COMPLIANCE OVERVIEW

Health Plan Eligibility: Do's and Don'ts

Employers sponsoring group health plans have some flexibility when deciding which groups of employees and dependents will be eligible for coverage. However, there are several crucial eligibility requirements employers should adhere to for health coverage. These rules can be categorized into important eligibility "do's" and "don'ts" for employers to follow.

A basic eligibility "do" is following the terms of the health plan's written plan document, including its eligibility rules. Also, to avoid potential penalties, applicable large employers (ALEs) should ensure they offer affordable coverage to their full-time employees. Other important "do's" include making coverage available for adult children up to age 26 and continuing to offer coverage for Medicare-eligible employees when the health plan is the primary payer.

Essential "don'ts" for health plan eligibility include offering coverage to nonemployees, such as independent contractors, and imposing waiting periods that exceed 90 days. Other crucial "don'ts" are overlooking applicable nondiscrimination requirements when establishing eligibility rules and excluding employees from coverage based on health status-related factors.

LINKS AND RESOURCES

- IRS questions and answers on the ACA's pay-or-play rules for ALEs
- Final rules on the ACA's age 26 requirement for young adults
- Final rules on HIPAA's nondiscrimination rules related to health status-related factors

Eligibility Do's

- Follow the terms of the official plan document
- Offer affordable coverage to all full-time employees (ALEs only)
- Offer coverage for adult children to age 26
- Continue to offer coverage to employees when they become eligible for Medicare

Eligibility Don'ts

- Offer coverage to nonemployees, such as independent contractors
- Impose a waiting period that exceeds 90 days
- Overlook nondiscrimination requirements
- Exclude employees based on health status-related factors

Eligibility Do's

Do Follow the Terms of the Plan Document

To comply with ERISA, a health plan must have an official written plan document that contains the plan's rules for benefits and eligibility. These rules should identify the groups of employees and dependents (e.g., children, spouses and domestic partners) who are eligible to enroll in the plan. The plan document should also describe any waiting period or other conditions for enrollment. The plan document is often comprised of multiple documents, including benefit descriptions provided by an insurance carrier or third-party administrator, and a "wrap" document that combines multiple benefits under one welfare benefit plan and satisfies ERISA's documentation requirements.

Following the written plan document in the day-to-day operations of the plan is a fiduciary duty under ERISA. Employers should be familiar with their written plan document and periodically review the document to make sure it remains current. Deviating from the health plan's established eligibility rules may also raise concerns about impermissible discrimination or favoritism in the workplace. For insured health plans, going beyond the plan's established eligibility terms may inadvertently create self-insured liability for the employer if the carrier denies claims based on the individual's ineligibility for benefits.

Do Offer Affordable Coverage to Full-time Employees (ALEs Only)

The Affordable Care Act (ACA) requires ALEs to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or potentially pay a penalty to the IRS. This employer mandate is also known as the "pay-or-play" rules. ALEs are employers that had, on average, **at least 50 full-time employees**, including full-time equivalent employees (FTEs), during the preceding calendar year. Small employers that are not ALEs are not subject to these rules and are not required to offer coverage to their full-time employees.

An ALE may be subject to a pay-or-play penalty if at least one full-time employee receives a premium tax credit for purchasing individual health coverage through an ACA Exchange (or Marketplace) and the ALE:

- Did not offer health plan coverage to at least 95% of full-time employees and their dependents;
- Offered health plan coverage to at least 95% of full-time employees but not to the specific full-time employee receiving the credit; or
- Offered health plan coverage to full-time employees that was unaffordable or did not provide minimum value.

Identifying which employees are full-time employees is central to the ACA's pay-or-play rules. A full-time employee is an employee who has, on average, at least **30 hours of service per week** or at least **130 hours per calendar month**.

Do Offer Coverage for Adult Children up to Age 26

The ACA requires health plans that provide dependent coverage for children to make the coverage available for adult children until they reach **age 26**. A "child" includes an employee's biological child, adopted child, stepchild or foster child. A health plan may not deny or restrict coverage for a child who is under age 26 based on whether the child is financially dependent on the participant, resides with the employee or with any other person, is a student, is employed, is unmarried, or any combination of these factors.

In addition, the terms of the plan providing dependent coverage of children, including premiums charged, cannot vary based on age (except for children who are age 26 or older). This means that adult children must be offered all the benefit packages available to other plan participants and cannot be required to pay more for coverage.

Do Continue to Cover Medicare-eligible Employees

When individuals have Medicare coverage and employer-sponsored health coverage, each type of coverage is called a "payer." Medicare's coordination of benefits rules decide which payer pays first on a health care claim (that is, pays primary). For example, health plans sponsored by employers with **20 or more employees** are typically the primary payers for individuals who are entitled to Medicare due to age.

The Medicare Secondary Payer (MSP) rules include requirements for employers that sponsor group health plans that are primary to Medicare. These requirements are intended to protect Medicare's secondary payer status. Employers with group health plans that are primary to Medicare must comply with the following requirements:

- The group health plan must provide a current employee (or a current employee's spouse) who is age 65 or older with the **same benefits under the same conditions** it provides employees and spouses under age 65;
- The employer cannot offer Medicare beneficiaries **any financial or other benefits as incentives not to enroll** (or terminate enrollment) in a group health plan; and
- The group health plan **cannot consider the Medicare entitlement** of an individual.

Thus, when an employer's group health plan is the primary payer, Medicare-eligible employees and spouses cannot be excluded from plan coverage or discouraged from enrolling in coverage. Also, employers cannot offer any financial or other incentive for an individual entitled to Medicare to not enroll (or terminate enrollment) in a group health plan that would pay primary.

Eligibility Don'ts

Don't Offer Coverage to Nonemployees

In general, employers should only offer health plan coverage to individuals who are their employees. Offering health coverage to nonemployees, such as independent contractors or directors, may inadvertently create a multiple employer welfare arrangement (MEWA). A MEWA is an arrangement that offers welfare benefits to employees of two or more employers that are not under common control or part of the same controlled group. Many states strictly regulate self-insured MEWAs, making these arrangements difficult to operate and administer. For example, to protect consumers from abusive MEWA practices, states may prohibit self-insured MEWAs from operating altogether or impose insurance carrier funding and reporting requirements on these arrangements. Depending on the state, operating an unlicensed MEWA can expose an employer to civil and criminal penalties.

In addition, offering health coverage to independent contractors may undermine an employer's classification of these workers as nonemployees. Because independent contractors are typically ineligible for employee benefits, offering health plan coverage to independent contractors may indicate that these workers have been misclassified. Misclassifying workers can have serious financial and legal consequences for an employer, such as liability for unpaid wages and employment taxes as well as penalties and fines.

Don't Impose a Waiting Period Exceeding 90 Days

The ACA prohibits group health plans from applying any waiting period that exceeds **90 days**. A waiting period is the period that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of the group health plan. All calendar days are counted beginning on the enrollment date, including weekends and holidays.

Other eligibility conditions that are not based solely on the lapse of time are generally allowed, such as being in an eligible job classification. In addition, employers may impose a requirement to successfully complete a **reasonable and bona fide employment-based orientation period** as a condition for eligibility for coverage under a plan. During an orientation period, an employer and employee can evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes can begin. However, any permitted orientation period may not exceed **one month**.

Don't Overlook Nondiscrimination Requirements

Federal tax law imposes nondiscrimination requirements on certain types of employee benefits to ensure employers do not impermissibly favor their highly compensated employees. These rules currently apply to **self-insured health plans** and arrangements that allow employees to pay their premiums on a pre-tax basis, or **Section 125 cafeteria plans**. The nondiscrimination requirements for fully insured health plans have been delayed indefinitely.

In general, a health plan will not have problems passing any applicable nondiscrimination test when the employer treats all its employees the same for purposes of health plan coverage (for example, all employees are eligible for the health plan, and the plan's eligibility rules and benefits are the same for all employees). However, treating employees differently may make it more difficult for a health plan to pass the applicable nondiscrimination tests. The following are examples of plan designs that may cause problems with nondiscrimination testing:

- Only certain groups of employees are eligible to participate in the health plan (for example, only salaried or management employees);
- The health plan has different employment requirements for plan eligibility (for example, waiting periods and entry dates) for different employee groups; and
- The employer maintains separate health plans for different groups of employees.

Before implementing one or more of these plan designs, employers should confirm that the arrangement will comply with applicable rules prohibiting discrimination in favor of highly compensated employees. If a self-insured health plan or cafeteria plan is discriminatory, highly compensated employees will lose certain tax benefits under the plan.

Don't Exclude Employees Based on Health Factors

The Health Insurance Portability and Accountability Act (HIPAA) prohibits group health plans from discriminating against individuals regarding eligibility, premiums or coverage based upon a health status-related factor. Health status-related factors include an individual's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. Group health plans may not discriminate with respect to eligibility between similarly situated employees based upon a health factor. Eligibility rules include those related to enrollment, the effective date of coverage and eligibility for benefit packages. In addition, under HIPAA, employers cannot:

- Require an individual to pass a physical examination to be eligible to enroll in health plan coverage;
- Exclude individuals from coverage because they participate in dangerous activities or have high health claims;
- Charge an individual within a group of similarly situated individuals a different premium rate based upon that individual's health factors; nor
- Delay enrollment in the health plan until an employee is actively at work (unless individuals who are absent from work due to any health factor are treated as if they are actively at work).