| Q&A from Assurex Global Webinar<br>"ACA and Benefits Compliance Update" | September 22, 2016 |
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| **Question** | **Answer** |
| Do we have to offer an opt out program? We pay 100% of the employee premium. | No, employers are not required to provide an opt-out when coverage is declined (waived). However, for employers who do, the opt-out should not be tied to the purchase of individual health coverage, and it may be necessary to consider it for affordability purposes under §4980H(b). |
| What if we reimburse only to offset high deductible? As deductible is used we reimburse no matter who's services are being covered by that portion of the deductible.. | Beginning with 2017 plan years, this may be a problem if the employee is enrolled in single coverage under the medical plan or if expenses are submitted for any family members not enrolled in the medical plan. The guidance in 2015-87 makes it clear that the HRA may only reimburse qualifying medical expenses for those individuals actually enrolled in coverage integrated with the HRA. |
| I'm fully funded, but what is an example of a transgender-related services? | This generally refers to gender transition surgery and accompanying prescriptions and treatment. |
| Are HSA's the same as HRA's as far as being used for family members that are not on the group medical plan? | No. While beginning in 2017 HRAs may reimburse expenses only for individuals actually enrolled in group medical coverage integrated with the HRA, HSA funds may be used to reimburse qualified medical expenses for the account holder and any tax dependents (including the spouse), regardless of whether the individuals are enrolled in an HDHP. |
| What if you have EE and Children HRA coverage. Then is it only to be used for EE and Children but not the spouse? | Correct |
| Can employers have an HRA for only dental expenses? | Yes |
| Are MLR rebates only for fully insured plans? | Yes |
| Are the rebates applicable for those covered by the health ins plan in the previous year? If so, what happens to the premiums paid by employees who are no longer employed? | While the rebates are calculated based on coverage during the previous calendar year, in regard to who should receive the rebate, there is some flexibility. The most common approaches are:<br>1. Returning the rebate to participants covered by the plan in the year in which the rebate is received (i.e. current plan year participants, including COBRA participants), or;<br>2. Returning the rebate to individuals who participated in the plan both in the year in which the rebate is received, and in the year used to calculate the rebate, which may include terminated employees.<br>DOL guidance points out that it will usually not be necessary to distribute rebates to former plan participants, stating "If [an employer] finds that the cost of distributing shares of a rebate to former participants approximates the amount of the proceeds, the fiduciary may properly decide to allocate the proceeds to current participants [only]…" In most cases, the amount of the rebate on a per participant basis will be so small that the administrative cost of distributing it to former participants will exceed the value of the rebate. |

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| Can the employee portion of the MLR be used to pay for a new benefit program like an EAP? | Although it is clear from the guidance that the rebate may be used for benefit enhancement, it is much less clear what would qualify as a benefit enhancement. Especially if additional programs and/or services might be available other than to those specifically enrolled in the plan for which the rebate was received, it is not clear that it would be viewed as an allowed distribution. In addition, benefit enhancement is often viewed by many as being the least favorable due to the complexity of making a benefit change (for what will normally be a very small “per participant” amount), and the increased cost to the plan in future years when a rebate may not be available. |
| Does there have to be 100 participants enrolled at the same time? Are dependents considered participants? Does participants include employees who decline coverage? | Group health plans subject to ERISA are generally required to submit an annual Form 5500 filing if the plan **has 100 or more participants as of the first day of the plan year**. The term participants considers only the employees or former employees enrolled in the plan, not those who waive, and does not consider spouses or other dependents. In other words, those ERISA plans with 100 or more employees or former employees enrolled are subject to Form 5500 reporting. Note - if the plan is funded (i.e. assets of the plan are segregated from the general assets of the employer (or sponsoring organization), generally by use of a trust), the plan is subject to annual reporting regardless of the number of participants. |
| If an employee has coverage through a spouse and provide proof can the have access to your company's HRA dollars? | Although not addressed clearly in Notice 2015-87, which discusses the coordination rules for purposes of HRA reimbursements, previous guidance indicates that an HRA may be integrated with another employer's group medical plan (e.g. through a spouse's employer) for purposes of satisfying health care reform requirements; therefore it is assumed that an HRA integrated with another employer's plan could also provide reimbursements for individuals enrolled in such plan. |
| In example 2... does this mean that an employee has to be allowed to opt out, even if they do not provide proof of other coverage? | The opt-out guidance itself does not require that individuals be allowed to waive or decline coverage, but applicable large employers (50 or more FTEs) who do not allow employees the option to decline coverage, regardless of whether there is proof of other coverage, must be careful that the offer meets §4980H requirements. §4980H rules require that full-time employees be provided an annual opportunity to accept or decline coverage; however, guidance indicates that automatic enrollment will meet offer of coverage requirements if the plan provides minimum value and is affordable based on the federal poverty line (i.e. employee contribution of approx. $95/month or less in 2016). |

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| Opt-Out Credit does this only apply for self insured plans? | No. An opt-out credit may be offered to participants under either a fully-insured plan or a self-funded plan. If the employer is an applicable large employer (50 or more FTEs), it may affect affordability depending upon how it is structured. If the opt-out is unconditional (available to all who waive), the amount of the credit must be added to the employee contribution for purposes of determining affordability. On the other hand, if the opt-out credit is conditional (available only to those who waive and provide proof of other non-individual coverage), it is not necessary to add the credit to the employee contribution when determining affordability. |
| Rebate to participants in the plan only? For example, we have 2 United Health Care plans and 1 Kaiser plan. We receive a rebate from UHC. Refund monies to UCH participants only? Do we need to try to figure out if it only one of the UHC plans, or can we refund flat amounts to al particpants? | The MLR rebate should be distributed only to participants of the plan for which the rebate was received. So if the rebate is received for the UHC plan, only the UHC plan participants should be included in the distribution. |
| we occasionally have employees who are enrolled in individual coverage when they become eligible for the group coverage who chose to waive. Can they recieve the opt-out cash for waiving that coverage? We do require proof of coverage, should we be distinguishing between group vs individual coverage? | To avoid violating health care reform rules, it is necessary to distinguish between individual and group coverage before providing a conditional opt-out credit. Employers who reimburse employees (whether on a pre-tax or after-tax basis) for individual coverage via an opt-out credit or other means are in violation of health care reform rules and may face a penalty of up to $100 per day per affected individual. |
| What about rebates for those now on COBRA? | Without clear guidance indicating it is okay to exclude such individuals, the conservative approach would be to include COBRA participants in the MLR rebate distribution unless the cost to distribute the rebate exceeds the amount of the actual rebate itself. |
| Will the Form 5500 apply to Church Plans in 2019? | Church group health plans meeting certain requirements (as well as most government plans) are generally exempt from ERISA and therefore are not required to comply with annual Form 5500 reporting requirements. We're not aware of anything in the proposed rules that would change this exemption. |
| With regard to the affordability/opt out credits - we have an opt out pay out program that is tied to longevity for eligibility so it is not offered to ALL benefit eligible staff making it what appears to be conditional - does that mean it does not need to be counted when determining affordability? | The arrangement described does not meet the specific definition of conditional for purposes of determining affordability. A "conditional opt-out" for purposes of determining affordability under 4980H(b) is specifically when the opt-out is tied to proof of other non-individual coverage. |
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