Q&A from Assurex Global Webinar "Affordable Care Act Regulatory Update"	September 25 & 26, 2013
Question	**Answer**
Q: Please clarify Grandfathered plans. Q: How do you know if your plan is grandfathered?	A: Group health plans that were in existence on March 23, 2010 (prior to ACA) are excused from some, but not all, of the health care reform requirements under ACA. However, if the plan makes any of the following 6 changes, the plan will lose its grandfathered status and will then become subject to all ACA requirements: (1) elimination of all or substantially all benefits to diagnose or treat a particular condition; (2) increase in an individual's percentage of a cost-sharing requirement (e.g., coinsurance); (3) increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points; (4) increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation); (5) decrease in an employer's contribution rate toward the cost of coverage by more than 5 percentage points; or (6) imposition of annual limits on the dollar value of benefits below the amounts outlined in the interim final regulations.
Q: Do all of these items apply to grandfathered plans?	A: Grandfathered plans must comply with the shared responsibility rules for employers and the waiting period rules. However, grandfathered plans are exempt from the cost-sharing limitations and the requirement for fully-insured small groups to provide essential health benefits.
Q: If an employee is covered under a Grandfathered plan but wants to go to the exchange to get insurance, would he/she be eligible to receive a tax credit	A: If any individual is eligible for an employer-sponsored plan, whether large or small group, that provides minimum value (60% actuarial value) and is affordable (employee contribution for employee-only coverage does not exceed 9.5% of household income), then that individual will not qualify for a subsidy through the exchange.
Q: Do I need to send to Notice of Exchange to SEASONAL employees?	A: Yes - the exchange notice must be sent to ALL CURRENT EMPLOYEES.
Q: Does notice of exchange need to go to COBRA recipients?	A: The exchange notice is required for employees only. If the COBRA participant is still an employee (i.e. COBRA for reduction of hours), the individual should receive a notice. However, it is not required to send the notice to COBRA participants who are not currently employees.

Q: Do you have to tell employees as of October 1st if your company will offer coverage as of 1/1/14 or does the notice just have to tell them there is an exchange to purchase coverage through?	A: It is only mandatory that the notice includes the information listed below (the format and additional information is at the discretion of the employer): • Informing the employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance; • Notify employees that if the employer's plan does not provide minimum value (as defined by the ACA), employee's may be eligible for a premium tax credit if the employee purchases a qualified individual health plan through the Marketplace; and • If the employee purchases a qualified health plan through the Marketplace, the employee would lose the tax free employer contribution to any health benefits plan offered, and premiums paid for individual coverage would be made on an after-tax basis. Beyond the information content required by regulation (which is all contained in the first page of the model notice), there is not much guidance. It is our recommendation that the employer provide basic eligibility information as well to let employees know whether or not they're eligible for employer-sponsored coverage.
Q: On the DOL Model Notice is the only requirement page 1....technically.	A: Yes, all the required content is found on page 1 of the model notice; however, we recommend that employers also include basic eligibility and plan information so that employees have what they need to look into coverage through the exchange and don't have to come back to the employer with as many questions.
Q: Please clarify the ER obligation to distribute Notice of Exchange when they have employees who receive benefits through the union. If union refuses to distribute notice to the EE, must they at a minimum provide to the ER a description of the coverage and the affordability of it. Absent that, can ER leave that information off the Exchange Notice since they do not know if its MV or affordable?	A: It is ultimately the employer's responsibility, not the union, to distribute the exchange notice to all employees. However, so long as the required content is included (see below), it is not necessary to provide eligibility and plan information. Content required by the statue includes: • Informing the employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance; • Notify employees that if the employer's plan does not provide minimum value (as defined by the ACA), employee's may be eligible for a premium tax credit if the employee purchases a qualified individual health plan through the Marketplace; and • If the employee purchases a qualified health plan through the Marketplace, the employee would lose the tax free employer contribution to any health benefits plan offered, and premiums paid for individual coverage would be made on an after-tax basis.

Q: We have a few 1099 contract employees. Would we be required to send a Market Place notice to those employees.	A: First of all, for purposes of the FLSA, an individual is either an independent contractor, or an employee. There is no such thing as a "contracted employee". If the individual is an employee, rather than an independent contractor, they should be sent an exchange notice.
Q: What is an employer's responsibility in terms of educating their employees on the individual mandate and tax? Particularly employees who waive medical coverage claiming it is too expensive, when the premiums do actually qualify as "affordable"?	A: The employer is responsible for providing the exchange notice with the required content (at a minimum). Employers may want to provide additional basic plan information, but that is not required. More importantly, if an employer offers minimum value coverage, that is affordable to most employees, it is in the employer's best interest to communicate that most employees and their families will not be eligible for subsidies through a public exchange.
Q: When sending the exchange notice, what additional information should the employer include to reduce questions from employees?	A: Basic plan eligibility, actuarial value, and affordability information is not required, but will assist employees comparing plans with those available in the Marketplace determining eligibility for tax subsidies through the exchange.
Q: Does the notice requirement include temps? Q: What about sub contractors that we hire but send 1099s to?	A: The exchange notice is required for current employees only. Whether or not the notice should be distributed to temp employees depends on their classification. If they are employees, rather than independent contractors, then the exchange notice should be sent to them. It is important to properly classify these individuals because besides penalties that may be assessed for misclassification by the DOL and/or IRS, there may also now be penalties under the ACA.
Q: I work for a staffing company. Often times we have consultants that come to us from other companies. Do they need to receive the Notice of Exchange? Q: When you say temps. on the exchange notice, does that include temps that are hired and paid through a Temp. Company? We hire temps but we do not pay the temp we pay the company that sends them to us and they pay the employee.	A: It is necessary to provide the exchange notice to all EMPLOYEES. If these consultants may be classified as employees of the staffing company, then they should receive the notice.
Q: To clarify, the 10/1 notice must also be provided to our "temps" that are hired through a temporary agency? The temp agency had us distribute their notice, but we were not planning to give them OUR notice.	A: If they are employees of the temporary agency, the temporary agency is responsible for distributing the notice. If they are your employees, you are responsible for distributing the notice.

Q: If we submit a w-2 to the IRS for someone, then we should send them a notice?	A: Typically, yes.
Q: So we're a municipal employer... does this mean we have to give the notice to council members?	A: The notice of exchange would only be required if council members were employees of the city.
Q: Do small groups have to abide by the 30 hour per week rule to determine eligible employees? Q: Explain the Full Time Employee 30 hr rule for both large employer and small employer. Will this be the definition in 2014 for both large & small employers.	A: No, the definition for full-time status is 30 hours of service or more per week as required under the shared responsibility rules for employers and therefore applies only to 'applicable large employers' (50 or more FTEs). Small groups may continue to define full-time and part-time status at their discretion.
Q: Due to the employer mandate delay, there has been confusion regarding the requirement for employers that sponsor a medical plan to "offer" that plan at least annually (referred to by some as "open enrollment"). Can Bob address the "annual offer" requirement? Does it apply to both large and small employers? Our understanding is that it has not been delayed.	A: Under the shared responsibility rules for employers, which have been delayed until 2015, there is a requirement to offer coverage at least annually. Therefore, 'applicable large employers' (50 or more FTEs), must have an open enrollment annually beginning in 2015 to avoid potential penalties. This rule does not apply to small groups.
Q: If you have a salaried employee who works variable hours, because they are on salary there is no time being kept. How is that going to be handled?	A: If such employee is being treated as full-time and offered benefits, it is not an issue. However, if such employee is not treated as full-time, IRS rules provide "equivalency" optional methods for determining full time status for employees whose hours are not tracked. An employer can use a day equivalency or a week equivalency method. For example, under the day equivalency method the employer would be required to credit the employee with 8 hours of service for any day worked. The other option would be to begin a system of tracking actual hours of service for salaried employees. Employers choosing to use one of the equivalency methods should consult with a qualified advisor regarding detailed rules related to the use of this method of tracking hours of service.

Q: How is the average 30 hours per week calculated? Specifically, how are Vacation, Holiday and other paid and unpaid time off treated in calculated the average hours?	A: The regulations provide that an employee's hours of service include (i) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and (ii) each hour for which an employee is paid, or entitled to payment, on account of a period of time during which no duties are being performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Additional things to keep in mind: • Hours of service includes all paid leave. • All hours of service performed for entities treated as a single employer (i.e., controlled group, common control, or affiliated service groups) must be taken into account. • Unpaid hours during FMLA or USERRA leave must be considered under one of two special rules applicable to these types of leave. • Hours of service include all hours of service for which an employee receives U.S. sources of income, but do not include hours of service compensated by a foreign source of income. Therefore, hours of service worked outside the United States, such as employees working overseas, generally will not count toward hours of service.
Q: I am a restaurant large employer. When we hire people we don't know for sure if they will work more than 30 hours per week...and knowing that they have to be covered if they do work more than 30 hrs per week, i am trying to figure out what the new hires look back period is to figure if they qualify for insurance on the first of the month after 60 days of being hired.	A: If based on the facts and circumstances upon hire, it cannot be determined that the employee is reasonably expected to average at least 30 hours of service per week, the employee is considered a variable hour employee and may be subjected to the look-back measurement period as set forth below (if the employer chooses). For new variable hour or seasonal employees, the measurement period may begin any date between the employee's hire date and the first day of the first calendar month after the hire date. Starting the initial measurement period on the first of the month would be easier administratively, because the employer would only have 12 initial measurement periods to keep track of with multiple new hires in each one; using date of hire would mean a different initial measurement period for every employee. Also keep in mind, the initial measurement period and the administrative period combined may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the start date (at most, 13 months plus a fraction of a month). Example - employee hired 3/18/14, measure 4/1/14 - 3/31/15, administration period 4/1/15 - 4/30/15, stability period 5/1/15 - 4/30/16 (employee must be offered coverage no later than 5/1/15).
Q: Must large employers offer dependent coverage?	A: Beginning in 2015, the shared responsibility rules for employers require 'applicable large employers' (50 or more FTEs) to offer coverage to full-time employees and dependent children (not spouses) or face potential penalties.

Q: If an employer provides coverage to dependants but does not contribute to premiums for dependants, can the employee receive a premium tax credit for their dependants?	A: If the dependent is eligible for an employer-sponsored plan which is affordable for the employee-only coverage (employee contribution for employee-only coverage does not exceed 9.5% of household income), then the dependents will not qualify for a tax subsidy.
Q: Who do the subsidies get paid to - the employee, the insurance company or the employer? Check? Tax Credit? Does this mean unless you file taxes, you don't get the subsidy?	A: The subsidies go to the individuals enrolling for coverage through the exchange (or Marketplace). The subsidies come in the form of tax credits and reduced cost-sharing for those that qualify. Most premium subsidies will be available in the form of advanceable and refundable tax credits (individuals have the choice of receiving subsidies with each monthly payment or of waiting and receiving a refund on taxes). If an individual chooses to receive the premium tax credit on a monthly basis the exchange will forward the tax credit directly to the insurance company and the individual will be required to pay only their portion of the premium.
Q: If you choose a 12 month measurement period, can the stability period be 6 months or does it have to be 12 months?	A: No. The stability period must be the longer of (a) 6 months; or (b) the length of the measurement period. Since the measurement period is 12 months, the stability period would also have to be 12 months.
Q: Please clarify...I am an over 50 employer. I understand I can avoid a shared responsibility penalty for this year. But if an employee goes to an exchange and qualifies for a subsidy, does 4980 (B) apply potentially or not?	A: No. There will be no penalties assessed on 'applicable large employers' (50 or more FTEs) under the shared responsibility rules for employers until 2015, even if employees do enroll for coverage and qualify for a subsidy in 2014.
Q: How do these delays in requirements affect employees qualifying for coverage at the exchanges on Oct 1 2013?	A: There may be fewer employers offering minimum value, affordable plans in 2014 because they are not required to do so until 2015, but otherwise there are no changes. Individuals may qualify for tax subsidies through the exchange (a) if they do not have access to employer-sponsored coverage that provides minimum value and is affordable; and (b) the individual has household income between 100-400% of federal poverty level.
Q: The requirement that individuals must have coverage, is this still applicable? If someone waives and can't prove they have other coverage, do we have to force them to take our lowest option plan? the lowest option we have met the requirement of minimum coverage and also costs less than 9.5% of our lowest paid employee	A: Yes, the individual mandate is still effective 1/1/14 and all individuals are required to have coverage unless they meet one of the exemptions. The penalty is on the individual if the individual fails to secure coverage, so there is no responsibility on the employer to force individuals to enroll for coverage under the employer-sponsored plan. Keep in mind, in 2015, 'applicable large employers' (50 or more FTEs) will be required to offer coverage to all full-time employees (30 or more hours of service per week), but still will not need to require such employees to enroll.

Q: For non-calendar year plans, can you remind us of the "few criteria" we had to meet under the transition rule previously and thus will likely have to meet again?	A: The previous transition relief rule was as follows: For those applicable large employers (50 FTEs or more) with existing non-calendar plan years as of December 27, 2012, transition relief is available if (a) at least 25% of ALL of the company's employees are covered under the non-calendar plan years (as of the end of the most recent enrollment period or any date between October 31, 2012 and December 27, 2012), or (b) 1/3 or more of ALL of the company's employees were offered coverage under those plans during the most recent open enrollment period before December 27, 2012. So long as the employer satisfies either (a) or (b) above, the employer will not be liable for any potential penalties prior to the 2014 plan year renewal. If transition relief is provided for 2015 (we will have to wait and see, but we think it is likely), then it would not be necessary to make changes until plan renewal in 2015; however, if transition relief is not provided, or if the employer does not meet the transition relief criteria, it will be necessary for the employer to make changes with the 2014 renewal because potential penalties for any full-time employees not offered coverage would begin to apply 1/1/15.
Q: Is large employer for this reporting still 250 or is it down to 50+ now. Q: Will the transition rule be extended for w-2 reporting for 2013 w-2's or will the information be required on 2013 w-2's?	A: Reporting health care costs on the W-2 is a different ACA requirement than the reporting we discussed during the webinar (reporting of 'minimum essential coverage' on Form 6055 and reporting of 'employer-sponsored coverage' on Form 6056). Employers are required under the ACA to report the costs of an employee's coverage on the employee's W-2. However, transition relief was provided for W-2 reporting for any employers with less than 250 W-2s; such employers are not required to report until further guidance is provided, so
Q: This reporting is only for large employers, right? Are there any reports that a small employer has to make?	A: 6055 coverage reporting is applicable to any groups (small or large) providing 'minimum essential coverage'. However the insurance carrier, not the employer will be responsible for this reporting for fully insured plans. 6056 reporting applies only to 'applicable large employers' (generally 50 or more FTEs)
Q: Does the employer reporting requirement apply to self-funded HRA plans?	A: Beginning in 2014 there will no longer be stand alone HRAs. Employers offering an integrated HRA with a group medical plan will include information on the combined plan in the required reporting.
Q: How will IRS determine who should be taxed for not having insurance since employer reporting has been delayed?	A: Individuals will have to report insurance coverage or lack of insurance coverage on individual tax returns. Improperly reporting coverage on the tax return will have the same consequences as failure to provide accurate information regarding any other matters on an individual tax return and may subject the individual to tax related fines and penalties.

Q: Can you speak more about coverage reporting for self-insured large employers. I heard monthly reporting requirement?	A: There will be no requirement to report to the IRS on a monthly basis. However, the required annual reporting will include monthly employee information, for example, which months the employee was covered by the plan.
Q: Does HRA apply to both small and larger firms?	A: Whether the group is small or large, stand-alone HRAs cannot be used to reimburse employees on a pre-tax basis for individual health insurance. HRAs are only allowed if they are 'integrated' with a group health plan.
Q: The out of pocket maximums, does this amount include the deductible or is this total (deductible + co-insurance + out of pocket max)?	A: All participant costs are included in the OOP maximum (deductibles, copays, out-of-pocket costs, etc.).
Q: I'm assuming deductibles are included in the OOP maximum? If so, and employer offers HRA that reimburses a portion of the deductible, is the $ reimbursed under the HRA excluded in calculating the OOP max (i.e., is OOP max calculated net of max HRA reimbursement available to employee)?	A: Yes, the deductible is included in the OOP maximum (all participant costs are included - deductibles, copays, out-of-pocket, etc.). If an employer offers an integrated HRA then only the portion the employee would be required to pay is included in the calculation of the OOP.
Q: Does the cost sharing include what employees pay toward health insurance premiums, for example, what comes out of their payroll check to pay for health insurance?	A: No, the premium (or employee contribution to the premium) is not included in the OOP maximum.
Q: Does the OOP Max only apply to in-network services or can there be a higher OOP max for out of network services? Q: Are their different deductibles/out-of-pocket limits for out-of-network services?	A: The OOP maximum applies to in-network services, so it is okay for there to be a higher OOP maximum for out-of-network services.
Q: I have a HMO carrier that is not including Rx copays in the OOP maximum (they considered the Rx a separate "rider" to the plan). How are they allowed to do this?	A There is a transition rule that applies to 2014 only. If Rx and the medical plan are administered by separate administrators, a plan may allow separate OOP maximums for the medical and the RX. However, beginning in 2015 all cost sharing will need to roll up into a single OOP maximum.
Q: What would be the legality of reimbursing an employee a % of their individual plan if they chose not to join your group plan	A: It is no longer possible for an employer to reimburse employees for the cost of individual plan coverage on a tax free basis. However, there is nothing that prevents an employer from implementing a cash in lieu of benefits plan, as long as the compensation provided to the employee is treated as taxable income.

Q: What happens if you are in more than one state and are a small group which state essential health benefits apply?	A: The state rules in place in the state in which the group policy is issued would determine the essential health benefits of that policy. It would not matter where employees live who are covered by the plan.
Q: For the 90 day waiting period- can you have that all the employee's must pass a probation period. Our probationary period is 90 days, but if the employee doesn't pass then we might extend by 30 or 60 days. Can we still have that requirement even though it would be over 90 days.	A: The August 2012 guidance provides that "eligibility conditions based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation." Following are several specific scenarios included in the proposed regulations: • Meeting certain sales goals or earning a certain level of commission, as well as attaining job-related training or licensure are generally allowed and do not trigger the 90-day waiting period limitation until eligibility is met. • Variable Hour and Seasonal Employees – if an employer chooses to use the optional look-back measurement method to determine eligibility, the employer may require a 3-12 month measurement period and 90-day administrative period consistent with the employer shared responsibility rules under IRS Code section 4980H. Coverage for employees who have enough hours of service during the initial waiting period must be offered no later than 13 months from the employee's hire date (plus a fraction of a month if the hire date is not the 1st day of the month). Keep in mind, an applicable large employer subject to the shared responsibility rules for employers may still be liable for potential penalties if coverage is delayed beyond 90 days even if substantive eligibility conditions delaying coverage are allowed for purposes of the 90-day waiting period limitation as set forth above.
Q: Has the rule that requires offering benefits within the first 90 days been delayed until 2015?	A: No, waiting periods cannot exceed 90 calendar days upon plan renewal on or after 1/1/14 (i.e. if a plan renews in March, the waiting period cannot exceed 90 calendar days beginning 3/1/14).
Q: Is the waiting period 90 working days or 90 calendar days?	A: 90 calendar days.
Q: Waiting period - best to hire on the FIRST day of the month? what about an employee hired on the 9th, 12, or 21st (for example) of the month?	A: Many people are choosing to use 1st of the month following 60 days for their waiting period, which would make it irrelevant which day the person is hired (this would always stay within the required 90 day limitation).

Q: We allow an employee to be eligible on the first of the month after 90 days because of the way our insurance is billed. This means it could be 119 days until he has coverage. Will this be allowed?	A: No, coverage must be effective no later than the 91st calendar day following eligibility. Waiting periods of 1st following 90 days will no longer be acceptable.
Q: Does the 90 day requirement include days not worked, i.e. weekends? Or do we count the number of days actually worked?	A: Yes…the waiting period cannot exceed 90 calendar days (regardless of whether those days are worked or not).
Q: In regards to the waiting period of no more than 90 days total. How does this affect employees who were hired within 90 days prior to this taking effect? For example, your plan renews 8/1/14. You hired an employee 7/1/14. Does the new less than 90 day waiting period apply to them or the old waiting period which may have been first of the month following 90 days?	A: For those individuals hired or newly eligible prior to the beginning of the 2014 plan year, as of the first day of the 2014 plan year, the individual(s) must be credited with any prior waiting period days; and if 90 days has already been incurred before the 2014 plan year renewal, such individual(s) must be allowed to commence coverage on the 1st day of the 2014 plan year. See examples below assuming a 5/1/2014 plan year renewal: • If the employee is hired 4/15/2014 (subject to a waiting period of 1st of the month following 90 days), the employee must be offered coverage no later than 7/14/14 (90 days after date of hire). • If the employee is hired 1/15/2014 (subject to a 6-month waiting period), and the new plan year begins 5/1/2014, the employee must be offered coverage no later than 5/1/2014.
Q: What is the definition of small group?	A: For 2014 and 2015 states can define small group for the purpose of insurance rating and underwriting rules. Most states define small group as 50 or less employees. Beginning in 2016 small group will be defined as 100 or fewer employees under a uniform method nationwide that includes counting part time employees on a pro-rated basis.
Q: What responsibility does an employer with union employees have regarding ensuring they receive their ACA benefits?	A: 'Applicable large employers' must offer coverage to all full-time employees beginning in 2015 or risk potential penalties under the shared responsibility rules for employers. This includes union employees.
Q: Is COBRA going away any time soon?	A: No, COBRA is not going away, but there may be more people able to get better coverage through the Marketplace, therefore decreasing the number of overall COBRA participants.
Q: I have no idea what the rules are for small employees. Where do I go for resources for small employees (we have 5 total) what are our rules we have to follow???	A: The best resource for assistance with requirements applicable to small employers would be the Assurex Global firm that invited you to this webinar.