Frequently Asked Questions - Impact of the ACA on GBP insurance coverage for state employees

This information is current as of its posting date, but ERS cannot guarantee the ongoing accuracy or completeness of the information. You are strongly encouraged to independently determine how, if at all, the Affordable Care Act (ACA) and the Marketplace (also known as the "exchange") may affect you and your family. ERS does not verify and does not exert editorial control over information on pages you may link to from this page.

After a waiting period, state employees are eligible for Group Benefits Program (GBP) insurance coverage. The Employees Retirement System of Texas (ERS) administers insurance benefits for eligible state agency employees and their family members. More eligibility information is available on the ERS website.

1. How is a GBP-eligible employee defined in state law?

The Texas Insurance Code (TIC) defines eligibility for the GBP. As of September 1, 2013, the following employees are eligible for GBP coverage.

- ***Full-time employee*** **(FTE)** "designated by the employer as working 30 or more hours a week." (TIC, §1551.003(9)); and
- ***Part-time employee*** "designated by the employer as working less than 30 hours a week." (TIC, §1551.003(11))

2. Do provisions in the Affordable Care Act (ACA), also known as federal health care reform, change eligibility rules for the GBP?

No. Nothing in the ACA changes GBP eligibility rules. No matter how many hours employees work, they still must meet state eligibility rules to qualify for GBP coverage.

3. How do state agency employers decide who is full-time and who is part-time?

The IRS issued some guidance (*IRS Notice 2012-58*) to help employers determine whether an employee is working full time. As of September 1, 2013, the GBP defines a full-time employee as one who works at least 30 hours a week. (TIC, §1551.003(9)). Starting in 2016, all state agencies will report annually to the IRS on how many FTEs were offered the required minimum level of insurance coverage for the previous plan year.

4. Will the new ACA definition of full-time employee change the insurance contribution?

No, the ACA does not dictate the insurance contribution. The General Appropriations Act sets the FY14-15 employer contribution at 100% for full time and 50% for part time employees. As of September 1, 2014, the employer's contribution is 100% for state and higher-education employees working at least 30 hours a week.

5. Will employers have to pay federal excise taxes?

As of January 1, 2015, the ACA requires employers to provide a minimum level of affordable insurance coverage to regular full-time employees and their children under 26 years of age, or pay a federal Employer Shared Responsibility Assessment (or "excise tax") *26 U.S.C. §4980H*. Paying a tax for one employee could make an employer liable for penalties on other eligible employees. ***Coverage offered under the GBP currently exceeds the minimum coverage requirements under the ACA.***

6. What is “affordable” coverage?

The IRS sets the affordability standard for insurance coverage *(IRS 26 CFR Part 1***)**. Starting January 1, 2015, the employee’s premium contribution cost for the employer-sponsored health insurance plan (for the employee only, not any other members of the family) may not exceed 9.5% of the employee’s household income for the year. Since the State pays 100% of the member-only contribution, coverage for regular full-time state employees and their dependents is considered “affordable.”

7. What if an employee declines dependent coverage because the employee believes it to be “unaffordable?” Will employers have to pay a penalty?

No. The employer’s responsibility is to offer the coverage, but the dependent is not required to enroll.

8. What if a retiree with less than 20 years of service declines individual coverage because the retiree believes it to be “unaffordable?” Will employers have to pay a penalty?

No. The ACA does not require employers to offer retiree coverage beyond COBRA, or 18 months.

9. If an employee waives coverage, who pays the penalty: the employer or the employee?

As of January 1, 2014, employees who waive GBP coverage will pay a federal penalty unless they buy a minimum level of insurance coverage elsewhere.

10. Does GBP coverage meet the minimum coverage requirement under the ACA?

Yes. GBP coverage currently exceeds the minimum coverage requirement under the ACA.

11. Who will notify employees of the exchange?

The employer, not ERS, is responsible for notifying all employees and proving that they received the notification. The ACA required employers to send notice to their employees by October 1, 2013 about their existing coverage and the option to use the federal insurance exchange. Going forward, new employees must be notified within 14 days of their start date. ERS has provided benefit coordinators with an overview of GBP benefits and a link to the model ACA employee notice provided by the Department of Labor.

12. Can an employee switch from the GBP to coverage on the exchange?

Employees who enroll in GBP coverage need to stay enrolled for the entire fiscal year unless they experience one of the QLEs outlined on the ERS website.

13. Who will pay the transitional reinsurance fee? Will the agency need to provide separate funding for this?

ERS will pay this fee when it becomes due. We estimated the cost of the fee in our contribution rates.

14. Are we authorized to provide another employer sponsored plan for non-GBP eligible employees?

Employers are free to offer alternative plans to individuals who are not eligible for the GBP, but again, we suggest talking with your legal counsel to determine if this is permitted for your institution. Also, please note that any individual who is eligible for GBP health insurance cannot be offered a plan that is not part of the GBP by an employer participating in the GBP.

15. Will ERS handle any part of the 6055 and 6056 reports? If not, will ERS provide us the information we need such as dependent SSN's?

Section 6055 of the Internal Revenue Code (IRC) requires each provider of minimum essential coverage to report to the IRS and furnish related statements to certain individuals. Section 6056 of the IRC requires applicable large employers to file information returns with the IRS and provide statements to their full-time employees about the health insurance coverage offered by the employer. The IRS has published Questions and Answers for the 1095-B and 1095-C. The IRS has also published the following forms and instructions:

- http://www.irs.gov/pub/irs-dft/f1094b--dft.pdf
- http://www.irs.gov/pub/irs-dft/f1095b--dft.pdf
- http://www.irs.gov/pub/irs-dft/i109495b--dft.pdf
- http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf
- http://www.irs.gov/pub/irs-dft/f1095c--dft.pdf
- http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf

ERS is researching the reporting requirements for HealthSelect. The HMO plans are expected to report directly to the IRS and CMS is expected to handle the report for the Medicare Advantage programs. You are encouraged to have your legal and finance staffs review the regulations, draft forms and draft instructions to determine how, if at all, these requirements affect your institution. You are also encouraged to coordinate with your payroll entity to ensure you are capable of making any required IRS filings and furnishing any required statements to appropriate individuals.

It appears that ERS will not be able to provide protected health information, which would include names, birthdates and SSN's of participants, including dependents, due to HIPAA restrictions. ERS hopes to update this FAQ as soon as more definitive information is available regarding these reporting requirements.