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Q&A FROM ASSUREX GLOBAL WEBINAR

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COMPLIANCE ISSUES RELATED TO EMERGING EMPLOYEE BENEFIT STRATEGIES

Q. On-site clinics COBRA: Can we have a single tier rate? Rather than EE, E + Spouse, etc...

A. There isn't any definitive guidance in regard to using tiers in charging a COBRA premium. So long as the employer can justify the cost being charged (tie it back to the actual expense of providing the service), it should be okay to use a single tier rate.

Q. So would the video telemedicine be the same as an onsite clinic? We offer it for free to all employees so would this be disqualifying to employees who are enrolled in an HSA?

A. In the absence of clear guidance indicating otherwise, if the telemedicine provides significant medical care (beyond merely preventive), and employees are not required to pay fair market value for the telemedicine video service prior to meeting the HDHP minimum deductible ($1350/$2700 in 2018), the conservative approach is to assume the employee is not eligible to contribute to an HSA.

Q. W2 box 1- isn't that wage # reduced by the Employee medical contributions?

A. Yes. Box 1 wages report an individual's taxable wages. In other words, it is the amount the employee receives in wages less any pre-tax contributions made toward employee benefits (e.g. medical, dental, vision coverage, health FSA, HSA, retirement).

Q. What if the telemedicine is a value add to a medical plan? it's not an extra cost to the employer.

A. Regardless of who pays for the telemedicine services (the carrier or the employer), if the plan participants are able to receive medical services without paying fair market value prior to meeting the HDHP minimum deductible ($1350/$2700 in 2018), the telemedicine services may cause HSA-ineligibility.

Q. I work at a hospital and once a claim goes through the insurance and there is a members responsibility, the hospital gives an employee a 40% discount. Would we be able to provide a Health Savings Account?

A. This operates as a type of HRA. Assuming plan participants are receiving coverage for medical care (beyond merely preventive) prior to meeting the statutory HDHP minimum deductible ($1350/$2700 in 2018) versus providing this discount only on a post-deductible basis, those participants would not be eligible to contribute to an HSA.

Q. If the employee signs up for AFLAC and reimburses the employer for all of the premium, but the employer pays the AFLAC bill for all employees enrolled and takes that premium from pre-tax income, is this subject to COBRA or HIPAA as an employer sponsored plan? We don't offer medical clinic or telemedicine and have 40 employees

A. There is a voluntary plan safe harbor under ERISA if the employer's role is limited, but allowing pre-tax elections will likely result in the plans being subject to ERISA (requiring plan documentation, SPD, Form 5500 filing, etc.). Regardless, if the plan provides medical care, the coverage is generally subject to COBRA unless the coverage would be available at the cost to the individual without the employment-related connection. It is less likely that such plans would be subject to HIPAA because many are considered excepted benefits. Bottom line, it's necessary to consider each benefit separately to best determine whether compliance requirements under ERISA, COBRA, HIPAA and the ACA may apply.

Q. If the onsite clinic is totally separate from the employer health plan, treats all employees for both preventive and symptomatic care, i.e. otitis, strep, etc. regardless of medical coverage, and does not charge for any of their services, why would this be included in the medical SPD? Thanks.

A. An onsite clinic is generally subject to ERISA and therefore requires a formal plan document and summary plan description (SPD). While such documentation could be created separately for the onsite clinic, it's often easier administratively to include it in a wrap document with other benefits (e.g. employer's medical plan).

Q. If telemedicine is sponsored by the Medical Plan and HDHP enrollees pay full cost for the visit, this does not impact the HSA correct?

Correct. So long as the participant pays fair market value for the medical services, it will not cause HSA-ineligibility.

Q. Do the CVS Minute Clinic fees allow HSA eligibility?

A. So long as the individual is required to pay fair market value for the minute clinic visit, it will not cause HSA-ineligibility.

Q. Lately telemedicine has explored adding mental health visits but they're charging double per visit...been asked a lot if that violates MHPAEA

A. Without more detail, we can't say for sure, but we would certainly recommend looking into this further as it would seem to violate the mental health parity rules (MHPAEA). MHPAEA rules require that financial requirements be provided "in parity" with those provided for medical/surgical benefits in the same category (e.g. outpatient in-network or outpatient out-of-network).

Q. Please go over the spousal carve-out and COBRA rule. I don't understand this not being COBRA eligible.

A. COBRA continuation rights are triggered only when there is a loss of coverage cause by one of the following events:

- voluntary or involuntary termination of employment other than by reason of gross misconduct;
- reduction of hours of the covered employee's employment;
- divorce or legal separation of the covered employee from the employee's spouse;
- death of the covered employee;
- dependent child ceases to be a dependent under the generally applicable requirements of the plan;
- a covered employee becomes entitled to benefits under Medicare; and
- an employer's bankruptcy, but only with respect to health coverage for retirees and their families.

Discontinuing eligibility for spouses is not one of the recognized events, and therefore, although there is a loss of coverage when the employer imposes a spousal carve-out, a COBRA continuation right is not triggered for spouses who lose coverage.

Q. So if the spouse loses their coverage because of the employer carve-out, what happens if the spouse does not have access to other coverage?

A. A change in spousal eligibility that causes a loss of eligibility/coverage will trigger a HIPAA special enrollment right requiring a group health plan (e.g. spouse's employer plan) to allow mid-year enrollment. If the spouse is not eligible for any other group health plan coverage, it will also trigger a special enrollment right to obtain individual coverage mid-year through a public Exchange.

Q. What about a program like FetchMD? This is a service that replaced White Glove and the company pays for most of the cost but they do charge those on the HDHP a $25 copay.

A. This may cause HSA-ineligibility, unless it can be argued that a $25 copay is fair market value for the services (although it sounds like that is not the case since the company is paying most of the cost).

Q. Would you be able to charge employees a higher rate of coverage if they work less hours. 30 hours employee pays more than a 40 hour employee even if they make the same hourly rate of pay?

A. Yes, it is possible to set different employer contribution amounts for different categories of employees, but then it is necessary to consider benefit nondiscrimination rules.

- Section 105(h) - If the plan is self-funded, Section 105(h) rules prohibit self-funded group health plans from favoring the highly compensated individuals in regard to eligibility, contributions, or benefits offered. Discrimination testing may be required to determine whether or not the proposed structure favors the highly compensated.
- Section 125 - Whether the plan is fully-insured or self-funded, assuming employee contributions are being handled on a pre-tax basis through a cafeteria plan, Section 125 rules also prohibit favoring the highly compensated individuals. All plans run through the cafeteria plan are generally aggregated for purposes of discrimination testing.

Q. Will a 24 hour nurse line provided by UHC make me ineligible for HSA?

A. No. Access to a nurses' line as part of the group medical plan should not interfere with HSA-eligibility.

Q. Affordability safe harbors -- do you need to use the same safe harbor for all participants? What groups can be treated differently?

A. An employer may choose to apply any of the safe harbors for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. The regulations provide that reasonable categories for this purpose generally include specified job categories, nature of compensation (hourly or salary), geographic location, and similar bona fide business criteria.

Q. What if your lowest cost is $0 to EE for coverage?

A. If the employee cost for single minimum value coverage is $0, then the coverage meets the federal poverty level (FPL) safe harbor and will be considered affordable for all plan participants.

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