium Reimbursement Claims work? (If applicable)

If Premium Reimbursement is one of your Plan options, the following conditions must be met before reimbursing any claims:

- The participant must be an active participant in the plan and have health premiums for coverage dates after his or her HRA effective date;
- The participant must provide a copy of the policy cover page indicating the effective dates of coverage; and
- The participant must show that the policy is active. Pre-payment of premiums is not allowed so you should reimburse only for the previous or current month's coverage.

Premium reimbursements are generally processed one time per month or quarterly, based on plan design. Increases or decreases in premium payments because of insurance rate changes are accommodated during the plan year. Group health premiums and individual health premiums can be allowed in your HRA Plan. However, there can be concerns related to individual premiums in relationship to HIPAA and ERISA regulations, which have not yet been clarified.

How does HIPAA apply to an HRA?

Special enrollment provisions may allow an employee to enroll or add dependents during the plan year if your HRA eligibility includes family members. HIPAA privacy rules apply to the HRA and privacy notices will need to be distributed to participants.

Under HIPAA regulations your employees are assured that certain health information, referred to as Protected Health Information (PHI), will be kept confidential. Disclosure of PHI for any purpose other than for "Plan Administration" such as quality assurance, claims processing, auditing and monitoring or for the purpose of obtaining payment is limited and subject to state and federal regulations. Your employees can contact the company "Privacy Officer" to obtain complete information about your company's privacy practices.

How does the Family & Medical Leave Act (FMLA) work with an HRA?

If FMLA rules apply to your company, participants are eligible to take medical leave and may also qualify for HRA continuation. After one year of employment with your company (minimum 1,250 hours during previous twelve months), an employee may be eligible for family or medical leave for any of the following reasons:

- Birth or adoption and first-year care of a child;
- Care of a child placed in the foster care of the employee; or
- Care of a spouse, child or parent with a serious health condition; or because of a serious health condition of the employee.

Your HRA is treated in the same way as you treat all other qualified health plan benefits.

How does COBRA apply?

COBRA gives employees and their covered dependents the right to continue group health coverage (medical, dental, vision insurance) including your HRA. See COBRA rules for details. NOTE: Colorado State Continuation does not apply to the HRA since it is a self-funded insurance plan.

How do we Handle Terminations?

Upon termination the participant, spouse and dependents, if applicable, must be provided with appropriate COBRA information and are eligible for continuation in the HRA. HRA premium payments must be sent to the COBRA Administrator monthly if continuation of coverage is requested. Failure to send premiums will remove the former employee or qualified beneficiary from being active in the HRA. Payments sent to the COBRA Administrator following termination are paid with after-tax dollars since the former employee is no longer receiving the company-paid HRA option as an employer-paid benefit.

How would Corporate Changes impact the HRA?

HRA Plan Coordinator and Administrator need to be aware that changes in the company's corporate structure **during** a plan year may produce some unanticipated results. If you know of any forthcoming mergers, acquisitions, changes from C-Corporation to S-Corporation structures or even layoffs, please remember to notify FlexMagic Consulting to determine how these changes will impact your HRA.

Where do we file our Plan Document?

Employers **do not file** the HRA plan document with any government agency. The plan document must be signed and kept in a safe place. All employers must have a written plan document that governs the operation of the HRA. Remember, the plan document and supporting materials (Summary Plan Description) are provided by Flex Magic Consulting, Inc. as "models." Your tax advisor and legal counsel should review and approve them.

What is included in a Summary Plan Description (SPD)?

ERISA and COBRA regulations require employers to provide each eligible employee with information on his or her rights under the employer's plan and clearly explain the plan design and rules. Note: If you are a public sector employer, you may not be required to follow ERISA regulations.

The FlexMagic provided SPD (Summary Plan Description) includes four parts:

- An overview of the plan document;
- The Information & Rules Page and Enrollment/Verification Memo;
- Claim Form, Reimbursement Instructions and HIPAA Privacy Notice; and
- COBRA Information Page.

The Information & Rules Page must be given to all benefit-eligible employees. See your HRA plan document for plan design specifics and eligibility requirements. The Summary Plan Description (SPD) must be given to eligible employees within 120 days after the start of the plan year or within 90-days after becoming a participant in the Plan. It must be distributed every fifth year if there have been modifications to your plan. It must be distributed at least every 10 years when no changes have been made.

If you include the Information & Rules Page along with the Enrollment/Verification Memo, Claim Form, Reimbursement Instructions, HIPAA Privacy Notice and mail the COBRA Information addressed to the employee, spouse and dependents; and make the plan document available you should be in compliance.

Note: *Non-English Speaking Employee Requirements*

If there are less than 100 employees and 25% are literate in the same non-English language, there must be a disclaimer in the SPD referring them to a person who can explain the information contained in the SPD.

If there are more than 100 employees and 10% are literate in the same non-English language, there must be a disclaimer in the SPD referring them to a person who can explain the information contained in the SPD.

How Long Sould Records be Retained?

At the end of each HRA y, it is prudent to store that year's documents and records in one place. Include:

- Signed Plan Document and Adoption Pages. (Keep current model document and current Adoption Pages in your Administration binder). NOTE: *FlexMagic Consulting, Inc. may notify you of the need to download an updated version of the document from time to time.*
- A full set of forms used for the previous plan year;
- IRS Publication 502 for the previous year;
- Participant claim forms and claims documentation; along with your administration and accounting records (always keep proof of claim denials and comments etc.) If the HRA is administered by a third-party make sure they keep these records for you.
- Employer copy of the 5500 Form (if applicable)

By following this procedure, should you be audited by the IRS, all pertinent records will then be easily accessible.

Upon the recommendations of our tax counsel the following suggestions apply:

- Tax returns and W-2's should be kept forever. The IRS can audit a company for "Gross Omission of Income" for six years. However, if fraud is found, there is no time limit on the review.
- Under ERISA Guidelines, 5500's (if required) should be kept for six years
Note: The employer should follow the advice of its own tax counsel.

Do we have to report HRA dollars on a W-2 Form?

Before-tax dollars paid through the HRA are never taxed and are not currently reported on the W-2 Form.

Is there a 90-Day Run-Out Period for Claims?

The FlexMagic document allows for a 90-day run-out period after the end of each plan year. Participants can submit claims for expenses incurred during the previous plan year during this time period only. The service must have been incurred during an eligible period of coverage while the employee was active in the plan. The 90-day run-out period does not extend the time for incurring expenses after the end of the plan year unless a plan allows a carry forward of dollars. During the 90-day run-out period there is tracking of two separate plan years.

Note: The HRA design can allow an unlimited run-out period with on-going eligibility, which would then provide payment of some health benefits in retirement.

Is there Discrimination Testing for HRAs?

The IRS requires that the HRA must be designed in a non-discriminatory manner. The discrimination test applies to the design of your HRA as it affects benefit-eligible employees. Discrimination tests are not based on utilization of the plan. The employer determines who is considered benefit eligible under the guidelines and this is stated in the plan document and on the Information & Rules Page.

- Employers cannot restrict benefit eligibility beyond three years of employment;
- Employers cannot require employees to be over 25 years of age to be benefit eligible;
- Union employees may be excluded from the group;
- Part-time or seasonal employees can be excluded, as can non-resident aliens with no U.S.A. income;
- Eligible expenses and limitations are the same for all employees (variations based on single coverage, single plus one and a family coverage are allowed);

- More than 2% Subchapter S-Corporation owners, sole proprietors and partners are not eligible to participate. *Note: According to IRS rules this includes most LLC and LLP owners.*

See your Information & Rules Page for your company's eligibility requirements.

The employer establishes a waiting period and requires a minimum number of work hours for benefit eligibility. These rules must be in writing, included in the plan document and disclosed to the employees.

Medical Plan Testing

Since an HRA is a qualified Health Plan under IRS Code Section 105(h) it is a self-insured plan. Self-insured medical, dental and vision reimbursement plans and other self-insured health insurance plans must comply with Code Section 105 testing. The plans must prove they do not favor highly-compensated employees as to eligibility or in the level of benefits provided under the plan.

Note: Eligibility tests are passed if one of these three requirements is satisfied:

- *At least 70% of all employees participate in the Plan;*
- *At least 70% of all employees are eligible to participate and at least 80% of these do participate; and*
- *The Plan must be offered to a "fair cross section" of employees that is found not to discriminate in favor of Highly Compensated Employees.*

The Benefits Test requires that all benefits provided to highly-compensated employees and their dependents must be provided for all other employees and their dependents.