Q&A on US Health Reform

Planning for Open Enrollment







Developed from Conner Strong's September 14, 2010 web briefing

On September 14, Conner Strong held a web briefing devoted to planning for the new health reform requirements and needed changes to benefit plans, open enrollment materials, and employee communications. We focused on new obligations under health care reform (e.g. grandfathered status disclosure and enrollment of eligible children to age 26), as well as open enrollment documents and procedures, and how to communicate changes to employees.

Health reform brings new issues and challenges as employers plan for the open enrollment process. This year's open enrollment period will be more challenging than ever as employers make changes to meet new health care reform requirements effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). New health care reform provisions require that employers change eligibility, plan terms, and tax treatment of some benefits.

The September 14 web briefing discussed these new employer requirements and provided charts, checklists, and a list of key next steps for employers.

We have prepared this Q&A in response to questions received from participants. To help keep our clients informed, we have also created a special section on our website providing information and tools you can use to review the major aspects of the law, what they mean, when they will take effect and what steps need to be taken to ensure compliance. Check back for daily updates, for news and analysis, and for updated tools to help you navigate this complex process.

Q1. Will employers now be required to cover dependents?

A1. No. The law does not require any plan to offer dependent coverage, but plans that do must make coverage available to adult children up to age 26 for plan years beginning after Sept. 23, 2010. This coverage mandate applies to both insured and self-insured plans.

Q2. Can we still define "dependent" for eligibility purposes in our plans?

A2. Yes. Plans can still determine whether to cover children and which children should be covered as long as it is based on the relationship of the children to plan participants and the age of the children up to age 26. For example, plans may exclude foster children or stepchildren from the definition of "eligible dependent" and not cover them.

Q3. What website do you recommend for the most complete explanation of changes for families and small businesses?

A3. See the Department of Health and Human Services (HHS) site at http://healthcare.gov/ to provide consumers with both public and private health coverage options tailored specifically for their needs in a single, easy-to-use tool. This site includes a section with frequently asked questions and a small employer section. HHS also offers a Spanish version of the healthcare.gov site (see CuidadodeSalud.gov). Other governmental sites of interest to employers on health reform topics include the White House, IRS, and DOL health reform sites.

Q4. Am I required to offer insurance to my employees?

A4. No. There is not a so-called "employer mandate" to provide insurance in the health reform legislation. But beginning January 1, 2014, a "Pay or Play" (free rider) assessment penalty will begin for certain large employers with an average of at least 50 employees working at least 30 hours per week during the preceding calendar year.

Q5. Do we have to cover part-time employees under our medical plan?

A5. No. But an employer penalty may apply for certain full-time employees (defined as at least 30 hours per week). There would be no penalty for not offering coverage to employees working less than 30 hours per week.

Q6. Is it true that employees will no longer be permitted to receive group health insurance from their employers on a tax-free basis, and employers will lose any corporate deductions they might have with respect to employer-provided health care benefits?

A6. No this one is not true. What will happen is starting next year the new law requires employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. But this reporting is for informational purposes only, to show employees the value of their health care benefits so they can be more informed consumers. The amount reported does not affect tax liability. The value of the employer contribution to health coverage continues to be excludible from an employee's income and it is not taxable.

Q7. Is an employer required to disclose the value of health benefits on the 2010 W-2 or will it begin with the 2011 W-2?

A7. The requirement for employers to report the cost of employer-provided coverage (employee plus employer portion) starts in tax year 2011. Although the new rule applies for employees' tax years beginning after December 31, 2010, payroll systems need to be updated for this change by January 2011. As a result of this requirement, most Form W-2s for tax year 2011will be issued in January 2012. But Form W-2s reflecting the new health insurance information must be available no later than February 1, 2011, in the event that an employee requests one.

Q8. Does the value of health coverage for dependents' from the day they turn 26 to the end of the calendar year have to be shown on an employee's W-2 as a fringe benefit?

A8. Yes. Employers are required to calculate and report the value of all "applicable employer-sponsored coverage" (which is the same definition of coverage that applies for purposes of the "Cadillac Plan" excise tax).

Q9. Our open enrollment is July every year. Can I wait to comply for another 10 months?

A9. Yes, that is correct. Plans have to comply with the health reform standards for plan years beginning on or after September 23, 2010. So if your plan year begins July 1, then your plan must comply by July 1, 2011. If your plan year begins in January, then your compliance date is January 1, 2011. But if your plan year begins October 1, then your compliance date is October 1, 2010.

Q10. What notices should employers give employees in writing and when?

A10. The new law has a series of new notification and communication requirements that start this year and extend over the next several years. Sample language that takes affect for calendar year plans as of Jan. 1, 2011 is reflected in our slides – for grandfathered plans, Annual and lifetime limit changes, the Revised dependent eligibility for older kids and the Primary care physician designation and OB/GYN self referral change.

Q11. What is the definition of a grandfathered health plan?

Q11. A grandfathered plan is a group health plan in existence on the law's March 30, 2010 enactment date. The rules allow grandfathered plans to make certain changes and still remain grandfathered, so for example plans can increase benefits, and make changes to conform to any required legal changes and still remain grandfathered. Adding new plan participants and dependents will also not change a plan's grandfathered status.

Q12. Why is having grandfathered plans so important?

A12. Grandfathered plans have advantages over non-grandfathered plans because grandfathered plans have fewer rules applicable to their plans. For example, they do not have to provide 100% coverage of preventive services, they don't need to comply with new internal and external claims appeals procedures, and they do not have to comply with new nondiscrimination rules applicable to insured plans.

Q13. Would we lose grandfathered status for introducing premium incentives for employees who participate in health screenings or wellness activities?

A13. No. Premium incentives are like discounts and would increase the employer percentage contribution and therefore they would not jeopardize grandfathered status.

Q14. An employer with a January 1, 2011 plan year makes a plan change that was either mandated by the carrier or by choice, effective April 1, 2010. On January 1, 2011, when health reform would be effective, has the employer lost its grandfathered status because a plan change was made after March 23, 2010?

A14. Not necessarily. The answer to whether the plan loses grandfather status depends on the type of change that was made, when the change was made, and whether the plan decides to revoke the change as permitted by the rules governing grandfathered status.

Q15. We have planned the special enrollment for adult dependents during our 2011 annual open enrollment period that runs for 2 weeks. Do we have to allow a 30-day enrollment window for the special enrollment?

A15. Yes. While the special enrollment period can run concurrently with annual open enrollment, it must last for 30 consecutive days (including written notice of the opportunity to enroll). When plans have annual open enrollment periods less than the required 30 days, they will need to extend the period for eligible dependents (and their parents) to enroll and make benefit option changes.

Q16. Does the requirement to provide coverage to children until they reach age 26 apply to other benefit options like child AD& D, child life?

Q16. No. The requirement applies to group health plans but does not apply to life insurance and accidental death & dismemberment coverage.

Q17. Do we have to offer COBRA when dependents reach age 26?

A17. Yes. The new law does not change COBRA requirements and COBRA will apply to adult dependents when they are qualified beneficiaries (the same as it applies to any other qualified beneficiaries).

Q18. Can employees use health flexible spending accounts (FSAs) to pay for their adult dependents out-of-pocket medical expenses?

A18. Yes. Employees can now use FSAs to pay for the out-of-pocket medical expenses of adult dependents.

Q19. How and when will this effect employees with children who have recently lost coverage because of age and or schooling (no longer full-time student)? For example, if you currently have an employee whose dependent is not covered because they are over 21 and currently not a student but is under 26 what happens come the next open enrollment in January 2011?

A19. Plans are required to offer an enrollment opportunity to a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan because, under the terms of the plan, the availability of dependent coverage ended before the attainment of the age 26. The rules specify that the age 26 coverage mandates applies even if the dependent is coming off COBRA. These dependents must be given the same special opportunity to enroll in this extended dependent coverage that must be made available to all dependents to age 26. Notices must be provided to employees about the special enrollment opportunity for these eligible dependents.

Q20. How will this effect a Qualcare Plan that only covers dependent until age 19 unless they are full-time student?

A20. The new rules require that for plan years beginning after September 23, 2010, all insured and self-insured group health plans that already allow dependent children to be included in the plan must expand that allowance for dependent children until they become 26 years old. Eligibility criteria based on factors such as student status, financial dependency, or residency, can no longer be imposed by plans or carriers (the only exception being that grandfathered plans can exclude those dependents who are eligible for employer-sponsored coverage until 2014).

Q21. What federal plans are available for employees not eligible for employer medical benefits?

A21. A public option was not part of the finalized health reform so there is no federal plan available for employees not eligible for medical benefits. The new law requires that states establish insurance Exchanges to offer private insurance choices by January 1, 2014 and large employers with 100 or more employees can purchase coverage through these Exchanges beginning January 1, 2017. Currently, employees not eligible for an employer plan can access individual insurance policies, or for eligible individuals, state high-risk pools, Medicaid, or Medicare. In addition, children in families who do not have health coverage due to a temporary reduction in income (for instance, due to job loss) may be eligible for the State Children's Health Insurance Program (S-CHIP), a federal/state partnership that helps provide children with health coverage.

Q22. What happens to part-time employees under the new regulations? Are they still ineligible for medical coverage or does the new regulations require some medical coverage?

A22. Effective January 1, 2014, all adults (whether employed or not) must have health coverage for themselves and their dependent children (this is known as the individual mandate). Individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax. Self-insured plans and insurers will be required to report certain coverage-related information to the individual and to the IRS. Individuals will generally pay the greater of a flat dollar amount and a percentage of income payment. The flat dollar amount penalty is $95 in 2014, $325 in 2015 and to $695 in 2016 and thereafter. The percentage of income limit is increased to 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and thereafter.