| Q&A from Assurex Global Webinar<br>"Into the Weeds! Answers to Specific Employer Benefits Questions We Have Received" | December 15, 2016 |
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| **Question** | **Answer** |
| 65+ can decline Part A and continue H.S.A contributions - correct? | Declining is not an option if the individual is receiving Social Security benefits.<br>Medicare Part A enrollment is automatic for some individuals (i.e., those who begin receiving Social Security benefits when they reach their SS eligibility age); these individuals simultaneously become eligible, enrolled, and entitled to Part A Medicare. The only way for an individual to decline Part A Medicare benefits is to delay receiving social security benefits also. An induvial cannot receive social security benefits and decline Part A Medicare. |
| How do we report an offer of coverage for employees who decline health coverage and take cash in lieu for aca? Can I still use Code 1A? | While a cash in lieu might affect the amount considered to be the employee contribution (depending upon whether it is conditional or unconditional), there is no special offer code used on Line 14. In other words, after considering the cash in lieu, if the employee contribution is approximately $95 or less per month, then Code 1A is appropriate, assuming coverage is also offered to spouses and dependents.<br><br>Guidance indicates the opt-out must be “conditional” in order to avoid having the cash option added to the employee contribution when determining affordability. In order for the opt-out to be considered conditional, it must be available only upon proof of other non-individual coverage, and the employee must attest that the employee and any family members have minimum essential coverage in place. On the other hand, an unconditional opt-out payment (available to anyone who waives coverage) must be considered part of the employee contribution amount for purposes of affordability. For example, when the employee cost for health coverage is $125 per month, but there is an unconditional opt-out payment of $75 per month if coverage is waived, the employee contribution for affordability purposes is $200 ($125 + $75). |
| Can a member change plans when adding a dependent or removing a dependent? | §125 rules allow for a change in coverage options (plans) when an employee gains or loses a dependent. However the rules provide only what is allowed; whether or not it is actually permitted will depend upon whether the cafeteria plan document allows it. |
| Can any exceptions to Section 125 be lawfully negotiated into a collective bargaining agreement? | Because the contract year for a collective bargaining agreement may not correspond with a cafeteria plan year, benefit changes may arise mid-year as a result of the bargaining process. The regulations clarify that the collective bargaining situation would be covered under the cost or coverage change rules (changes allowed upon changes in cost or significant additions/reductions in benefits), except that health FSA elections generally cannot be changed. |

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| Can you define significant cost change? | Nowhere in the rules is the term "significant" defined, therefore it is up to the plan sponsor to determine what is and what is not significant. If the change is deemed “significant”, the rules allow participants to change election amounts, switch to another similar plan, and even drop/enroll in coverage depending upon whether there is a significant increase or decrease.<br>Generally a review of the plan document is required to determine whether the plan in question recognizes a significant change in premium, thereby triggering the opportunity to make a new mid-year election (§125 rules indicate what is permitted, not what is required). The plan document MAY allow employees to make changes and/or even newly enroll or terminate due to a change in premium. NOTE – if there is a desire not to allow changes upon a significant increase or decrease, the plan document could be amended accordingly. |
| I have recently come across a different type of loss of coverage. What if an employee under you gets dropped off of coverage during their spouse/parents open enrollment? is that a qualifying event? I was under the impression that this particular event would not be an involuntary loss of coverage because they are still technically eligible? | If coverage is not renewed during open enrollment, the change would not trigger a HIPAA special enrollment right requiring the employer and/or insurance carrier to allow mid-year plan enrollment in another group health plan.<br>While not required to allow the change, if coverage is dropped or added during open enrollment and there is a desire to make corresponding changes mid-year on another employer-sponsored group health plan, §125 rules permit a mid-year change in elections during the open enrollment of another employer-sponsored plan when the other employer plan has a different plan year (e.g. spouse's employer plan has a different plan year). Therefore, it would be necessary to check with the plan document to understand whether or not coverage may be added or dropped and corresponding elections could be made mid-year. |
| If the HIPAA Notice of Privacy Practices is part of open enrollment, how does that satisfy the dependent notification? | The Privacy Rule provides that a single notice to the primary insured/covered employee is sufficient to meet the notice requirement for his or her dependents. |
| If we have an employee that turns 65 in July and chooses to enroll in Medicare, what do we do with their health insurance coverage? | While enrollment in Medicare will affect HSA-eligibility, it generally will not affect eligibility for coverage under a group health plan (e.g. HDHP). Medicare Secondary Payer (MSP) rules require employers with 20 or more employees to offer the same coverage to those age 65 and older, and also prohibit such employers from taking into account Medicare coverage or incenting employees not to enroll in the employer's group health plan. Therefore, in most cases, coverage under the employer's group health plan will not be affected upon enrollment in Medicare unless the employee voluntarily chooses to drop the group health plan. |

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| If the spouse is in a HDHP and the other spouse is in a non HDHP - can they enroll in a HSA? | Generally yes, unless the other spouse is enrolled in a general-purpose health FSA, which will typically provide reimbursement for both spouses and thereby make both spouses ineligible to contribute to an HSA. If the employee is enrolled in HDHP coverage and does not have any other disqualifying coverage, regardless of whether any family members are HSA-eligible or not, the employee may contribute an HSA. This situation is described in IRS Notice 2008-29, Q/A 16:<br>Q-16. How do the maximum annual HSA contribution limits apply to an eligible individual with family HDHP coverage for the entire year if the family HDHP covers spouses or dependent children who also have coverage by a non-HDHP, Medicare, or Medicaid?<br>A-16. The eligible individual may contribute the § 223(b)(2)(B) statutory maximum for family coverage. Other coverage of dependent children or spouses does not affect the individual's contribution limit, except that if the spouse is not an otherwise eligible individual, no part of the HSA contribution can be allocated to the spouse.<br>In addition, even though the spouse (or dependents) may not be eligible to contribute to an HSA due to other non-HDHP coverage, the HSA funds may still be used to reimburse their expenses. Reimbursement from an HSA is not dependent upon HSA-eligibility. Once the HSA is established, the funds may generally be used to reimburse qualifying medical expenses for the account holder, as well as the account holder's spouse and other tax dependents. |
| Just to clarify, a change in coverage costs or deductibles - we are required to allow the change to 125 or our plan does not have to require the allowance? | When there is a change in the employee/employer contribution toward the premium mid-year, §125 rules permit different changes depending upon whether the change in the employee contribution is considered to be significant or insignificant. Separately, when there is a change in the benefits offered under the plan (e.g. change in copays or deductibles), §125 rules permit changes if the addition or curtailment of coverage is considered to be significant.<br>The employer is not required to allow mid-year election changes in either situation, but would be permitted to under §125 rules. It would be necessary to check with the plan document to understand what is allowed. |
| What about FSA contributions, can they change those mid year? | While most change in status events will allow a change in DCAP election (assuming consistency requirements are met), mid-year changes in health FSA elections are more limited. Upon gaining or losing a dependent, or a change in eligibility for the employee or dependents, mid-year changes are typically permitted for health FSA elections. However, upon changes in cost or benefits under the medical plan or changes under another employer's group health plan, health FSA election changes are not permitted mid-year. |

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| When must privacy notices be distributed by? | There are a few important timeframes to pay attention to: First, the notice must be distributed to all participants at the time of enrollment (a notice sent to the primary insured is sufficient for purposes of providing the notice to dependents). Secondly, a covered entity must provide a reminder to all participants of the availability of the notice at least once every three (3) years. An employer may meet this reminder requirement if it provides the notice annually as part of its open enrollment materials. Finally, the covered entity must provide the notice to anybody (participants and non-participants) who requests it. |
| Who polices employers to be sure they are complying with HIPAA? | The Office of Civil Rights (OCR) is the division of the Department of Health and Human Services (HHS) that is responsible for oversight of HIPAA Privacy & Security Compliance. |
| With respect to employer's who contribute to Taft-Hartley plans, is it the Union that is obligated to comply with HIPAA, or does the employer still have some HIPAA compliance obligations for that employee population? | The covered entity under HIPAA is the health plan itself, not the employer. So in the case of a Taft-Hartley plan it would be the plan sponsor and/or administrator (typically the union who sponsors the plan) who would be responsible for the HIPAA compliance obligations of that plan. |
| Does posting online qualify for satisfying the HIPAA Privacy notice requirement? | No - the NPP must be individually delivered to the individual entitled to the notice. So posting only on a website or otherwise making the notice available to individuals (e.g., posting at the workplace) won't substitute for the required actual delivery. However, the health plan may include the NPP with other written materials that are mailed to the individuals (except that the notice cannot be combined in a single document with a HIPAA authorization), or the employer could include the notice with an SPD or with enrollment materials. The NPP can also be provided by email, if the recipient has agreed to receive an electronic notice and that agreement hasn't been withdrawn. (However, if the health plan knows that the email transmission to an individual has failed, it must provide a paper copy of the notice to the individual.) Also note that if the employer maintains a website that contains information about the covered entity's (i.e., the health plan's) customer service or benefits, then the NPP must be posted on and made available electronically through the website. But this requirement is in addition to - not in place of - the general delivery requirements. |
| What are the fines associated with not complying with HIPAA | Penalties range greatly - from $100 to $50,000 depending on the severity of the violation and the level of intent or neglect associated with the violation, as well as the extent of harm caused by the violation. |
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