

Question and Answer Session

Lunch & Learn – Health Reform

May 20, 2010

Albuquerque, New Mexico

- Q. What does “auto enrollment” and “opt out” mean?
- A. Under the PPACA, large employers that offer coverage will be required to automatically enroll employees into the employer’s lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage. Opt out means to decline or waive coverage.
- Q. Please clarify the adult dependent coverage.
- A. Young adults that do not have access to employer sponsored coverage will be allowed to remain on their parents’ plan up to the age of 26. A dependent’s marital status or tax filing status has no bearing on this ruling.
- Q. Please review the Flexible Spending Account limits that will be imposed in 2013.
- A. As of January 1, 2013, contributions will be capped at \$2,500 each year, indexed for the Consumer Price Index starting in 2014. This is in Section 9005 of the PPACA, as amended by section 1403 of the Reconciliation Bill.
- Q. Does “minimal essential coverage” apply to employee only as far as what the employer must provide?
- A. Guidance has not yet been written confirming “minimal essential coverage,” but it is implied that legislation is geared towards the employee coverage only. It is to be seen if that will expand to family coverage.
- Q. What exactly falls under the term Cafeteria Plan?
- A. We like to think of the Cafeteria Plan as a three legged stool. The first leg is a premium only plan which governs the pre-tax deductions for plan premiums. Secondly, a flexible spending account (FSA) is pre-tax money set aside by the employee for non-reimbursed medical expenses. The last component is dependent care reimbursement. Employees have the opportunity to set aside pre-tax funds for dependent care. There are other sub-sets under the Federal guidelines for Cafeteria Plans, but these make up the most highly utilized and familiar benefits. The only benefit affected by health reform guidelines is the FSA – limits will be capped and, beginning in 2011, over the counter medications will not be considered reimbursable expenses unless a doctor prescribes them. Vision and dental care will be affected by these new guidelines.
- Q. Can the Comparative Effectiveness Fee be passed on to employees?
- A. No, the Comparative Effectiveness Fee is the sole responsibility of the employer sponsoring the health plan.
- Q. What information are employers required to disclose for W-2 reporting?
- A. “Health care reform requires employers to calculate and report the aggregate cost of applicable employer-sponsored health insurance coverage on employees’ Form W-2s. Although the new rule applies for employees’ tax years beginning after Dec. 31, 2010, payroll systems need to be updated for this change by January 2011. This deadline is imposed because employees are entitled to request their Form W-2s early if they terminate employment during the year.

As a result of this requirement, most Form W-2s for tax year 2011 will be issued in January 2012. Form W-2s reflecting the new health insurance information must be available no later than Feb. 1, 2011, in the event that an employee requests one.

Plans for which coverage costs must be reported under the new requirement include:

- Medical plans.
- Prescription drug plans.
- Executive physicals.
- On-site clinics if they provide more than *de minimus* care.
- Medicare supplemental policies.
- Employee assistance programs.

Coverage under dental and vision plans is included unless they are "stand-alone" plans. However, the cost of coverage under health flexible spending accounts, health savings accounts and specific disease or hospital/fixed indemnity plans is *excluded* from the reporting requirement." - Maureen M. Maly, Faegre & Benson LLP

We are still awaiting specific direction from the IRS on how to set up the information on the W-2, but we recommend keeping your eyes and ears open for guidance especially if you generate your own payroll!

- Q. Would it be more effective to pay fines or to have insurance?
- A. The million dollar question for all employers. The current schedule of fines appears to make it more appealing to pay the fines than administer an employer sponsored plan with regulations, actuarial data to collect and reporting to contend with annually. The answer to this question is a personal choice for employers who want to recruit and retain employees with their benefit package. Employer will lose the ability to manage their own benefits without being limited to the Exchange plans and face the possibility of those fines increasing over time without having the opportunity to go back to an employer sponsored plan...the future factors and how they will affect each employer are somewhat unknown.
- Q. Where can I find more about the small business tax credit?
- A. The IRS has wonderful tools and forms for small businesses. Everything can be found at: <http://www.irs.gov/newsroom/article/0,,id=223666,00.html>.
- Q. What effect will health reform have on non-profits?
- A. It appears that there are not many exceptions for non-profit organizations. The intent of the Reconciliation Act treats non-profits with the same regulations and legislation. We would have to assume at this time that non-profits will also need to adhere to the same guidelines (i.e. coverage of dependents to age 26, grandfather status and other changes) as do for-profit employers with group health plans.
- Q. How will my employees on other coverage (i.e. Indian Health Services, Medicaid, Medicare or TriCore) be affected by reform?
- A. Employees will be able to keep these coverages without being affected. These will be considered a waiver for employer sponsored plans and exclude employees from any penalties.
- Q. If an employee has a pre-existing condition and wants to enroll in the temporary high risk pool, can they do so?
- A. Individuals who wish to enroll in the high risk pool must be without coverage for six months before they can enroll. It is also worth noting that employees participating in a Premium

Only Plan (pre-tax premium deduction) cannot terminate their premium deductions without a qualifying event.

- Q. When employers are regulated to offer coverage and cannot have more than a 90 waiting period for new employees, how will this effect temporary, seasonal or staff that come and go from a plan?
- A. Beginning in January of 2014 employers will not be able to have a waiting period longer than 90 days and 30 hours will be considered full time. Currently most carriers allow employers to enroll a re-hire without satisfying the waiting period if they have not been gone for more than 30 days. I would assume that this practice will still remain. Changing the hours worked to 30 per week may change individual's temporary, seasonal or part time status opening up your employer sponsored plan to more individuals – remember this is the goal of health reform. Employers will have less of an opportunity to exclude employees from coverage or circumvent penalties for not covering employees due to hours worked or extensive waiting periods.