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Q&A FROM ASSUREX GLOBAL WEBINAR

2018 REGULATORY WRAP-UP AND A LOOK FORWARD TO 2019

DECEMBER 20, 2018

Q. Why and or how did the Texas district court judge determine that the individual mandate is inseverable from the rest of the ACA?

The judge argued that based on how the Supreme Court previously ruled, and how Congress chose to enforce various portions of the ACA, the ACA cannot stand without all of its parts, including the individual mandate.

Q. In your opinion, will Association Health Plans (AHPs) actually create a reduced price and as much coverage as what is out there right now?

A. This is really hard to predict…certainly AHPs could cut costs by recruiting primarily healthy individuals and providing less coverage. How often such efforts will be successful or attractive, and how that will affect the larger coverage market remains to be seen.

Q. Why is an employee given a subsidy when they know they are a full-time employee and coverage is offered through the ER for EE & all dependents? Our coverage is affordable and covers all the minimum benefit rules.

A. There are two possibilities:

(i) The employee might have household income that makes the coverage unaffordable (e.g. due to alimony payments or capital losses). If the coverage is affordable based on one of the affordability safe harbors, the employer doesn't face any penalty, even if the coverage is actually unaffordable based on the employee's household income.

(ii) The employee may have provided incorrect information to the Exchange about income or the employer-sponsored coverage that was offered when applying for the coverage and subsidy.

Q. Can an AHP reject a valid group/member?

A. AHPs cannot condition eligibility for membership or coverage based on any health factor. AHPs must treat all similarly situated individuals the same, and cannot treat separate employers as different groups of similarly situated individuals (which limits the ability of AHPs to rate employers differently by risk). That being the case, the AHP could get creative in writing eligibility rules for membership, for example, designing eligibility to include membership only for a particular occupation that is more likely to bring in healthier members.

Q. How is managing hours for purposes of avoiding ACA obligations different from prohibiting overtime when those laws change

A. We cannot comment on overtime obligations as that is outside our scope of expertise (that would be better addressed by employment law counsel). Solely for purposes of compliance with §4980H, applicable large employers should be careful when "managing hours" (preventing employees from working 30 or more hours per week) solely for purposes of avoiding the requirement to make an offer of coverage. This is especially true for positions which historically provided full-time hours.

Q. What is the need for AHPs, when most businesses have access to a PEO?

A. It's still not clear exactly how AHPs might prove beneficial, but they open the door for plans to include sole proprietors and independent contractors (and their family members) as well as small and large employers. In addition, it's possible the AHP might only involve coverage options, while PEOs often provide a broader range of services.

Q. If I have 150 employees and 100 are union employees in which we pay their health and welfare to the union trust. Do I include all our employees when I calculate the 95% rule or only the 50 non union employees?

A. It is necessary to include union and non-union employees when determining whether coverage was offered to 95% of full-time employees as required under §4980H(a), but contributing toward coverage provided by the union generally counts as an offer of coverage.

Q. How is the waiting period (first of month after 90 days) for benefits counted in percentage of employees required to be offered coverage? If we have an influx of new hires (in the waiting period) then a couple of months may not be at 5%.

A. §4980H rules allow for a waiting period or initial measurement period (e.g. for variable hour employees under the look-back measurement method). So long as coverage is offered no later than 1st of the 4th month following eligibility, or no later than 13 and a partial month following date of hire as a variable hour employee (assuming the employee averages full-time during the initial measurement period), the employee is not counted as full-time while in the waiting period or initial measurement period. Such time is considered a "limited non-assessment period" and Code 2D can be used to indicate why coverage was not offered during such months.

Q. Our 226J letter identified only a handful of employees for our 2 companies. It's not clear, do we only respond to those few employees that were identified?

A. It's important to look at the ESRP Summary Table set forth within the Letter 226J (about halfway into the letter) to determine what is triggering the proposed assessment. If the table indicates a proposed assessment under §4980H(a), the issue is that the employer reported that coverage was not offered to 95% or more of full-time employees each month. If coverage was offered to 95% of full-time employees, it is necessary to certify to the IRS accordingly and indicate that a mistake was made in reporting. Separately, it's also necessary to review the coding for the employees listed on Form 14765 (the list indicates which employees received subsidized coverage through a public Exchange). If any of the coding does not accurately reflect the employees' full-time/part-time status or the coverage offered, it should be updated to avoid potential penalties under §4980H(b) as well.