

# Benefit Beat



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## Should You Re-Classify Your Employees?

Employment classification has created much angst between government agencies, both federal and state, and employers. At the heart of this conflict is whether an individual should be classified as an independent contractor, or as an employee. Contrary to popular belief, an employer does not necessarily have the discretion to classify employees as independent contractors, or as common law employees; rather, it is determined by the facts and circumstances of the work relationship.

The IRS has just offered a Voluntary Classification Settlement Program (VCS Program) to allow employers to re-classify individuals from independent contractor to employee status, and avoid significant tax liability, including interest and penalties.

To qualify for the VCS Program, the employer must:

1. Have historically classified the affected group as independent contractors;
2. Filed the appropriate Form 1099s for the three prior years; and
3. Not currently be under audit by the IRS, the DOL, or any state agency.

If the employer determines that the group of individuals should actually be classified as employees, the employer can file a Form 8952, and enter into a closing agreement to re-classify, on a prospective basis, a group of individuals as common law employees.

As part of this settlement, the employer would pay 10% of employment tax liability for the most recently closed tax year. This amount could be significantly less than what the employer might owe if audited.

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### **What Should An Employer Do?**

In determining whether the VCS Program is right for you, remember that in addition to the IRS and Treasury Department's interest in proper classification of employees, the Department of Labor and certain state entities also have a vested interest in independent contractor vs. employee status. The VCS Program is not binding on these organizations.

Further, several weeks ago, the IRS and Department of Labor entered into a memorandum of understanding, together with several state agencies, to share information relating to employee status, all of this in an effort to ensure that individuals are properly classified.

The bottom line is, employers should make certain that their workforce is properly classified, and if an employer has any questions about compliance with federal and state employment status laws, it should consult with its legal and tax advisors.

#### *IRS Resource Information:*

- **Overview of the Voluntary Classification Settlement Program**
- **VCSP Frequently Asked Questions**
- **Form 8952, Application for Voluntary Classification Settlement Program and instructions**
- **Announcement 2011-64**

## **IRS Clarifies Qualified Medical Expenses**

The IRS has issued three recent Information Letters relating to the determination of qualified medical expenses.

As background, for a medical expense to be reimbursed by certain medical reimbursement plans, such as a flexible medical spending account (FSA), a health savings account (HSA), a health reimbursement arrangement (HRA), or an Archer medical savings account

(Archer MSA), the expense must be specifically for the purpose of *"...the diagnosis, cure, mitigation, treatment, or for the purpose of affecting any structure or function of the body..."* [IRS Section 213(d)].

These Letters are important reminders about how an expense should be analyzed to determine whether it is reimbursable as a permissible medical expense under a particular plan. Two of the letters specifically underscore that the plan, particularly an FSA, an HSA, or an HRA can define the types of medical expenses that are reimbursable. Plans are not obligated to reimburse all of the types of expenses that could otherwise be reimbursed.

### **Concierge Services**

In one of these letters, a question was asked specifically about concierge services (**IRS Information Letter 2011-0027**). Concierge services can come in many forms. In this instance, an annual fee is paid to a medical practice for *"heightened access to physicians, a comprehensive annual physical, minimum half-hour doctor visits, and access to dietitians and exercise therapists"*. According to the IRS, depending on what the concierge fee is specifically for, some, all or none of it may actually qualify as a medical expense. This Letter did not address the specifics of concierge expenses; rather, it simply says that if it is determined the concierge expense would qualify as a medical expense, the plan, itself, determines whether it would be reimbursable.

### **Hearing Aid Repairs**

**IRS Information Letter 2011-0055** specifically affirms that hearing aid repairs are reimbursable as a medical expense. But again, the IRS underscored that it is the plan, itself, that defines whether the expense is reimbursable, under its terms and conditions.

### **Medical Foods**

In **IRS Information Letter 2011-0035**, the IRS addressed the deductibility of special foods or food supplements as a qualified medical expense. In a nutshell, if the food supplement is determined to be medically necessary, as proven by a physician diagnosis, then the cost of the food supplement that exceeds the cost of food for normal nutritional needs could be deductible as a medical expense. Likewise, these expenses could be reimbursed from medical spending accounts, as long as the plan so permits.

### **Reporting Welfare Benefit Plan Failures - Updated Form 8928**

The IRS has updated its **Form 8928 and Instructions**. This form is to be used by group health plans and employers to self-report certain welfare benefit plan failures, including but not limited to violations relating to:

- COBRA;
- HIPAA portability, access and renewability provisions;
- Discrimination based on a health factor, including genetic information;
- Mental health parity rules;
- Minimum hospital lengths of stay in connection with childbirth;
- "Michelle's Law";
- Comparable employer contributions to health savings accounts and Archer MSAs;
- Health care market reform provisions of the Affordable Care Act; and
- Coverage for pediatric vaccines.

While this form has not changed significantly from the prior form, it does specifically include Michelle's Law, and certain market provisions of the Affordable Care Act. The important reminder here is that plan sponsors make every effort to ensure compliance with these laws; and that they do regular audits. Any violations should be corrected immediately.

### **Medicare Mandatory Reporting for HRAs: Increased Threshold Levels and Exhausted Account Balances**

As a means of enforcing the Medicare Secondary Payer (MSP) Rules, the Centers for Medicare and Medicaid Services (CMS) impose a reporting requirement upon insurers, third party administrators, and plan administrators of self-funded, self-administered group health plans. CMS considers health reimbursement arrangements (HRAs) to be a group health plan for purposes of the MSP rules; and thus, subject to the Medicare Mandatory Reporting Requirement. See prior *Benefit Beat* articles:

- ♦ **Mandatory Medicare Reporting for HRAs Clarified**, Aug, 2010; and
- ♦ **Updated Information: Mandatory Medicare Reporting for HRAs**, June, 2010.

On September 27, 2011, CMS issued some clarifying **Guidance** relating to the HRA reporting requirement:

- **Increased Threshold Levels.** HRAs have been subject to the reporting requirement if the HRA exceeds \$1,000. According to the recent guidance, this threshold is increased to \$5,000, effective October 3, 2011, applicable to the HRA's next reporting year. This increased threshold should come as good news for certain stand-alone HRAs in that it may relieve them of certain reporting obligations.
- **Exhausted Account Balances.** This guidance provides that if an HRA is subject to the Medicare Mandatory Reporting Requirement, and if an individual has exhausted his/her benefit coverage under the HRA for the remainder of the coverage term, a termination notice must be filed with a Coordination of Benefits Contractor (COBC) in the next regularly scheduled MSP Input File Submission. In the alternative, this notice may be provided by contacting the COBC call center (1-800-999-1118).

Once the individual account has been replenished in an amount exceeding \$5,000, the reporting entity must then submit a new record reflecting the start date of the new coverage period. This provision became effective September 27, 2011.

## **A Final Reminder: Provide Medicare Part D Notices by October 14<sup>th</sup>**

The Medicare Part D enrollment period is October 15 to December 7, 2011. Therefore, all Medicare Part D notices of creditable or non-creditable coverage must be provided ***prior*** to October 15, 2011.

- Model Individual Creditable Coverage Disclosure Notice Language (**English** or **Spanish**)
- Model Individual Non-Creditable Coverage Disclosure Notice Language (**English** or **Spanish**)

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