Q&A from Assurex Global Webinar "When Do Various ACA Requirements Go Into Effect?"	November 20 & 21, 2013
Question	**Answer**
Q: Are there any regulations about what is considered a "short-term" hire?	A: Under the shared responsibility rules for employers (section 4980H) effective in 2015, the guidance provides that employers may treat temporary employees (full-time or part-time) as variable hour employees through 2014, therefore allowing them to be subject to the optional look-back measurement period if the employer so chooses. It is expected that there will be additional guidance around temporary employees going forward that may place time limits and/or other restrictions on how temporary employees are treated; however, through 2014, temporary employees may be treated as variable hour employees.
Q: Are those hours worked or does vacation hours paid included in that 1560 hours per year?	A: When counting hours for the shared responsibility rules for employers (section 4980H) effective in 2015, the employer must consider 'hours of service' rather than simply hours worked. 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.
Q: can he/she just have the $500 balance? Q: $500 rollover question... what if an employee carries over the $500, but then does not want to enroll in FSA the next year?	A: If an employee does not participate in the plan the following year, any unused portion of the election amount or carryover amount must be forfeited. An employee can participate in the following year and not make any additional contributions to the plan, In this case the employee would only have the carry over amount available for reimbursements.
Q: CAN OUR EMPLOYEES GO TO THE EXCHANGE AND BUY INSURANCE EVEN THOUGH THEY WOULDN'T QUALIFY FOR THE SUBSIDY BECAUSE OF ACCESS TO AN EMPLOYER PROVIDED PLAN ?	A: Yes - most individuals are eligible for insurance through the Exchange. Individuals are eligible for coverage through the Exchange (Marketplace) so long as the individual • is a citizen, national, or lawfully present and is not incarcerated. On the other hand, individuals are only eligible for subsidies if they do not have other disqualifying coverage and household income is 100-400% of federal poverty level (FPL).

Q: Can we give the exchange notices at the same time they are eligible for benefits or do we need to do it sooner? Q: For new hires and the exchange notice, how many days do we have to send it to them?	A: Exchange notices must be provided to new hires within 14 days of hire.
Q: Is the reinsurance fee in addition to the $63 that we paid this year already?	A: No, it is the same thing. Insurers and plan sponsors or TPAs on behalf self-funded groups are responsible for paying reinsurance fees in 2014, 2015 and 2016. The fees are calculated by multiplying the annual contribution amount ($63 in 2014) by the average number of individuals covered under the plan during the year. There was no $63 fee related to the ACA payable in 2013.
Q: Cost Sharing Limitations: Do the out-of-pocket limits apply to non-network services? Do grandfathered plans need to comply? Q: If in-network cost sharing meets the criteria, but the out of network cost sharing does not does the plan comply?	A: The out-of-pocket maximum applies to in-network services; therefore there may be additional costs for out-of-network services and the plan will still be compliant. Cost sharing limitations (limit on annual deductible and out-of-pocket maximums) do not apply to grandfathered plans.
Q: Do you think the definition of full time as 30 hours will remain?	A: Congress would have to amend the law for the requirement to change. Keep in mind, this definition of full-time status applies only to 'applicable large employers' (50 or more FTEs). Small groups may continue to define full-time status as they do today.
Q: does $500 roll over apply to limited use FSA? Q: What about people moving from Flex Plan to HSA/HD plan? Can they carry over to limited scope FSA?	A: Yes - the $500 can also be carried over to a limited purpose FSA.
Q: Does an employer with a calendar year plan have to choose either the grace period or the $500 rollover for the FSA? If we do not have the grace period, do we have to make a change to one or the other change in 2014 plan?	A: Whether it is a calendar year plan or non-calendar year plan, the plan cannot ever have both the grace period and the carryover provision in place. The plan is not required to offer a grace period or the carryover option for 2014, but if it chooses to do so, the plan must offer either the grace period or the carryover provision, but not both.

Q: Does the PCOR fee apply to AFLAC, cancer policies, etc. that the employee pays for themselves through payroll deduction?	A: The PCOR fee applies to most group health plans, unless they meet the definition of an 'excepted benefit' (i.e. certain health FSAs, limited scope vision or dental). The fee also does not typically apply to disease-specific policies or indemnity policies but companies like AFLAC sell a variety of products so you would need to check with the carrier regarding any specific policy.
Q: Does the $10,200 premium limit for the Cadillac tax apply to total annual plan cost, or employee's contribution amount?	A: For the 'Cadillac tax', the 40% excise tax on the amount above the applicable annual premium coverage is based on the total premium, not just the employee contribution.
Q: Does the $500 Health FSA rollover build up over multiple years, or does it reset to $500 every year?	A: The maximum amount that can be carried over in any plan year is $500. It cannot be added to any amount that was carried over from a previous plan year.
Q: Example: Our current plan has a waiting period of 90 days - 1st of the month following. On 1/1/2014, we will be updating this to 1st of the month following 60 days. For an employee hired on 11/1/2013 - would their eligibility be 2/1/14 or 3/1/14.	A: The individual would need to be offered coverage no later than the first of the month after 60 days of employment since that is the plans eligibility provision effective in 2014.
Q: for a plan with an hra integrated with a medical plan, does the employer have to pay the reinsurance fee, or does the carrier pay it?	A: The IRS has released guidance which clarifies that HRAs are not subject to the reinsurance fee as long as the HRA is integrated with a fully insured or self-funded group health plan.
Q: For the 1st of the month following 90 days, does this apply to LTD?	A: No, the prohibition on excessive waiting periods (cannot exceed 90 calendar days) applies only to group health plans. LTD policies are not considered group health plans.
Q: For the small group rating & underwriting rules, does this apply to self funded groups or only fully insured?	A: The small group market rules included those described in the legislation as "requiring fair health insurance premiums and guaranteed availability/renewability" apply only to fully-insured plans. However, no health plans (fully insured or self-funded) are allowed to impose pre-existing conditions for plan years beginning on or after 1/1/14.
Q: How about W-2 cost reporting for 2014?	A: Yes, W-2 reporting is required in 2014. The requirement to report health insurance costs on W-2s is already in effect and will continue on an annual basis going forward. However, until further guidance, those employers which filed less than 250 W-2s the prior year are not required to report.

Q: How does the reinsurance fee get paid and to whom do self-insured ERs pay the fee?	A: Contributing entities must provide enrollment data to HHS by November 15. HHS will provide notification of the amount due by the later of December 15 or 30 days after receiving the data and payment is due 30 days after notification. HHS has recently released guidance that it will collect reinsurance contributions in two installments—the reinsurance contributions for reinsurance payments and administrative expenses will be collected at the beginning of the calendar year following the applicable benefit year, and the contributions for payments to the U.S. Treasury would be collected at the end of the calendar year following the applicable benefit year.
Q: What is the effective date for pre-existing waived on all members, children and adults?	A: As of plan years beginning on or after 1/1/14, group health plans are prohibited from imposing any pre-existing condition exclusions. Therefore, for a non-calendar plan year, that rule will apply as of the first plan year in 2014.
Q: How is medical leave of absence factored in for hours worked in a look back period? A fulltime employee could lose benefits.	A: Keep in mind that is necessary to track 'hours of service' and not just hours worked. Those employers choosing to implement a look-back measurement are required to follow the rules for any 'special unpaid leave'. 'Special unpaid leave' is unpaid leave under FMLA, USERRA or jury duty. To prevent periods of special unpaid leave from reducing an employee's hours of service during the measurement period, the employer is required to average the hours of service using one of the two following methods: (i) Determine average hours of service by excluding any periods of special unpaid leave during the measurement period and applying that average for the remaining measurement period; or (ii) Impute hours of service during the periods of special unpaid leave at a rate equal to the average weekly hours of service for weeks that are not part of a period of special unpaid leave.

Q: I hear this reinsurance fee may go away for self-funded plans after the first year? Any update on where this stands?

A: In the recently released proposed rules, HHS proposed that the definition of 'contributing entity' (responsible for making reinsurance payments) be modified to mean: "(a) a health insurance issuer; or (b) a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of appeals) or plan enrollment."

Therefore, the only entities being excused from the reinsurance payments for 2015 and 2016 are those with self-funded plans that also self-administer. Self-funded plans that use a third party administrator are still required to make the reinsurance payments.

Q: I thought the enrollment date for 3/16 thru 3/31 the coverage would be in effect on 5/1 so the individuals would be safe from the individual mandate tax.

A: So long as individuals enroll by 3/31/14, regardless of when the coverage is actually effective, the individual will be excused from the individual mandate tax.

Q: If I have a March 1 renewal date, do I need to change my waiting period January 1, 2014 or March 1, 2014? Thank you.

A: The waiting period for a March plan year renewal will not need to be adjusted until 3/1/14.

Q: If we did not report health costs on the 2012 W2's are we exempt from reporting the health costs on the 2013 W2s?

A: If the entity filed less than 250 W-2s in the prior tax year, the group is exempt from reporting health coverage costs until further guidance is released.

Q: IF we have the grace period, can we just continue with that for 2014? Will we be able to continue with the grace period beyond 2014? We would not be doing the rollover

A: Yes, it is possible to continue offering a grace period in 2014 and going forward so long as the $500 carryover is not offered. It is not allowed to offer both options.

Q: Individual Mandate tax - does it apply to each individual in the family not insured?	A: Yes, all individuals are required to have minimum essential coverage or pay a tax beginning in 2014 (unless the individual meets one of the exceptions). The following are exemptions: • individuals who cannot afford coverage—defined as individuals for whom a required contribution for coverage would cost more than 8% of their household income; • individuals whose household income does not exceed the threshold for filing a federal income tax return; • members of certain Indian tribes; • members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits (religious conscience); • members of a recognized health care sharing ministry; • individuals who are incarcerated; • individuals who are not lawfully present in the U.S.; • individuals who have a gap in coverage for less than a continuous three-month period (this exemption may only be used for one period without coverage in a year); and • individuals who are extended a hardship exemption as determined by the Secretary of Health and Human Services (HHS).
Q: Is it the employee cost only that is reported on the employee's W2? I have heard both way. Employee only, Employee and Employer cost.	A: No, it is the total premium that should be reported on the W-2, not just the employee contribution.
Q: Is that reinsurance fee applicable to small businesses?	A: Yes, the reinsurance applies to all size groups. However, fully-insured groups will typically be paid by the insurer.
Q: Is the Cadillac tax for all employers?	A: Yes, the Cadillac tax will generally apply to all employers (large and small, self-funded or fully-insured).
Q: Is there a proposed "format" for the 6056 Employer Plan Report, i.e. a sample?	A: Not yet, but additional guidance has been promised before the reporting is required in 2015.

Q: just to verify, a municipal government still falls under "small employer" if they have less than 50 employees, correct? or do all government employers have to comply with large employer rules regardless of the size of the staff?	A: A government entity will only have to comply with the shared responsibility rules for employers under Section 4980H if the entity meets the definition of an 'applicable large employer' - 50 or more FTEs.
Q: Non-discrimination - would this relate to offering higher compensated employees are offered a better health plan	A: Employers are not required to provide the same benefits for all plans or to all employees. However, any time there are different eligibility requirements, plan benefits or cost-sharing, potential discrimination issues should be considered. • For self-funded groups (subject to nondiscrimination rules under section 105(h)), employers may not discriminate in favor of highly compensated employees (roughly defined as the top 25% of employees). Under 105(h) there are tests that must be met if there are different benefits for different employees, otherwise the plan will be deemed discriminatory. • For fully-insured groups, similar rules are to be released in the near future, likely making them effective in 2015.
Q: Can you quickly review the optional measurement period	A: For 'applicable large employers' with variable hour or seasonal employees, the proposed regulations have provided a safe harbor look-back measurement method that can be used (at the employer's option) to determine eligibility over a 3-12 month measurement period. The determination of variable hour and seasonal employee eligibility using a measurement period is too complex to address in detail in this forum. You should seek the advice of the Assurex Global partner firm that invited you to this webinar.
Q: pcori fee, self funded example, why not due by 7-31-14 instead of 7-1-15?	A: PCOR fees are due no later than July 31st of the year following the last day of the plan year. Therefore, for a plan ending 5/30/14, the fee is not due until 7/31/15.
Q: So I have an EE that switched from a HDHP with HSA to a PPO plan. He is not electing Flexible dollars now, but he can still use his HSA correct?	A: Yes, although the individual can no longer contribute to the HSA if the individual is no longer enrolled in an HDHP, the individual can still continue to be reimbursed by the HSA for qualified medical expenses.

Q: So, if I understand correctly, if our plan year for the FSA goes from October of 2013 to September 2014 we would have to amend this plan change by 12/31/13?

A: If the plan does not have a grace period, the amendment must be adopted no later than the last day of the 2014 plan year. If the plan currently has a grace period, there are two options: (i) Adopt the new carryover for 2014 by amending the plan documents no later than the last day of the 2014 plan year; or (ii) Adopt the new carryover for 2013 by amending the plan documents (and also retroactively eliminating the grace period) no later than the last day of the 2013 plan year.

However, keep in mind, the plans ability to retroactively eliminate a grace period provision previously adopted for the plan year may be restricted by other non-Code (e.g. ERISA, etc.) rules. Consequently any plan sponsor considering retroactive plan amendments which eliminate an existing grace period should seek the advice of a qualified advisor.

Q: We are a small employer with 35 employees however we are part of a "large group. Do we go by the Large employer rules or small employer rules. we are fully insured.
Q: Is it true that if you own 2 completely seperate Companies you cannot take each Company as a seperate entity as far as number of employees, but instead have to add them to get your "total" ?

A: For purposes of the shared responsibility rules for employers under Section 4980H, it is necessary to consider the Section 414 rules in regards to controlled groups/affiliated service groups. If the various entities are considered to be part a 'controlled group' under Section 414 rules, it's necessary for all entities within the controlled group to be considered together for purposes of determining 'applicable large employer' status (50 or more FTEs).

If total FTEs amongst the entities within the controlled group are 50 or more FTEs, all entities within the controlled group are required to offer coverage to all full-time employees (30 or more hours of service per week) to avoid potential penalties under the shared responsibility rules for employers beginning in 2015. However, such penalties will apply separately to each entity within the controlled group.

Q: W-2 Health Cost Reporting : do Union employees, covered under union packages, get included in the 250 count?

A: When determining whether an employee filed less than 250 W-2s, all employees are counted (including union employees).

Q: we previously had probationary employees up to six months, we have shortened this to 90 days. When we have persons that have been here on temp status and 1/1/14 occurs do we start counting the 90 days from their date of employment, say in November, or do we start the 90 days on 1/1/2014

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 1/1/14 plan year renewal:
• If the employee is hired 12/15/14 (subject to a 6-month waiting period), the employee must be offered coverage no later than 3/15/14 (90 days after date of hire).
• If the employee is hired 9/15/14 (subject to a 6-month waiting period), the employee must be offered coverage no later than 1/1/14.

Q: What if you are a union contractor who does not sponsor the plan and cannot get the information to complete the exchange notice.

A: Ultimately it is the employer's responsibility to ensure that all employees (including union employees) receive the exchange notice. Ideally, efforts can be coordinated with the union to include plan information and make things easier for the union employees to understand their potential eligibility/ineligibility for tax subsidies through the exchange. However, only the following content is required: • 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: What is the government's official reasoning for the w-2 reporting beyond the proof of coverage?

A: The reporting is for informational purposes only. The stated purpose is to provide "*useful and comparable consumer information to employees on the cost of their health care coverage."*

Q: What is the penalty if you keep a service waiting period that is longer than 90 days?	A: Code section 4980D imposes a civil penalty of up to $100 per day excise tax for failure to meet any ACA requirements. Any noncompliance is required to be self-reported on tax Form 8928. In addition, other civil action and related expenses may apply (i.e. civil action brought by the DOL or plan participants for failure to comply).
Q: When you keep referencing participants - does this mean employees covered by the plan or the employee and all of their dependents?	A: Both PCOR fees and reinsurance fees apply on a per participant basis (all covered lives rather than just an employee count). There are multiple methods provided in the regulations that employers may use depending on whether the group is fully-insured or self-funded. Depending on the group, choosing one method over another may result in lower costs for the employer.
Q: When you refer to "Effective first plan year in 2014" - if a plan doesn't renew until June 1, 2014 is that the effective date or January 1, 2014 for all the larger employers as far as the waiting period?	A: For a June 1, 2014 plan year, the waiting period must be adjusted not to exceed 90 calendar days as of 6/1/14.
Q: Will small employers have to use a measurement period approach to determine when they have to offer coverage to those employees who work on a part-time basis but whose hours may vary over the course of the year? Currently offer coverage to those who regularly work 30 hours or more per week.	A: No. Small employers (for these purposes less than 50 FTEs) are not required to offer coverage to full-time or part-time employees, but rather may choose to do so. Small employers are also not required to use 30 hours as the definition of full-time status. Therefore, it is not necessary for a small employer to use the measurement method for variable hour employees unless it is helpful to do so in accordance with the plan's eligibility rules.
Q: Wouldn't you need to set up the measurement period for the hand full of variable hour employees? Even if the majority of your employees are not variable?	A: No, it is still possible for the employer to measure eligibility for such employees on a monthly basis (as it is measured today). It is not required that the look-back measurement method be used.

Q: For the 6056 report, can you tell us what data is going to be required based on what you know now?
Q: What info will be required on 6055 & 6056?

6055 Coverage Reporting
1. The name, address, and taxpayer identification number (TIN) of the primary insured.
2. The name, dates of coverage, and TIN of each individual covered under a policy.
3. Whether coverage is a qualified health plan offered through an Exchange.

6056 Employer Plan Reporting
1. The employers name, date, and employer identification number (EIN).
2. A certification as to whether the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage.
3. The number of full-time employees for each month during the calendar year.
4. The name, address, and taxpayer identification number of each full-time employee during the calendar year and the months during which that employee was covered under any of the employer's health plans.

If an employer offers employees minimum essential coverage, the report must also include:
1. The length of any waiting period.
2. The months during the calendar year for which coverage under the plan was available.
3. The monthly premium for the lowest cost option under the plan.
4. The employer's share of the total allowed costs of benefits provided under the plan.

Q: Is the Cadillac tax for self insured based on COBRA cost or actual cost of the plan?

A: Cadillac tax regulations have not yet been released and are not likely to be released any time soon so details on applicable premium calculation are yet to be determined. However, Self-funded COBRA rates should be developed based on actual plan cost so the costs will likely be similar (subject to changes in the final rules).

Q: What does it mean by the age rate spread of no more than 3:1? We have been shown rates for 2014 and it goes by age and the older you are, the more the cost?

A: In general the cost for the oldest age bracket can be no more than 3 times the cost for the youngest age bracket.