
Benefit Comply Health Reform FAQ

May 2010

Health Reform Employer Q&A

Please note: A number of issues addressed in these questions will be subject to significant regulatory interpretation by the agencies responsible for various parts of the legislation. The answers to the questions reflect our current understanding of the issues but are subject to change as additional guidance and clarifications are issued.

Throughout the questions we referred to the health reform legislation as the Affordable Care Act (ACA). This terminology has been adopted by the Department of Labor in recent publications. This reference includes rules contained in both the Patient Protection and Affordable Care Act (H.R. 3590) and the Reconciliation Act of 2010 (H.R. 4872).

Effective Dates

Q: What is the effective date of the new insurance coverage provisions for grandfathered plans?

A: The requirement to cover children to age 26, the pre-existing condition limitations for children under age 19 and the prohibition on lifetime maximums are effective on the first plan year beginning after 9/23/2010. For example, plans with a plan year beginning on January 1st would be subject to these provisions on 1/1/2011, however, plans with a plan year beginning August 1, 2010 would not be subject to the new rules until 8/1/2011.

Small Employer Tax Credit

Q: How does a "small employer" receive the credit? What agency is responsible for getting the tax credit to the employer?

A: An employer with less than 25 FTEs applies for the tax credit when they file their annual income tax. The IRS has posted detailed information on how to calculate and apply for the credit at:

<http://www.irs.gov/newsroom/article/0,,id=220809,00.html>.

Q: We are a small employer. We pay 80% of the insurance for full time (40 hours and up) but only cover 20% for full time (30 hour to 40 hour), would we be eligible for the tax credit?

A: The employer will earn a credit only for employee coverage where the employer pays at least 50% of the employee premium. In this example, the employer would be eligible for a credit based on the amount paid for the full-time employees, but not for amounts paid toward their part-time employees since the employer contribution is less than 50% toward the part-time employee coverage.

Q: Does the tax credit mean that an "S" Corp that has no tax to pay will get \$ directly to them?

A: The tax credit only reduces the current year's tax liability (except for tax exempt organizations), so if an employer has no tax liability in a given year the credit must be carried over to future tax years. The IRS has said they will release

Reporting Requirements

Q: Is the amount that we are reporting on W-2s for tax year 2011 actually taxable?

A: The value of health benefits will be reported on an employee's W-2 beginning for the 2011 tax year (W-2's distributed in 2012). This is a reporting requirement only and does not change the tax treatment of the benefits provided.

Q: Reporting aggregate cost of health coverage on the W-2, does that include medical, dental, vision, long/short term coverage?

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A: The W-2 reporting requirement applies to any “group health plan” made available to an employee which is excludable from the employee's gross income under Code Sec. 106. The reporting requirement does not include contributions to a Section 125 health FSA. It also appears that it will not include “excepted benefits” such as standalone dental and vision coverage. The IRS is expected to release detailed rules regarding the calculation of the required reporting.

Q: For the new W-2 reporting, the employer must disclose the value of employee's health coverage. Is that the COBRA rate, or the total premium rate?

A: The employer will report the total cost of the plan.

Grandfathered Plans

Q: Please define "grandfathered plans" one more time. Our plan renewed on 5/1/2010 with no changes. Is our plan grandfathered?

A: An employer group health plan that existed on March 23rd, 2010 is considered a grandfathered plan. An employer plan that renewed on 5/1/2010 with no changes would still be considered a grandfathered plan. The ACA is not clear about what changes can be made to a plan without causing the loss of grandfathered status. This is an important area of the law and significant guidance is expected from the regulatory agencies. As of May 10th, 2010, no guidance on grandfathered status has been released.

Q: As an employer with a fully insured health plan, at renewal if there is not a change to the plan but just the premiums, would we lose our "grandfather status"?

A: Detailed guidance is needed to determine what changes to a plan would cause the loss of grandfathered status, but a renewal with a rate change and no other significant plan changes not cause the loss of its grandfathered status. As of May 10th, 2010, no guidance on grandfathered status has been released.

Plan Coverage Requirements

Young Adult Child Coverage

Q: Can we still carve out spouses if they are eligible for coverage at their own employers?

A: There is nothing in the Affordable Care Act that requires employers to offer spouse coverage until 2014. In 2014 large employers (those with 50 or more employees) may be subject to a penalty if they do not offer coverage to full time employees (those that work 30 hours or more) and their spouses and dependents.

Q: If a 24 year old child of an employee is married with 2 children of his own and has a job which offers no insurance, Must our plan allow the employee to enroll the 24 year old child, but not the child's spouse or children?

A: Yes that is correct. The ACA does not require a plan to cover the spouse or dependents of the adult child.

Q: Please define “older children” or “young adults” that are subject to the coverage requirement.

A: The Affordable Care Act requires plans that offer coverage to dependents to make the coverage available until an adult child reaches the age of 26.

There is significant confusion regarding the related IRS rule which makes coverage provided to adult children a tax free benefit to employees as long as the child has not reached age 27 by the end of the tax year. The IRS tax rule does not require plans to cover children to age 27, it simply extends the tax free status of the benefit. The tax definition is structured this way because under current tax law the child must maintain tax free status the entire tax year for that coverage to be tax free to the employee.

Q: Do adult children under age 26 have to be living with the covered parent to be eligible?

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A: No, there is no residency requirement.

Q: If an insurance company implements coverage for children to age 26 before a plan's required effective date under the law, does the employer have to offer it before their plan year renewal?

A: Whether the employer has any flexibility regarding the eligibility definition in a fully-insured plan depends on the employer contract with the insurer.

Q: Our summary plan description currently states you have to be a student to qualify as a dependent; however, it looks like this will no longer be a requirement, is this correct?

A: Yes. Once the adult child provision applies to a plan it can no longer make student status a criteria for dependent eligibility for children up to the date they turn 26.

Q: If our plan does not include/cover dependants, does the older children rule mean that we will be required to cover dependants?

A: The ACA does not require an employer to offer dependent coverage. If a plan does offer to cover employees dependents, that coverage must be extended to children up to the date they turn 26. However, beginning in 2014 employers may pay a penalty if they do not provide qualifying coverage to full time (30 hours/wk) employees and dependents.

Q: Do employers have the right to charge separate rates for extending dependent coverage?

A: No. The DOL has issued regulations that require plans to charge the same for young adult children as charged to other eligible dependents

Q: If a couple has a 19 year old child, but they are divorced would either have to cover the child since the child is not considered a dependent after 18 in divorce courts (child support, etc)?

A: A plan of ether parent would be required to offer coverage to the child up to the date they turn 26.

Q: Does COBRA count as "eligible for other coverage" for a 25 yr. old under the young adult child coverage rule?

A: An adult child is not eligible for coverage if they are also eligible for other employer sponsored group coverage (for example coverage offered where the child works). The ACA does not specifically address COBRA as "other coverage" however if an adult child has a COBRA event and does not elect the COBRA coverage within the election period they are no longer eligible for that coverage. At that point it is anticipated the child would be eligible to enroll in a parent's plan. Further guidance on this issue is expected.

Q: For dependents who have had a lapse in health coverage due to no longer qualifying as a dependent on current plan dependent rules and are now eligible to enroll under the young adult coverage rule will they be subject to a pre-existing condition clause?

A: The rule to cover young adults simply requires plans to treat older children in the same way as other dependents eligible under the plan. Existing plan requirements such as enrollment periods and pre-existing conditions that apply to other dependents would also apply to coverage for young adult children.

Q: The state of WI currently requires coverage for dependents up to age 27. Would federal law override this or would they be covered under fed law until 26 and then fall under state law to 27?

A: No. The federal ACA requirement does not trump existing state insurance laws that provide greater coverage.

Q: Referring to dependents 26 and under, if there is an increase to a family premium when a dependant is added, who is responsible for the increase?

A: This will depend on the employer's contribution arrangement with its employees. The older child is simply one more "covered dependent" on the plan. If the employer charges employees a different amount based on the number of dependents covered on the plan, then the employee would be responsible to make the additional contribution in the same way they would if they added any other dependent to the plan.

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Q: When determining if an adult non-dependent child is not eligible for another employer's group health plan, do you suggest having both the employee (parent) and the adult child sign a document stating there is no access to another group health plan?

A: It is anticipated that the process to certify dependent eligibility will work much the same as it does now relative to full-time student status. While nothing in the health reform legislation specifically prohibits requiring a certification directly from the older child, most plans will rely on the employee's statement or require some type of employee affidavit.

Lifetime and Annual Maximums

Q: If someone has already hit their lifetime limit and is off the plan, due to the elimination of lifetime limits effective after 9/23/10, will we be required to add that individual back onto our plan?

A: If an individual is eligible under the plan as an employee or dependent, the plan would be required to allow them to re-enroll. Guidance is needed to determine if the individual would have any special enrollment rights other than those already offered by the plan to other eligible individuals (i.e. open enrollment period, special enrollment, etc.)

Waiting Periods

Q: Has there been a change in the maximum waiting period allowed by employers for new employees? For instance, the maximum waiting period was 180 days of full-time employment, but I had heard this changed to 90 days. If so, when does that take effect, and what is the new maximum period?

A: Beginning in 2014 plans may not have a waiting period of more than 90 days. This rule will also apply to grandfathered plans.

HSA/FSA/HRA Rules

Q: Regarding the 2013 rule limiting Section 125 FSA contributions to \$2,500, is the limit per family or per person?

A: The statute does not specifically limit the contribution to a family so it is anticipated that the limit will apply to each individual. If an employee and spouse each have access to a separate Section 125 health FSA they would each be eligible to make a \$2500 contribution. However, as of May 10, 2010 no regulations have been issued by the IRS and it is possible the maximum could apply to a family. Employers are advised to review this rule prior to the 2013 effective date.

Q: Our FSA plan runs from 7/1/10 through 7/1/11. Does the over the counter drug reimbursement change apply to us effective 1/1/2011?

A: Yes. Over the counter drugs are no longer eligible expenses beginning 1/1/2011 under an FSA, HSA or HRA plan regardless of plan year.

Q: If our health care FSA plan year starts on 11/1, how will the \$2500 cap affect our plan year?

A: The rule specifically states that an individual may not make an election to contribute more than \$2500 annually to a Section 125 health FSA after 12/31/2012. The effect of this rule is that elections made prior to 1/1/2013 will be valid for an entire FSA plan year that begins prior to 1/1/2013.

Employer Mandate

Q: How are part time employees counted on a pro-rated basis? Example: We have 48 full time employees and provide coverage, but we have 82 part time employees who are not offered coverage.

A: Beginning in 2014 the ACA requires large employers to offer qualifying coverage to all full time employees (defined as 30 hours per week) or face a possible penalty. While the act does not require employers to offer coverage to employees

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who work less than 30 hours, part time employees are used to calculate if an employer qualifies as a "large employer".

A large employer is defined as an employer having "at least 50 full-time employees during the preceding calendar year". Part-time employees are factored into the calculation of number of employees on a monthly basis by taking the total number of hours worked by all part-time employees and dividing by 120 hrs.

In the example in this question, assume the 82 part-time employees worked an average of 20 hrs/week.

82 PT employees X 20 hours = 1640 total hours. $1640 \div 120 = 13.67$ FTE. The employer in the example would be considered a large employer with over 61 FTE (48 FT + 13.67 FTE = 61.67).

Q: Does "affordable cost" cover the entire family or employee only?

A: The affordable cost criteria (less than 9.5% of household income) applies to employee only and family coverage.

Q: As a small employer who would not be mandated to offer coverage, but currently does offer coverage, is there an instance where I would be required to pay a penalty if I do not offer paid employer dependent coverage?

A: No. The employer penalties only apply to "large employers" with 50 or more employees.

Q: Are there required employer contributions to plans? Example if you are currently paying 50% of the employee only cost, do we have to increase this contribution?

A: The ACA does not set a specific required contribution level, however beginning in 2014, the employer contribution level will directly impact the possibility of the employer paying a penalty. Large employers (50 or more employees) may be subject to a penalty if an employee; 1.) earns less than 400% of the federal poverty level, 2.) the employee's contribution to the employer plan exceeds 9.5% of their household income and, 3.) the employee opts-out of the employer plan and purchases subsidized coverage through an exchange.

Q: I heard there had to be an employer pro-rated contribution to health care for part-time (less than 30 hours) employees--is that wrong?

A: Nothing in the ACA requires employers to provide coverage to employees who work less than 30 hours per week.

Q: Does the calculation of FPL consider the total household income? What if an employee makes less than 400% of FPL based on their individual income but the addition of the spouse's income far exceeds the 400% of FPL amount?

A: Federal poverty level is based on total household income

Q: Under the definition of "affordable coverage" is the out-of-pocket amount the employee pays the basis for calculating the penalty? In other words, what if an employer pays some of the premium and the employee pays the balance? Which amount is used as the basis?

A: Only the employee's required contribution to a plan is used to determine if the plan qualifies as "affordable coverage"

Q: Does the 9.5% premium maximum for employees to pay include all premiums (health, dental, vision, etc) or is it just their health insurance premium?

A: The affordable premium calculation does not include stand alone dental or vision coverage, however if dental and vision benefits are paid as part of a single health plan, the total cost of the plan would be used.

Q: To be eligible for the state subsidy, does the employee have to meet BOTH the 400% poverty level and greater than 9.5% premium cost, or just one or the other.

A: For individuals who are eligible for qualified employer sponsored coverage to qualify for subsidized coverage through the exchange they must meet both requirements; 1.) their income cannot exceed 400% of FPL and, 2.) their required contribution to the employer plan must exceed 9.5% of their household income.

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Q: Relating to "Play or Pay" penalty, how is household income figured by the employer? We may not know spousal income, etc.

A: The employer will not be required to determine the employee's household income. This will be done by the state insurance exchange. The exchange will certify if an individual is eligible for a premium tax credit or cost sharing reduction. Once an employee is certified, it is unclear at this point if the exchange will communicate directly to the employer or if the employee will be responsible to provide this information to their employer.

Q: When the exchange determines if someone qualifies for the subsidy, will there then be a grace period which would allow the employer to reduce the employee contribution to less than 9.5% so that the employer can avoid the penalty.

A: The penalty will be assessed on a monthly basis according to the number of employees who qualify for subsidies. If an employer reduces an employee required contribution, they would no longer be eligible for subsidized coverage and the employer penalty would not apply. The actual process regarding the details of the administration of employer penalties still needs to be determined.

Q: Our company defines FT employees as working 36 hours per week. Will we now have to start offering coverage to employees working 30-35 hours per week?

A: If an employer does not offer qualifying coverage to all employees working 30 hours a week they will face the potential to pay a penalty under the employer mandate rules. Some employers may choose to continue current eligibility rules and pay the penalty instead. Employers must analyze the financial impact based on the number of employees involved and the cost of extending benefits to a broader group of employers, compared to the potential penalty.

Free Choice Voucher

Q: We are a small employer who would not be required to provide health coverage. Currently we do offer coverage. Would we be subject to the Free Choice Voucher?

A: The free choice voucher requirement applies to any employer regardless of size who offers qualifying coverage to their employees and pays a portion of the premium.

Q: Is the Free Choice Voucher paid to the employee in one lump sum or over the course of the year?

A: The free choice voucher is provided to a qualified employee on a monthly basis.

Automatic Enrollment

Q: If you "auto enroll" employees, do you enroll for single coverage and can you pre-tax the premium without the employee's authorization?

A: The ACA does not address the pre-tax treatment of premiums for individuals who employers must auto-enroll. As of May 2010 regulations from the DOL and/or the IRS are needed address this.

Q: For the automatic enrollment, is it any 200 employees or only full-time/eligible employees when determining the necessity of auto enrollment?

A: The automatic enrollment requirement applies to any employer with more than 200 full-time employees.

Q: Will there be an option for employees to "opt out" of automatic enrollment?

A: Yes

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General

Q: Are Church plans exempt from HCR legislation?

A: Church plans that provide benefits through a fully-insured arrangement will be subject to most of the provisions contained in the ACA since many rules apply to both the employer plan and the insurance company who issues fully-insured policies. There is some confusion regarding which provisions will apply to self-funded church plans and additional guidance on this issue is expected.

Q: Do different requirements apply to self-funded plans?

A: Other than the questions regarding self-funded church plans, most requirements in the ACA apply equally to self-funded and fully-insured plans.

Q: Does the health reform address when coverage ends (i.e. on the birth date or at the end of the month of the birth date)?

A: No. Nothing in the health reform legislation changes the terms of a plan regarding when an individual loses eligibility for the plan.

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