Health Coverage for Family Members: Do's and Don'ts

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Employer-sponsored health plans typically offer coverage for employees' family members, specifically their spouses and children. Some employers also offer coverage for employees' domestic partners. There are several important "do's" and "don'ts" for employers to follow when offering health coverage for family members.

In general, before the start of each plan year, employers should review their plan documents, including their Summary Plan Descriptions (SPDs), to ensure they accurately describe the plan's eligibility rules, including those for family members. Any changes to the plan's eligibility rules should be communicated to employees through an updated SPD or a Summary of Material Modifications (SMM). Also, employers should consider these important requirements regarding coverage for family members:

- Do remember to offer COBRA coverage to spouses upon a divorce, even when an employee drops their coverage in anticipation of the divorce;
- Don't vary coverage by age for children under age 26; and
- Do report and withhold taxes on the fair market value (FMV) of health coverage for domestic partners who are not tax dependents (unless employees pay for the coverage on an after-tax basis).

Legal Spouses

Most employer-sponsored health plans allow eligible employees to enroll their lawful spouses, although federal law does not require employers to offer health coverage for spouses.

Do Understand the Tax Rules for Spousal Coverage

Employer-provided health coverage for legal spouses is nontaxable. In general, an individual is considered a spouse for federal tax purposes if they are recognized as a spouse under applicable state law. Also, employers can allow employees to pay their health plan premiums for spousal coverage on a pre-tax basis through a Section 125 cafeteria plan.

Do Provide HIPAA Special Enrollment Rights

Employees often enroll their spouses in health coverage during an initial enrollment period when they are hired (or otherwise become eligible for coverage) or an annual enrollment period that occurs before the start of each plan year. The Health Insurance Portability and Accountability Act (HIPAA) requires health plans to provide special enrollment opportunities for spouses when certain events occur during the year, including the following:

- **Marriage**: Employees must be able to enroll their newly acquired spouses following a marriage; and
- **Loss of eligibility for other health coverage**: Employees must be able to enroll their spouses following a spouse's loss of eligibility for other health coverage. This may occur, for example, when a spouse reduces their hours (or terminates employment) and is no longer eligible for health coverage through their employer.

When special enrollment rights apply, health plans must allow an enrollment period of at least 30 days following the date of marriage or loss of eligibility. Coverage must be effective no later than the first day of the first calendar month beginning after the date the plan receives a timely enrollment request.

Don't Overlook Common Cost-saving Measures

To help control costs, employers can implement spousal carve-outs (or surcharges) for spouses who have health coverage available through their own employers. These special rules work as follows:

- **Spousal carve-out**: A spousal carve-out can take a variety of forms. One type of spousal carve-out provides that working spouses with available health coverage through their own employers are ineligible for coverage through the employee. Another type of spousal carve-out requires working spouses to enroll in coverage offered by their own employers to be eligible for coverage through the employee, which allows the employer's health plan to coordinate benefit payments with the spouse's health plan; and
- **Spousal surcharge**: A spousal surcharge is an additional premium or contribution that an employee must pay for spousal coverage if the spouse has coverage available through their own employer and chooses not to enroll in that coverage.

In general, federal law does not prohibit group health plans from incorporating a spousal carve-out or surcharge. However, depending on how it is structured, this type of plan design may raise discrimination concerns (e.g., sex or marital status discrimination). To help avoid potential discrimination issues, spousal carve-outs and surcharges should be applied uniformly to all plan participants.

In addition, employers may consider offering a health reimbursement arrangement (HRA) to encourage employees and their spouses to opt out of their health plan coverage and instead elect coverage through a spouse's employer. This type of HRA—called a **spousal incentive HRA**—reimburses employees on a tax-free basis for out-of-pocket medical expenses incurred under the spouse's employer's group health plan, such as deductibles, copayments and coinsurance. Spousal incentive HRAs can lower an employer's health care spending by reducing the number of individuals covered under its health plan.

Don't Forget About COBRA Continuation Coverage

COBRA is a federal law that requires private-sector employers with **20 or more employees** to provide covered employees, spouses and dependent children (qualified beneficiaries) who lose health coverage due to certain events (qualifying events) with an opportunity to continue coverage for a limited period of time. Each qualified beneficiary has independent election rights, which means they have an independent right to elect COBRA coverage regardless of what other qualified beneficiaries do.

Many states have their own continuation coverage laws for fully insured group health plans that are similar to COBRA. These state laws, which are sometimes called mini-COBRA laws, often apply to fully insured group health plans maintained by employers with fewer than 20 employees. Thus, even if a plan is not subject to COBRA, it may nevertheless be required to provide continuation coverage under state insurance law. Self-insured health plans maintained by private-sector employers are typically not subject to state continuation coverage requirements.

Covered spouses are entitled to elect COBRA coverage when their health coverage would otherwise end due to the following qualifying events:

- The employee's termination of employment (or reduction in hours);
- A divorce or legal separation of the employee and their spouse;
- The employee's death; or
- The employee's entitlement to Medicare.

Under a special rule, COBRA must also be offered if health coverage is reduced or eliminated in anticipation of a qualifying event (for example, an employee drops health coverage for their spouse during open enrollment in anticipation of a divorce). In this type of situation, the reduction or elimination is disregarded when determining whether there is a loss of coverage due to the qualifying event. Thus, if a covered employee eliminates coverage of their spouse in **anticipation of their divorce**, then upon receiving notice of the divorce, the health plan must make COBRA continuation coverage available to the spouse as of the date of the divorce. Failing to recognize when health coverage for a spouse is dropped in anticipation of a divorce is a common COBRA compliance mistake. To address this problem, an employer may want to notify spouses who are dropped from coverage that they must notify the employer (or third-party COBRA administrator, if applicable) of any divorce to protect their COBRA rights.

Children

Most employer-sponsored health plans allow eligible employees to enroll their children, although federal law does not require employers to offer health coverage for children. However, applicable large employers (ALEs) that do not offer affordable health coverage to their full-time employees and their children may be liable for a penalty under the Affordable Care Act's (ACA) employer shared responsibility rules (or "pay-or-play" rules).

Do Understand the Tax Rules for Dependent Coverage

Employer-provided health coverage for children is nontaxable through the end of the year in which a child attains age 26, regardless of whether the child qualifies as a tax dependent. Also, employers can allow employees to pay their health plan premiums for dependent children on a pre-tax basis through a Section 125 cafeteria plan through the end of the year in which the children attain age 26.

Some health plans may allow adult children to remain eligible for coverage past age 26, voluntarily or due to a state insurance mandate. The taxability of a child's coverage after the year in which they attain age 26 depends on whether they qualify as dependents for federal tax purposes. When adult children are not tax dependents, federal tax law generally requires employers to impute the FMV of the dependent coverage as income to employees, unless employees pay for the coverage on an after-tax basis.

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

The ACA requires ALEs to offer affordable, minimum value health coverage to their full-time employees (and their dependents) or possibly pay a penalty. ALEs are employers that employ, on average, at least 50 full-time employees (including full-time equivalent employees) during the preceding calendar year. The term "dependent" means an employee's child who is under age 26. For purposes of these rules, a child is a dependent for the entire calendar month in which they attain age 26. Thus, an ALE's health coverage for children should go through the last day of the month in which they attain age 26. For purposes of these rules, an employee's child includes a biological child or an adopted child, but does not include stepchildren and foster children.

Despite the dependent coverage requirement, an employer's liability for a pay-or-play penalty is triggered only by a full-time employee receiving a subsidy for coverage through an Exchange, regardless of whether any dependents are eligible for, or receive, a subsidy. Note that an employee is not eligible for an Exchange subsidy if their employer offers health coverage that is affordable and provides minimum value.

Do Provide HIPAA Special Enrollment Rights

In addition to a health plan's regular enrollment periods, HIPAA requires health plans to provide special enrollment opportunities for dependent children when certain events occur during the year, including the following:

- **Acquisition of new dependent**—Employees must be able to enroll their newly acquired dependents following a marriage, birth, adoption or placement for adoption;
- **Loss of eligibility for other health coverage**—Employees must be able to enroll their dependent following a dependent's loss of eligibility for other health coverage. This may occur, for example, if the employee's child loses eligibility for coverage due to a job loss;
- **Termination of Medicaid or CHIP eligibility**—Employees must be able to enroll their dependent after they lose coverage under a Medicaid or a state Children's Health Insurance Program (CHIP) due to a loss of eligibility; and
- **Eligibility for premium assistance subsidy**—Employees must be able to enroll their dependent if they become eligible for a premium assistance subsidy through a Medicaid or state CHIP.

When special enrollment rights apply, health plans must allow an enrollment period of at least **30 days** following the date of marriage, birth, adoption, placement for adoption, or loss of eligibility for other health coverage. This enrollment period must be at least **60 days** following a special enrollment event that is a termination of Medicaid or CHIP eligibility or eligibility for a premium assistance subsidy. In general, coverage must be effective no later than the first day of the first calendar month beginning after the date the plan receives a timely enrollment request. However, when a new dependent is acquired through birth, adoption or placement for adoption, coverage must be effective retroactively to the date of birth, adoption or placement for adoption.

Don't Vary the Terms of Coverage for Children Under Age 26

The ACA requires health plans that provide 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 child's eligibility under this rule must be based solely on their age and relationship to the employee. 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 has 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.

Some states have their own laws that require insured health plans to cover dependent children into adulthood. These state mandates continue to apply to insured health coverage, to the extent they require coverage past age 26.

Don't Forget About COBRA Continuation Coverage

Dependent children are qualified beneficiaries who are entitled to elect COBRA coverage when their health coverage would otherwise end due to the following qualifying events:

- The employee's termination of employment (or reduction in hours);
- The loss of dependent status under the plan's eligibility rules;
- A divorce or legal separation of the employee and their spouse;
- The employee's death; or
- The employee's entitlement to Medicare.

Dependent children's COBRA rights are separate and independent of their parents. Also, children born to, or adopted by, a covered employee during a period of COBRA coverage are considered qualified beneficiaries with their own COBRA rights.

Domestic Partners

Some employers design their health plans to allow employees to enroll their domestic partners in coverage. In general, a domestic partnership is an interpersonal relationship between two adults who live together and share a domestic life but are not married to each other. At the federal level, there are no laws that provide legal rights to unmarried couples in domestic partnerships. However, a handful of states have enacted domestic partnership or civil union laws that provide state law rights to couples in these relationships.

Employers offer domestic partner benefits for a variety of reasons. For example, depending on workforce demographics, domestic partner coverage may be an effective way to attract and retain talent. Also, a few states have laws that require health insurance coverage for domestic partners.

Do Consider Options for Eligibility Rules

There are no uniform rules for defining a domestic partner for purposes of health plan eligibility. Some employers establish their own definitions, while others reference state or local domestic partner registration systems. Some commonly used eligibility requirements require that domestic partners:

- Share a common residence and a significant portion of financial responsibilities;
- Be at least 18 years of age;
- Register as domestic partners if there is a state or local domestic partner registry; and
- Not be legally married to anyone or engaged in another domestic partnership.

It is common for employers to require that employees provide an affidavit, certification or other formal statement affirming domestic partner eligibility when couples have not registered their domestic partnership under a state or local registry.

Employers must also decide if a domestic partner's children will be eligible for coverage and, if so, the corresponding eligibility parameters (for example, residency, dependency, student status). Many times, these children are eligible for coverage if stepchildren are also covered, or if they qualify as tax dependents. However, a domestic partner's child is unlikely to be the employee's tax dependent because, in most cases, the child will be the dependent of another taxpayer, such as the domestic partner or the child's other parent.

Do Provide HIPAA Special Enrollment Rights

Domestic partners (and their children) have HIPAA special enrollment rights if they are eligible for coverage under the terms of the health plan. HIPAA regulations define a "dependent" for special enrollment purposes as "any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant." This means that health plans offering domestic partner coverage must comply with certain HIPAA special enrollment rights for domestic partners (and their children, if eligible for coverage).

HIPAA requires health plans with domestic partner coverage to provide special enrollment opportunities for domestic partners when the following events occur during the year:

- **Loss of eligibility for other health coverage**—Employees must be able to enroll their domestic partners (or their children, if eligible) following a loss of eligibility for other health coverage. This may occur, for example, if a domestic partner loses eligibility for health coverage due to a job loss;
- **Termination of Medicaid or CHIP eligibility**—Employees must be able to enroll their domestic partners (or their children, if eligible) after they lose coverage under a Medicaid or a state CHIP due to a loss of eligibility;
- **Eligibility for premium assistance subsidy**—Employees must be able to enroll their domestic partners (or their children, if eligible) if they become eligible for a premium assistance subsidy through a Medicaid or state CHIP; and

- **Acquisition of a new dependent child**—Employees must be able to enroll their domestic partner's newly acquired dependent children following a birth, adoption or placement for adoption, if eligible for coverage.

HIPAA also requires health plans to provide special enrollment rights following the acquisition of a new dependent through marriage. Because domestic partners are not recognized as spouses under federal law, HIPAA special enrollment rights are not triggered when an employee acquires a domestic partner. Some plans go beyond what HIPAA requires and allow employees to enroll their newly acquired domestic partners. Before implementing a plan design that provides greater enrollment rights to employees, employers should consult with their health insurance issuers or stop-loss carriers.

Don't Forget to Impute Income for Taxable Benefits

Federal tax law only permits tax-free health coverage for spouses, children to age 26 and tax dependents. This means that the value of domestic partner benefits is nontaxable only if the domestic partner qualifies as a dependent under federal tax law. To qualify as a tax dependent, the domestic partner must generally:

- Have the same primary address as the employee for the year;
- Be a member of the employee's household;
- Receive more than half of their support for the year from the employee;
- Not be anyone's "qualifying child" for tax purposes; and
- Be a citizen or national of the United States, or a resident of the United States or a country contiguous to the United States.

When a domestic partner qualifies as a tax-dependent, the employee can pay for the coverage on a pre-tax basis through a Section 125 cafeteria plan.

If a domestic partner does not qualify as a tax dependent of the employee, employers are required to **report and withhold taxes on the FMV of employer-provided health coverage for the domestic partner (unless employees pay for the coverage on an after-tax basis)**. This raises both the employee's taxable gross income and the employer's payroll taxes. Some employers "gross up" an employee's salary to offset the tax consequences of domestic partner benefits (that is, reimburse employees for the extra taxes they are required to pay on the value of domestic partner benefits).

Don't Offer COBRA Continuation Coverage

COBRA requires covered health plans to provide continuation of coverage when certain events (e.g., termination of employment) cause a qualified beneficiary to lose coverage under the plan terms. A qualified beneficiary is an individual who was covered by the employer's health plan on the day before a qualifying event occurred and who is an employee, an employee's spouse or former spouse, or a dependent child. **Domestic partners are not qualified beneficiaries for COBRA purposes and do not have their own COBRA election rights**.

Even though an employee's domestic partner has no independent COBRA rights, an employer may choose to extend comparable benefits with the approval of their plan's insurance issuer or stop-loss carrier. Also, employees who lose coverage due to a termination of employment or reduction in hours may elect to continue the coverage in place before the qualifying event, which may include coverage for a domestic partner. An employee receiving COBRA coverage may also add coverage for a domestic partner during an open enrollment period if similarly situated active employees are permitted to do so under the plan.

LINKS AND RESOURCES

- Federal regulations regarding HIPAA special enrollment rights.
- "An Employer's Guide to Group Health Plan Continuation Coverage under COBRA," a Department of Labor resource

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