December 15, 2016

Into the Weeds! Answers to Specific Employer Benefits Questions We Have Received.

Presented by Benefit Comply

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- Welcome! We will begin at 3 p.m. Eastern

- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.

- You will be able to submit questions during the webinar by using the “Questions” box located on your webinar control panel.

- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.

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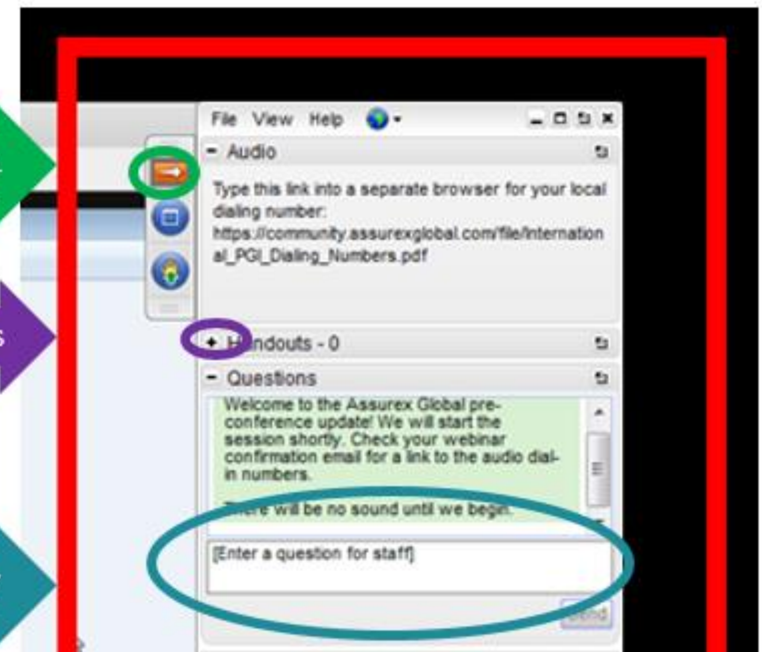

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Can my employee drop their plan and move to a spouse's plan in the middle of the plan year?

And obviously we get the reverse question - Can my employee join my plan in the middle of the plan year because their spouse lost their job or (or some other reason)?

Mid-year Plan Changes

- There are three separate issues that must be considered whenever an employee wants to make a mid-year plan change
  - Section 125 election change rules
    - Applies if the employee made an election of benefits under Section 125 and they want to change their pre-tax election amount
  - HIPAA special enrollment requirements
    - When someone is trying to enroll in a plan mid-year
  - Plan specific eligibility rules

Mid-year Plan Changes

- Answer: It depends on why they are making the change!
  - Section 125 rules state that an employee's pre-tax salary reduction election is irrevocable for the plan year unless the employee is experiencing one of a number of specific events
    - Absent an allowable event, the employee could drop the coverage, but the employer cannot change the pre-tax payroll reduction
  - When the question is if the employee (or spouse or dependent) can enroll in the plan mid-year, the plan is required to allow the change only if the individual is experiencing a HIPAA special enrollment
    - HIPAA special enrollment events are always a permitted Section 125 event that allows an election change
    - Theoretically a plan could be more liberal in allowing mid-year enrollments, but that would depend on the plan eligibility rules and what the carrier would allow

Mid-year Plan Changes

- HIPAA Special Enrollment Events
  - Loss of eligibility for group health coverage or health insurance coverage
  - Becoming eligible for state premium assistance subsidy
  - Acquisition of a new spouse or dependent by marriage, birth, adoption, or adoption

- Section 125 Election Change Events
  - Change in status (most common)… *e.g.,* marriage, birth, adoption of a child and various employment status changes
  - Cost or coverage changes… *e.g.,* significant increase or decrease in the cost of benefits provided, significant expansion or curtailment of coverage
  - Accommodation of other laws… *e.g.,* HSA, COBRA, HIPAA, and now the ACA

Mid-year Plan Changes

- Section 125 Election Change Events (cont.)
  - Change in Status Includes Six Categories of Events
    - Change in employee's marital status
    - Change in the number of dependents
    - Change in employment status
    - Dependent satisfies or ceases to satisfy definition of dependent
    - Change in residence
    - Commencement or termination of adoption proceedings
  - Cost or Coverage Changes
    - Cost changes with automatic adjustment of participant contributions
    - Significant cost changes
    - Significant curtailment of benefit or loss of benefit option
    - Significant expansion of benefit or addition of benefit option
    - Change in coverage under another employer's plan

Mid-year Plan Changes

- Section 125 Election Change Events (cont.)
  - Accommodation of Other Laws
    - HIPAA Special Enrollments
    - COBRA Qualifying Events
    - Judgments, Decrees or Orders
    - Medicare or Medicaid Entitlement
    - FMLA Leaves of Absence
    - ACA - Employee is eligible for an ACA Special Enrollment Period or the employee seeks to enroll in a plan through a Marketplace during annual open enrollment period

  - HSA contributions made through cafeteria plan (employer required to allow monthly changes)

I have a fully-insured health plan and my insurance company sends out a HIPAA privacy notice every year, does that mean I don't have to send one?

HIPAA Privacy Notice

- Notice of Privacy Practice (NPP) Requirements
  - Employer health plans are considered “Covered Entities” and must provide a NPP to plan participants at the time of enrollment
    - NPP must also be provided when requested by a participant
    - Then a reminder must be sent at least once every three years that the NPP is available
    - New NPP must be provided if there is a material change in the entity’s HIPAA policies or procedures (2013 changes to model NPP were material!)

- Practical Considerations
  - Employer Plan Covered Entities
    - Medical
    - Dental
    - Health flexible spending account (FSA)
    - Health Reimbursement Account (HRA)
    - Rx coverage
  - An NPP provided by insurance company does not address other covered entity plans offered by the employer

HIPAA Privacy Notice

- Practical Considerations (cont.)
  - Employer can create one NPP that applies to all plans sponsored by the employer
  - If employer is providing an NPP to participants at every enrollment period (which is a common practice) there is no reason to distribute a “reminder” communication
- Distribution Methods
  - If employer maintains website with information about plan’s customer service or benefits, NPP must be made available electronically through website
  - Must be individually delivered to the individual entitled to the notice (may be included with other written materials mailed to individual or included with an SPD)
    - A single notice to the insured/covered employee is effective for all dependents covered under that plan
  - May be provided by email if recipient has agreed to receive it electronically and agreement hasn’t been withdrawn
  - If a reminder is needed, may be mailed or included in a plan-produced newsletter or other publication, with information about availability of NPP and how to obtain a copy
  - Employer may rely on third party to distribute NPP, but remains liable for delivery

Can employers impose a surcharge or carve-out coverage for spouses with other coverage available? How about for dependents?

Spousal Coverage

- Summary
  - Unless required under applicable state law, employers are not required to offer coverage to spouses
    - §4980H requires applicable large employers to offer coverage only to full-time employees and their dependents (children)
  - Employers choosing to offer coverage to spouses have quite a bit of flexibility, including the ability to condition coverage on whether the spouse has coverage available elsewhere (e.g. through the spouse's employer)
    - Employer could choose not to let spouses enroll at all or require the spouse to pay up to 100% of the cost of coverage

Dependent Coverage

- Current ACA Requirements
  - §4980H requires applicable large employers to offer coverage only to full-time employees and their dependents (children)
  - In addition, employers who choose to offer coverage to dependents must generally offer coverage through age 26
- Carve-out for those eligible for other coverage generally not allowed
  - Employers who choose to offer dependent coverage are generally required to offer such coverage through age 26 without regard to tax dependency, residency, marital status, employment status, eligibility for other coverage and/or student status
- Surcharge might be possible for those eligible for other coverage
  - So long as the employer continues to make coverage available and doesn't restrict any of the benefits, it may be possible to impose a surcharge so long as it is not based on age
  - If the surcharge applies for any dependent who is eligible under another plan, it may be okay, but a surcharge which applies only for those who are a certain age would not
    - If the surcharge applies only for those who have other job-based coverage (which would only apply to those of a working age), that might be an issue

I want to offer a severance to an employee after termination that includes 6 months of paid health insurance. When should I start COBRA?

Severance Agreements & COBRA

- COBRA Event Date
  - The termination of employment is a COBRA event if it causes the loss of coverage at the time of the termination OR "at some time in the future"
- Maximum COBRA coverage period depends on how the employer handles the COBRA notice
  - COBRA period runs from actual event date unless the plan optionally extends the start of COBRA to the loss of coverage date
  - Option to extend COBRA from loss of coverage date
    - *The end of the maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the plan until a later date. If, however, coverage under the plan is lost at a later date and the plan provides for the extension of the required periods, then the maximum coverage period is measured from the date when coverage is lost.* [Treas. Reg. §54.4980B-7, Q/A-1(b)(1)]
  - In this case the employer is allowed to provide the COBRA notice after the loss of coverage

Severance Agreements & COBRA

- Maximum COBRA coverage period depends on how the employer handles the COBRA notice (continued)
  - If employer wishes the COBRA period to run from actual event date even if paying for coverage during severance
    - Best practice is for employer to provide "special" COBRA notice at the time of the event stating the relevant dates and clarifying that employer will be paying for the first "X" number of months of COBRA
    - If COBRA notice is sent at end of extended coverage period, it must make clear what the maximum COBRA period is that applies to that person (i.e. form termination date not the loss of coverage date)
- Warning!
  - If employer wishes to offer the extended COBRA coverage, they should make sure their carriers will allow an extension of COBRA eligibility

We have a smoker and non-smoker employee contribution cost. The difference is almost 50% of the plan premium. Can I still do that now with the new EEOC wellness regulations?

Smoker vs. Non-smoker Employee Contributions

- Background
  - HIPAA wellness rules allow a tobacco-related wellness incentive of up to 50% of the applicable plan premium
- New EEOC Wellness Rules
  - Maximum incentive for wellness plans subject to the ADA is 30%
  - EEOC rules only apply if the employer is asking the employee disability-related questions or doing some kind of medical testing
  - Do new EEOC rules apply to smoker vs non-smoker rates?
    - Yes – if the employer is doing a medical test to test for nicotine use
    - No – if the employer simply ask the employee to attest to not using tobacco
      - Asking employees if they smoke is not asking a disability-related question under the ADA

Can employees age 65 and older contribute to a Health Savings Account (HSA)?

Health Savings Accounts (HSAs)

- HSA Eligible Individuals
  - Only eligible individuals can make contributions to their HSA account
  - Ineligible individuals may still use funds already in their HSA account to pay for eligible unreimbursed medical expenses
- Who is an HSA Eligible Individual?
  - Must be enrolled in a qualified High Deductible Health Plan (HDHP) and may not have any other “disqualifying coverage”
  - Individuals who cannot have an HSA
    - Individuals enrolled in non-HDHP coverage
    - Individuals who can be claimed as tax dependents
    - Individuals entitled to (enrolled in) Medicare

Health Savings Accounts (HSAs)

- HSAs and Medicare
  - Individuals who are both eligible and enrolled in ("entitled" to) Medicare are ineligible to contribute to an HSA
  - Medicare Part A enrollment is automatic for some individuals (i.e., those who are already receiving Social Security benefits when they turn 65). These individuals simultaneously become eligible, enrolled, and entitled upon reaching age 65
    - Choosing not to enroll in Part B does not help
  - Other individuals become eligible for Medicare, but must file an application in order to become enrolled in benefits (e.g. working individuals who have attained age 65 and are eligible to receive Social Security benefits but have not applied for them)
    - NOTE – sometimes those choosing to delay Social Security benefits will be retroactively enrolled in Medicare (up to 6 months), which may affect the annual HSA contribution limit
  - Spouse's Medicare entitlement (and resulting HSA-ineligibility) does not impact the employee's ability to maintain and contribute to an HSA

Health Savings Accounts (HSAs)

- Example – Individual enrolled in self-only HDHP coverage and not enrolled in Medicare until July 1st, 2016
  - Annual contribution maximum for 2016 = $3,350 + $1000 catch-up contribution
  - Eligibility determined monthly on the 1st day of the month
  - Contributions are calculated based on 1/12 of annual max times number of months that an individual is eligible
  - Assuming individual was HSA-eligible for 6 months (Jan-Jun), the individual could contribute up to $2,175 at any time during 2016
    - $3,350 + $1,000 = $4,350/12 = $362.50 x 6 = $2,175
- Excess Contributions/Corrections
  - Employer HSA contributions are non-forfeitable, so generally the employer may not recoup the contributions, but should re-characterize any excess contributions as taxable income to the employee if possible
  - In order to avoid a 6% excise tax on the excess contributions, the employee should request a distribution of the excess contributions and earnings before the individuals' federal income tax filing deadline (including extensions)

Can employers exclude employees who are 65 or older from plan eligibility, or incent them not to enroll?

Medicare Secondary Payer (MSP) Rules

- MSP rules determine which plan is primary if an individual is covered by a group health plan and Medicare
  - Age-based Medicare entitlement
    - Employers with 20 or more employees, group health plan is primary
    - Employers with fewer than 20 employees, group health plan is secondary
  - Disability-based Medicare entitlement
    - Employers with 100 or more employees, group health plan is primary
    - Employers with fewer than 100 employees, group health plan is secondary
  - Retiree coverage, Medicare is primary
- CMS Data Match process helps identify situations where another payer may be primary to Medicare
  - Employers who are contacted are required to complete a questionnaire about group health plan information on identified workers either entitled to Medicare or married to a Medicare beneficiary
- Group health plans of employers with 20 or more employees are primary to Medicare, and therefore such employers are:
  - Required to offer the same benefits to employees age 65 and older
  - Prohibited from discouraging employees from enrolling in their group health plans or from offering any “financial or other incentive” not to enroll

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