

Frequently Asked Questions

Vol. I No. I

STATUS CHANGES/SPECIAL ENROLLMENT RIGHTS

Q. After the birth of a child, may an employee add other previously not covered children to the health plan, as part of the special enrollment rights provision?

A. Regarding your question about the couple who have insurance under the plan for themselves only (I assume as employee plus spouse), and now have a birth of a new child and would like to add the new child, **AS WELL AS THE OTHER PREVIOUSLY NOT COVERED CHILDREN:**

HIPAA is very clear that only the employee, spouse and newly acquired dependent receive special enrollment rights under this provision. Thus, other dependents (such as the siblings of the newborn child) are NOT entitled to special enrollment rights upon the employee's acquisition of a new dependent.

However, a plan COULD go beyond what HIPAA requires and permit pre-existing dependents to enroll along with other individuals who have special enrollment rights when a new dependent is acquired. Some plans deem this appropriate when, for example in this case, there is a multi-tier rate structure. In that case, the cost to cover the employee, spouse and newly acquired dependent is the same as to cover the entire family. Plans that wish to do this must expressly allow such "tag-along" provisions in their written plan documents, and should secure the approval of their insurance carriers or stop loss providers.

Regarding any Section 125 issues related to the new election, cafeteria plan regulations permit election changes for coverage if the dependents who have special enrollment rights, and also permit election changes to add other dependents at the same time, thus going beyond what is required under HIPAA's special enrollment rules (Treasury regulation 1.125-4(b)(2)).

HSA/HRA/HDHP

Q. If an employee's family status changes mid year (due to a death), how does this impact maximum contributions to an HSA?

A. The instructions to Form 8889 provide added detail about how a change in HDHP coverage during the year affects the calculation of an individual's HSA contribution limit under the last month (*a/k/a* as a proration rule) rule. The instructions provide that if an individual is treated under the last month rule as an HSA-eligible individual for the entire taxable year, but changes his or her HDHP coverage that year (i.e. from family coverage to self-only HDHP coverage), then he or she may contribute up to the **greater** of:

a): the maximum amount that may be contributed for the taxable year, based upon his or her actual HDHP coverage (i.e. self-only or family HDHP coverage) for each month of the year; or

b): the full HSA contribution limit for the taxable year based on the type of HDHP coverage that he or she had on December 1 of that year (\$2,900 if he or she had self-only HDHP coverage on 12-1-08, and \$5,800 if he or she had family coverage on 12-1-08).

Given the facts at hand, the amount calculated for option (a) above would be 3 months (since she was married at least a portion of that month) at the family threshold limit, and 9 months at the self-only threshold for a total of \$3,625. The calculation in (b) above yields the amount of \$2,900, since she had self-only coverage in 12-1-08. The greater of these amounts is \$3,625 and that is the cumulative amount of contributions (except for catch-up contributions) that could be made to the HSA in 2008.

HIPAA

Q. When is it necessary to supply HIPAA certificates of creditable coverage for health FSA's?

A. The requirement to supply HIPAA certificates of creditable coverage for Health FSA's is dependent upon whether or not that particular plan is "excepted" from the HIPAA provisions. Some FSA's are, and some are not.

Under HIPAA, plan administrators of group health plans that are not excepted benefits must issue certificates of creditable coverage to individuals who lose coverage under an employer-provided health plan, or who would have lost coverage but for an election to take COBRA continuation coverage (Code Section 9801(e)(1)(A)).

Many health FSA's will not have to provide a HIPAA certificate, because they are excepted benefits; however, if a health FSA is not an excepted benefit it must provide a HIPAA certificate. Keep in mind that even if a health FSA meets the criteria to be an excepted benefit, such plans are generally subject to HIPAA's other provisions...i.e. the HIPAA privacy and security requirements.

The conditions that must be met to qualify for the exception (and therefore not issue creditable coverage certificates) are detailed at Code Section 106 © (2), and are as follows:

- 1). *Maximum Benefit Condition.* The maximum benefit payable under the health FSA to any participant for a year cannot exceed two times the participant's salary reduction election under the health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the health FSA for the year, plus \$500), and
- 2). *Availability Conditions.* Other non-excepted group health plan coverage (i.e., major medical coverage) must be made available for the year to employees by reason of their employment.

So, In English, here is what that means:

Maximum Annual Benefit refers to the entire available health FSA benefit (including amounts received during any 2 ½ month grace period) that the participant has elected to receive for a year—i.e., the participant's salary reduction plus any employer contributions. **Therefore, if the health FSAs are funded exclusively by employee salary reductions, they will, by definition, meet the excepted benefits rule and not be subject to HIPAA creditable coverage certificate provisions, if they also meet the Availability Conditions, below.**

However, if there is a provision for matching employer FSA contributions, the health FSA may or may not meet the excepted benefit provisions. In this case, a health FSA with matching contributions **will satisfy the Maximum Benefit Condition only so long as the employer matching contribution does not exceed the greater of the participant's salary reduction, or \$500.**

I will not go into detail, but if the plan sponsor employs a "cashable credit" system of employer contributions to their cafeteria plan, they should be concerned about whether their health FSAs will satisfy the Maximum Benefit Condition if there is a possibility that more than \$500 in employer-provided credits may be directed into the health FSAs.

As far as satisfying the HIPAA Availability Condition, so long as the employees eligible for the health FSA are also eligible for major medical coverage and the entry dates for both are the same, the Availability Condition will be satisfied even if some eligible employees take health FSA coverage, but opt out of major medical coverage. If, however, the eligibility provisions under the health FSA are more liberal (i.e., more employees are eligible for the health FSA than for the major medical plan), then the Availability Condition will not be met, and the HIPAA certificate of coverage requirements will be invoked.

COBRA SUBSIDY PROVISIONS

- Q. Terminated employee electing COBRA qualifies for the subsidy. Terminated employee is divorced and required to cover dependent children on health insurance by court order. The issue is the dependent children's other parent has group health insurance available through their employer. Does this disqualify the terminated employee from receiving the subsidy for himself? How about for his dependent children?
- A. The law is clear that mere eligibility is all it takes to disqualify an individual from the subsidy, and even though the ex-employee has a Court order to furnish insurance, the children are eligible for another GROUP plans...even though that spouse has no legal responsibility to cover them.

Therefore, the ex-employee remains eligible for the subsidy for his own coverage, and may cover his dependent children under COBRA from his prior employer; however, the additional cost to cover these dependents will not be eligible for the COBRA subsidy.

The step by step process to calculate the premium, and related subsidy, can be found in the IRS Notice 2009-27, Q/A 25, Example #3:

Step #1). Calculate the full employee only premium, and multiply it by 35 percent.

Step #2). Calculate the difference between the full premium for the employee plus children rate, and the full premium for the employee only rate.

Step #3). Add the amounts from Step #1 and Step #2. This is the amount of monthly premium the AEI must submit each month.

Step #4) The amount of the subsidy that the employer will seek in payroll tax credits is 65 percent of the employee only premium.

So, if the full employee only premium is \$300 and the full employee plus children premium is \$800, the AEI must submit \$105 (35 percent of \$300), plus \$500 (the difference between \$800 and \$300), for a monthly total of \$605, to cover himself as an AEI, plus his 3 daughters who are not AEIs.

The employer would file for a payroll tax credit equal to \$195 (65 percent of the full employee only premium).