

Health Care Reform – FAQs

Updated June 21, 2010 – Version 11

This document is comprised of questions received from Council members and answered by The Council's attorneys at Steptoe & Johnson LLP. All section references are to the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) ("PPACA") or the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) ("HCEARA"), as indicated in each response. Many of the changes in the legislation are in the form of amendments to the Public Health Service Act. References to that Act in this document will be to PHSA. This document will be updated as information is received.

If you have additional questions, please contact your Harden Account Manager.

Please keep in mind that the information provided here is not intended to be, and should not be construed, as a legal opinion or advice. It is recommended that you consult with your own attorney or other adviser relating to your specific circumstances or those of any organization you advise.

Contents

- I. Employer Mandate Issues**
- II. Employer Tax Credits**
- III. Market Reform / Plan Design Requirements**
- IV. Medical Loss Ration / Rebating Issues**
- V. "Grandfathered" Plans / CBAs**
- VI. Limited Benefits (e.g. Mini-Med) Plans**
- VII. Issues Regarding Self-Insured Plans**
- VIII. Taxes, FSAs, HSAs, HRAs, PPACA Titles IX and X**
- IX. Fees**
- X. Long term Care Insurance**
- XI. Wellness Premium Subsidies**
- XII. Reinsurance Program for Early Retirees**
- XIII. Miscellaneous Issues**

I. Employer Mandate Issues

A. General

PPACA § 1513; HCEARA § 1003(c)
(Apply To “Large” Employers -- >50 Employees)

1. **If an employer offers health benefits to full-time employees but not to its part-time employees, is that employer subject to the mandate penalties?**

No. The FTE calculation for part-time employees (monthly hours worked divided by 120) is relevant only to determine whether the employer is larger than 50 employees. Employer penalties appear to be based solely on real full-time employees (so if you have 40 full-time employees and 1000 part-time employees, you are subject to the penalties but only for 10 people if you offer no coverage (after the 30-person deduction for penalty calculation purposes). This is one of the many areas in which regulatory clarification/verification will be sought at the earliest opportunity.

2. **When they talk about employers providing coverage to employees, are they referring to coverage on the employee only or are they including coverage for the employee's dependents?**

The mandate includes coverage for the employee's dependents.

3. **Do the employer mandate penalties apply to full-time employees living abroad or to expatriate plans?**

The employer mandate section does not explicitly address this issue, and it is one that should be clarified through rulemaking. We believe that employers should not be penalized under the mandate provisions for employees living abroad, though, both because the individual mandate exempts U.S. citizens living abroad (see PPACA § 1501 (adding IRC § 5000A(f)(2))) and because citizens living abroad will be ineligible to purchase coverage through any individual plan offered through an Exchange (see PPACA § 1312(f)).

4. **One of the biggest issues we see at this time is the staffing industry and probably the hotel/motel/restaurant businesses and their reliance on “consultants” and other temporary workers. There is some thought to the 30 hours per week but how is that determined over a period of time as they are “placed” at intervals based on job need?**

A few things on this. First, the mandate penalties apply to “employees” of the “employer.” For temporary workers, the first inquiry will be – for what company are they the employees? The staffing company or the company that is contracting with the staffing company? Second, the legislation dictates that the calculations are made on a per month basis and they are made retrospectively at the end of your tax year. Any individual is an “employee” and that works more than 30 hours per week is designated as a Full-Time Employee. The definitions of who qualifies as an “employee” are unchanged so the traditional IRS definitions apply. The only exception to this FTE calculation is for employees that are classified as

“seasonal”. The IRS will be promulgating regulations to further clarify these requirements (including, for example, who qualifies as a “seasonal” employee and how hours of service are calculated for salaried employees).

5. How are “temporary” employees treated? (Employees whose employment is explicitly temporary in nature and who do not work more than 12 consecutive weeks.)

If those employees qualify as “seasonal” employees under the regulation that will be issued, they are exempt from the full-time employee calculations and penalties as noted above. A plan also can impose a 90-day wait on plan participation (see Section III.B) and also effectively bar such an employee from participating in the plan without being subjected to penalties. You should note, however, that such temporary employees would be considered to be part of the full time employee calculation for the months in which they were employed if they cannot be classified as “seasonal” under the rules.

6. What is the definition of an “employee” for purposes of the mandate?

The statute does not include an independent definition and it therefore will incorporate the current standard definitions for who qualifies as an “employee” under existing federal law.

7. What if the contracted worker is not associated with a contracting company, but they are self-employed? Are they alone responsible for their own coverage and not the company contracting them?

The employer mandate applies only to an employer’s full time “employees.” If a person is not an “employee” of the employer but rather is self-employed, the mandate would not apply to the self-employed person.

8. What factors do we need to consider when all employees are officers & shareholders? If the employer decides to stop offering coverage, does that mean that all employees who are officers & shareholders can go out on exchanges? Is there any penalty (small group < 10 employees)?

Keep in mind that the employer mandate does not apply to small employers (ones with 50 or fewer FTE employees), so if the employer here has fewer than 10 employees, there would be no penalty if the employer decides to stop offering coverage. Note, however, that an employer of this size may be eligible for tax credits if it provides coverage (see Section II below). With respect to large employers, the employer mandate applies to all full time employees regardless of their shareholder or officer status.

9. There was a portion of the reform that was in the earlier version of the reform as it relates to employers who are in Construction. ERs in this industry would not be able to utilize the under 50 ee provision as it pertains to the rules - so all Constructions ERs would be required to comply with all new rules and regs - do you know if this made it into the final version of the reform?

The special provision for construction industry employers was removed from the final version of the legislation.

10. Are domestic partners covered by the mandate?

Only if they qualify as a “dependent.”

11. Say we have 1,000 full-time employees that are eligible for coverage. 800 are currently enrolled in our group health plan. 100 of the remaining 200 are covered either under a spouse's group health plan, Medicare, VA, or other retiree plan. The remaining 100 have elected no coverage. We pay 75% of single coverage, or about 325.00 a month per covered employee. How much extra, if any, will it cost us each month for the 100 who are covered elsewhere, or for the other 100 who have elected no coverage?

The legislation dictates that you must make the coverage available to every full-time employee. If you have employees that opt to decline that coverage, you are not subject to a penalty unless the employee applies for and receives a subsidy through an Exchange-provided plan or they are eligible for a voucher (both as discussed below).

12. In addition to what the employer has to pay in the example above, how much will each of the 100 employees who have elected no coverage have to pay to remain uncovered?

Starting in 2014, the individual mandate penalty will be the greater of a flat dollar amount or a percentage of family income as follows: \$95/individual or 1% of family income in 2014; \$325/individual or 2% of family income in 2015; \$695/individual or 2.5% of family income in 2016, and it will rise in accordance with cost-of-living adjustments thereafter. (PPACA §§ 1501 (adding IRC § 5000A) & 10106(b); HCEARA § 1002)

13. Does the legislation address Service Contract Act employees who currently opt out of coverage and elect Tricare? How would the employer be affected?

There are no specific provisions in the new legislation that address Service Contract Act employees. The employer’s obligation would therefore be the same as for any other employer – to offer coverage to full-time employees or to pay the \$2000 per employee fine. Having the option to opt-out for the Tricare coverage does not appear to equate to a failure to offer coverage.

14. How much can you charge your employees without getting penalized and who determines the values/costs on a self-insured plan?

There are no rules on how much you can charge per se. After January 1, 2014, employees will have the Exchange option if they have family incomes below 400% of the Federal Poverty Level and –

- If they would pay more than 9.5% of their family income in premiums for the least expensive employer-provided plan or are responsible for more than 40 percent of the cost of coverage of that plan (i.e., the plan is “unaffordable,” they will qualify for an Exchange subsidy and the employer will pay a \$3k fine/fee if they do so.
- If they would pay between 8 and 9.5% of their family income in premiums for the least

expensive employer-provided plan, they are eligible for the “Wyden” vouchers and can take the employer’s plan contribution and apply it to an Exchange plan on a tax-exempt basis. Under the voucher provisions, if the Exchange plan costs less than the employer’s plan contribution, the employee keeps the difference.

The manner in which the cost of coverage a self-insured plan will be calculated will be determined by regulation but it is likely to be based on the COBRA actuarial value.

- 15. We offer health insurance to our employees. We pay 50% of the premiums per month; the employee pays the other 50%. We do not pay any of the premiums for their spouses or their dependents. The employee pays 100% of that premium. We offer medical, dental, prescriptions and vision; we currently do not offer life insurance. Will that remain the same?**

There are no rules in the legislation that dictate the amounts employers must contribute toward premiums. However, employers that offer dependent coverage but require the employee to pay for 100% of dependent coverage should keep in mind that such arrangements could trigger the unaffordability provision of the employer mandate. This provision may subject the employer to a penalty if the premium for family coverage under the employer’s plan would cost more than 9.5% of family income for an employee whose family income is less than 400% FPL (or if the employee would be responsible for more than 40% of the plan’s cost of coverage), and the employee obtains a federal subsidy to buy insurance from an Exchange.

- 16. To determine household income, isn’t there a privacy issue here?**

Regulations must be issued by HHS to define the procedures for seeking a federal subsidy to buy coverage through Exchanges, but we anticipate that those rules will task the Exchanges with collecting and evaluating information on family income, rather than employers.

- 17. How will the “actuarial value” of the plans be calculated?**

There has been a lot of confusion about “actuarial value” and how it will be calculated. The term only has meaning for non-grandfathered individual and small group (<100) plans but – for those plans – it is a projected total cost of coverage for the average plan enrollee. This includes both: all potential payments by the plan participants (premiums, deductibles, out of pockets) and the projected plan expenditures on behalf of the average plan participant. The details of how that number will be established will be developed by regulation.

- 18. Example----150 employees on the employer plan, Company X underwrites the plan, and at open enrollment 10% or 15 of the employees take the voucher and go buy from the exchange. My assumption is they would be the younger/healthier employees wanting the lower rates so they could pocket the difference between the employer voucher and the exchange premium. Now Company X has a different risk and could charge different premiums. That seems messed up, doesn’t it?**

I’m just a poor lawyer.

- 19. I have a question for you on large groups (1,000 employees). If a larger employer were to NOT offer benefits and elect to pay the \$3,000 penalty to the Exchange, it would cost them \$3,000,000. That would be a great deal for them as they are self-funded and claims and fees are in excess of \$5,600,000. Am I missing something, or would all the large employers be able to save millions?**

It is worse than that as the maximum penalty for employers that offer no coverage is \$2,000 per employee under the Health Reconciliation Act. (H.R. 4872 §1003(b)(2)). Of course, there is no penalty at all that is imposed today on an employer that does not offer health insurance to its employees.

- 20. Will Union employees be used in the calculation of determining number of employees? The employer doesn't provide insurance to them but pay it through union dues.**

The formula for calculating employer size in the employer mandate provision makes no distinction between union and non-union employees.

- 21. What are the employer requirements in a Union environment?**

The employer mandate provisions do not draw distinctions between union and non-union environments. As for implementation of market reforms, while Section 1251(d) of PPACA had been widely interpreted to provide that grandfathered health plans under collective bargaining agreements (i.e., those under CBAs ratified before March 23, 2010) need not implement the relevant reforms until the current CBA expires, regulatory guidance on the subject of grandfathering has interpreted the statute to provide that there is no delayed effective date for grandfathered CBA plans, meaning that such CBA plans will be required to implement the reforms applicable to grandfathered plans at the same time as non-CBA grandfathered plans, (e.g., the first plan year after September 23, 2010 for the reforms which specify this as an effective date). The regulatory guidance may also be interpreted to allow insured grandfathered CBA plans that make changes which would cause loss of grandfather status to wait until expiration of the current CBA before they must adopt the reforms required of non-grandfathered plans, a matter that is not explicit now but may be clarified in further guidance from HHS. Note that the definition of a "plan year" for a CBA plan will depend on how this term is defined in the plan documents, and those documents and the plan's advisors should be consulted to determine what the plan year is for a particular CBA plan. *(FAQ added/updated 6-21-10).*

- 22. If you have different business under separate tax id#'s will each business be accountable separately? Or on a consolidated basis?**

For purposes of the employer mandate, the legislation says the IRS definition will apply in terms of deciding whether a group of companies will be considered as separate entities or a single entity. Generally, the IRS rules say that if companies are under common control, they will be considered a single entity. So if the different businesses have separate tax identification numbers but are under common control, expect them to be treated as a single employer for employer mandate purposes.

- 23. Does the opt-out penalty only apply to employee coverage, meaning if the employee drops their dependents from coverage and covers them through the exchange but selects employee-only**

coverage, the employer does not pay a penalty?

The employer mandate requires only that coverage be “offered” to employees and their dependents. We interpret this to mean that if such coverage is offered and an employee accepts it for herself but declines it for her dependents, there is no penalty if the dependents then go to the Exchange.

- 24. We also have a client whose function is to supply work programs for individuals with mental or physical handicaps. These individuals work approximately 10-18 hours a week doing various tasks for the company or doing contracted work for other employers. Should these individuals be counted as Part-time employees and should their salaries be counted in Non-discrimination testing calculations if the group loses grandfather status?**

The status of these workers for purposes of the employer mandate depends on whether they are “employees” of the client, and if so, the average number of hours they work each week. The health care reform law does not change the definition of who qualifies as an “employee,” so the traditional IRS definitions apply. If these workers are actually not “employees” of the client, the inquiry ends there because the mandate applies only to an employer’s “employees.” If these workers are indeed employees of the client, the second inquiry to determine whether they are part-time is whether they work fewer than 30 hours per week. The legislation dictates that the calculations are made on a per month basis and they are made retrospectively at the end of your tax year. Those who work an average of less than 30 hours per week are considered part-time. The legislation did not change the rules regarding non-discrimination testing calculations, so a plan that is subject to the non-discrimination rules needs to apply the current calculation framework.

- 25. How often are the penalties assessed to a large employer?**

The penalties set forth in the statute are annual amounts (\$2,000 or \$3,000 as the case may be), but it is to be calculated on a monthly basis (i.e., the number of FT employees x 1/12 of \$2000) or the number of subsidized FT employees offered “unaffordable coverage” x 1/12 of \$3000). However, the statute leaves it to the Treasury Department to issue rules on how frequently the penalties will have to be paid. The payments may be assessed annually, monthly, or on another periodic basis that Treasury prescribes.

- 26. If an employer of 50+ employees does not offer health insurance in 2014 and is required to pay the \$2,000 annual penalty, will the employer be penalized for those employees that have other coverage (military retiree, Medicare, spouse coverage, individual, etc.)?**

Yes. The penalty provision of the statute directs that a penalty be paid for each full-time employee. No exception is provided for those employees who have coverage through other means.

- 27. Several of our clients are Native American Tribes that offer medical insurance to their non-tribal administrative and casino employees. Does the Tribe need to comply with all PPACA rules for the non-tribal employees?**

The statute does not contain exemptions for tribal employers.

28. Will plans have the right to refuse spouses IF the spouse has coverage through their own employer?

We will need definitive guidance from HHS on the scope of coverage of spouses under the employer mandate; however, the employer mandate provision of the statute penalizes large employers that fail to offer coverage to “full time employees (and their dependents).”

29. Our 13 companies currently are under a MEWA. When calculating number of full-time employees, would we calculate by individual company or treat companies as one?

For purposes of the employer mandate, the legislation says the IRS definition will apply in terms of deciding whether a group of companies will be considered as separate entities or a single entity. Generally, the IRS rules say that if companies are under common control, they will be considered a single entity. So the answer to this question depends on whether or not the companies under the MEWA are under common control.

30. Where do government entities fall into this? Do we still have to figure if we are “large” or “small”?

The employer mandate provisions do not exempt government entities.

31. If our plan has fewer than 50 employees, will we be required to comply with the reporting requirements, (non-discriminatory testing, etc.) or are we unaffected by this bill completely?

The answer to this question depends on the particular provision in question, and small employers should not assume that they are completely unaffected by the legislation. With respect to the employer mandate, an employer with fewer than 50 employees is exempt. However, with respect to reporting the value of health insurance coverage on W-2 forms, for example, there is no exemption for small employers who provide coverage to their employees.

In addition, there is no small business exception to the non-discrimination rule, although businesses with fewer than 100 employees can take advantage of the Simple Cafeteria Plan safe harbor, which allows them to be deemed in compliance with the non-discrimination rule if they are establishing a new plan or offering new benefits, and they make contributions on behalf of all employees to plan benefits of either –

- A uniform percentage for all employees that is equivalent to at least 2 percent of each employee’s income, or
- An amount for each employee which is not less than the lesser of (i) 6 percent of the employee’s compensation for the plan year or (ii) twice the amount of the salary reduction contributions of each “qualified employee”

In addition, all plan benefits must be available to all employees who work more than 1,000 hours in a plan year. The safe harbor is eliminated if the employer makes plan contributions (either directly or through a matching program) at a rate that is higher for highly compensated employees than it is for other employees.

32. Employers that start out as "small" employers now and then develop to be "large" employers somewhere during the next couple of years, what happens as far as the "grandfathering" aspect?

The grandfather rule has nothing to do with employer size. Grandfathering depends on the date a plan was established (whether before or after March 23, 2010) and on whether a plan undergoes changes that cause it to lose grandfather status (an issue that has not yet been addressed in detail by HHS regulations).

In terms of whether an employer that is presently considered "small" remains exempt from the employer mandate if it subsequently grows to 51+ employees, the legislation does not address this particular circumstance. However, because the assessment of whether an employer must pay an employer mandate penalty is to be made on a monthly basis, it appears that an employer could be considered a "small" employer some months but not others, depending on the number of full time and full-time-equivalent employees the employer has each month. We hope that regulations on this issue will include some accommodation to address the administrative difficulties such a regime could entail.

33. Has there been any guidance/clarity on whether they key market reform provisions apply to retiree plans?

Guidance on application of the market reform provisions has not yet been issued, and the answer to this question will depend on the definition of "retiree plans." We note, however, that the market reforms apply (depending on the particular provision involved) to "group health plans" and "health insurance issuers offering group or individual health insurance coverage," broad terms that do not appear to contain exceptions for plans that cover retirees.

34. How does this affect Taft Hartley plans?

All of the reform provisions apply. As for implementation of market reforms, while Section 1251(d) of PPACA had been widely interpreted to provide that grandfathered health plans under collective bargaining agreements (i.e., those under CBAs ratified before March 23, 2010) need not implement the relevant reforms until the current CBA expires, regulatory guidance on the subject of grandfathering has interpreted the statute to provide that there is no delayed effective date for grandfathered CBA plans, meaning that such CBA plans will be required to implement the reforms applicable to grandfathered plans at the same time as non-CBA grandfathered plans, (e.g., the first plan year after September 23, 2010 for the reforms which specify this as an effective date. Note that the definition of a "plan year" for a CBA plan will depend on how this term is defined in the plan documents, and those documents and the plan's advisors should be consulted to determine what the plan year is for a particular CBA plan).

The regulatory guidance may also be interpreted to allow insured grandfathered CBA plans that make changes which would cause loss of grandfather status to wait until expiration of the current CBA before they must adopt the reforms required of non-grandfathered plans, a matter that is not explicit now but may be clarified in further guidance from HHS. (FAQ added/updated 6-21-10).

B. Vouchers

PPACA § 10108

(Apply to any Employer Contributing to Group Coverage)

35. Can you explain how the vouchers work?

As noted above, a “voucher” essentially is a payment made by an employer to an employee to be used by the employee to purchase Exchange-provided coverage. An employee may ask to receive the voucher if that employee’s family makes less than 400% of the federal poverty line (400% FPL is approximately \$90,000 in 2010 for a family of 4) and if the employee is required to pay between 8 and 9.5% of his or her family income in premiums to purchase coverage through the employer. The amount of the voucher is the amount of the employer’s plan contribution that otherwise would have been made by that employer on the employee’s behalf. The employee must use the voucher to purchase Exchange-provided coverage and the voucher payment is not subject to income tax to the extent it is applied to purchase such coverage. Any coverage may be kept by the employee but is subject to taxation. The Exchange will notify the employer when an employee has opted to enroll in an Exchange provided plan and is eligible for the voucher payment but the mechanics on how that notice will be provided and how the payments will be processed will be determined by regulation.

36. With the voucher program, was there contemplation by the government about how people leaving the employer funded plan will impact the final rates of the employer plan?

No.

37. Who will determine the household income as the employer only knows the amount of the employee's income and not any spouse information? Is it the employer, employee or federal government's responsibility to determine the household income?

HHS must issue rules concerning the Exchanges and eligibility determinations, but we anticipate that the Exchanges, rather than employers, will be tasked by HHS to collect income information from those seeking subsidies to buy insurance through the Exchange.

38. If employers are required to offer free choice vouchers to ALL employees, can you please define ALL? Is this referring to all full time employees and PT or just FT?

Full-time employees who have family income of less than 400% of FPL, and for whom the premiums for employer-based coverage would cost 8-9.5% of their family income, would be eligible for vouchers.

Since the employer mandate only applies to full-time employees, we would not anticipate that the scope of the voucher provision would cover part-time employees. However, it is not outside the realm of possibility that the voucher provision could be interpreted to apply to part-time employees who meet the criteria. This is so because the text of the voucher provision refers only to “employees,” and not “full-time employees.” Thus, even though employers are not obligated to cover part-timers, those who do opt to cover them should be aware of the possibility that the statute could be interpreted to obligate them to provide vouchers to qualifying part-timers once an employer undertakes to provide coverage to those employees.

This is an issue that we hope will be clarified in regulatory guidance on the employer mandate.

- 39. When talking about the premiums being 8-9.5% of income, what is being defined as "premiums"? Would that include deductibles (as in a HDHP), and if so would it be offset by an amount the Company provides in an HSA?**

The criteria to qualify for a voucher references the employee's "required contribution," which for this purpose is defined as the portion of the "annual premium" an individual would have to pay for self-only coverage (or that an employee with family coverage would have to pay for that family coverage). So it appears that deductibles would not be included in this part of the analysis.

- 40. What is the definition of "unaffordable coverage"? Does unaffordable coverage include family coverage or just single coverage?**

While the legislation is not a model of clarity on this question, we interpret it to define unaffordable coverage by reference to the premium amount for self-only coverage for individual employees, and by reference to the premium amount for family coverage for those employees who purchase family coverage.

- 41. With regard to "unaffordability" penalties levied on employers: If an employer has a dual or multi-option plan, and EE contributions on an EE's preferred option are over 9.5% of their income (and they are less than the 400% FPL), but there is still an affordable option in the employer's plans, and the employee chooses the exchange, because the exchange offers a plan that is more the plan design that he wants, would that employer still have to give a free choice voucher or pay a penalty because that employee doesn't choose an affordable option in the employer's plan, but goes to the exchange to get what the employee feels is a "better" plan design?**

Unfortunately, the statute does not address the question of employees who have selected more expensive options. This is an issue that should be addressed in regulatory guidance implementing the employer mandate.

C. Automatic Enrollment

PPACA § 1511 (adding Section 18A to the Fair Labor Standards Act)
(Apply to "Large" Employers -- >200 Employees)

- 42. For groups with 200 or more employees, there is language that states they must enroll employees automatically unless they opt out. Is that true?**

Yes.

- 43. When does this requirement take effect?**

That is unclear. Experts have proposed dates ranging from immediately to 2014. Our reading is that the

requirement takes effect after the Secretary of Labor issues rules implementing the requirement; we expect that to take place this year.

44. What if the employer offers more than one plan? How could the automatic enrollment be accomplished?

The legislation directs the Secretary of Labor to develop rules to administer this requirement but the legislation also contemplates multi-option plans and simply directs the employer to automatically enroll employees in any one of the plans. An employer could enroll different categories of employees in plans with different rate structures, for example, but keep in mind that the ability to do that would be limited by the non-discrimination rule if the lesser paid employees are paying more than the higher paid employees. For both, however, the non-discrimination rules do not apply to existing plans (other than self-insured plans to which these rules already apply).

45. Does the auto-enrollment requirement relate to new hires or does it include auto-enrollment for Annual Enrollment each year?

The auto-enrollment provision clearly applies to new hires. The question of whether it applies to current employees during open enrollment periods is not clear, and is an issue we hope will be addressed by rules to be issued by DOL to implement the auto-enrollment requirement.

II. Employer Tax Credits

PPACA § 1421 (adding § 45R to the Internal Revenue Code)
(Available Only To "Small" Employers -- < 25 Employees)

46. Is the Section 1421 small business tax credit available for tax-exempt small employers?

Yes. There is an explicit provision addressing the manner in which the credit shall apply to such employers.

47. Do we know if an owner is excluded from the average salary calculation and how an employer would actually go about filing for the credit (part of corporate tax return)?

"Owners" are excluded from all of the credit calculation. An "owner" is someone who owns 2% or more of an S Corporation or 5% or more of any other small business. The credit will be part of the corporate tax return.

48. My client's company is a limited liability company (partnership for federal income tax purposes). Do you know how the credit works in this case? Does it flow through to the partners?

We believe it would because partnerships are eligible for the tax credit but we are not tax attorneys so you will have to consult your tax professional for guidance regarding exactly how this will work

mechanically.

- 49. What if it's set up where the CEO and his wife are the only employees, and each get paid a salary of \$25,000 but have other income (not from the company) that takes them above \$40,000, does that mean his company doesn't qualify?**

As noted above, contributions to the health coverage of owners are excluded from the credit calculation.

- 50. Is this credit available to employers that already offer group plans?**

Yes.

- 51. How will this program be implemented?**

The IRS has issued guidance on the tax credit program, which is available on its website at <http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6>.

- 52. Small businesses must have fewer than 25 employees and less than \$50,000 in average wages. Our small business has a total of 9 employees, but 4 of our employees are sales reps who earn a low base salary but high commissions. Will we be required to include commissions in the average wage calculation? Two employees have waived participation under our small business group health plan, because they are covered under their spouses' plans. Will we be required to include their salaries and commissions in the average wage calculation?**

IRS guidance states that “‘wages’ means wages as defined for FICA purposes,” so we interpret this to mean any income that is reportable on a W-2 as wage income will be counted in the average wage calculation regardless of its form. The wages of all employees must be figured into the calculation regardless of whether they participate in the employer's plan.

- 53. How do municipal governments collect credits when they don't file taxes?**

Assuming the municipal government qualifies by having less than 25 full time equivalent employees and by being an incorporated entity with a formal tax-exempt status under Section 501 of the Internal Revenue Code, it could receive a federal payment in the amount of the credit.

- 54. We pay employee premium only. Employees pay for their dependant coverage. How does this affect our standing for the small employer credit?**

It does not affect the employer's eligibility. IRS guidance advises as follows: the requirement that the employer pay at least 50% of the premium for an employee applies to the premium for single (employee-only) coverage for the employee. Therefore, if the employee is receiving single coverage, the employer satisfies the 50% requirement with respect to the employee if it pays at least 50% of the premium for that coverage. If the employee is receiving coverage that is more expensive than single coverage (such as family or self-plus-one coverage), the employer satisfies the 50% requirement with respect to the employee if the employer pays an amount of the premium for such coverage that is no less than 50% of

the premium for single coverage for that employee (even if it is less than 50% of the premium for the coverage the employee is actually receiving). See IRS FAQs available at <http://www.irs.gov/newsroom/article/0,,id=220839,00.html>.

III. Market Reform / Plan Design Requirements

A. Implementation/Timing

- 55. A number of the changes in the reconciliation bill state that the changes are effective for plan years six months after enactment. Does that mean the later of six months or the new plan year?**

Several of the reforms, such as the ban and limitations on lifetime and annual limits, go into effect “for plan years beginning on or after the date that is 6 months after the date of enactment.” (PPACA § 1004 (a)). The date that is six months after enactment is September 23, 2010, so the answer depends on when your new plan year starts. If your new plan year starts January 1, 2011, any changes that are required under this effective date provision of the law must be made for the plan beginning on January 1, 2011. If, however, your new plan year starts before September 23, 2010 – for example, on July 1, 2010 – such a plan must adopt the relevant changes starting July 1, 2011.

For plans that are part of Collective Bargaining Agreements, PPACA had been widely interpreted to provide that grandfathered CBA plans (i.e., those under CBAs ratified before March 23, 2010) need not implement the relevant reforms until the current CBA expires. However, regulatory guidance on the subject of grandfathering (discussed in Section V below) has interpreted the statute to provide that there is no delayed effective date for grandfathered CBA plans, meaning that such CBA plans will be required to implement the reforms applicable to grandfathered plans at the same time as non-CBA grandfathered plans, (e.g., the first plan year after September 23, 2010 for the reforms which specify this as an effective date. Note that the definition of a “plan year” for a CBA plan will depend on how this term is defined in the plan documents, and those documents and the plan’s advisors should be consulted to determine what the plan year is for a particular CBA plan). The regulatory guidance may also be interpreted to allow insured grandfathered CBA plans that make changes which would cause loss of grandfather status to wait until expiration of the current CBA before they must adopt the reforms required of non-grandfathered plans, a matter that is not explicit now but may be clarified in further guidance from HHS. (FAQ added/updated 6-21-10).

- 56. If an employer has a three-year contract for their health plan, could the compliance date be three years from this September?**

To definitively answer this question you would need to check with your counsel concerning your specific plan, but there should be an annual date in the governing documents that defines the “plan year” even if the benefits, premiums and other terms/conditions of the plan are otherwise locked in for the 3 year contract period. The first compliance deadline for the plan will be the first “plan year” after September 23,

2010. The only possible exception is for insured grandfathered plans maintained pursuant to a collective bargaining agreement that was in effect on March 23, 2010 (the date of PPACA's enactment): regulatory guidance on grandfathering (discussed in Section V below) suggests that if such plans make changes that would cause loss of grandfathered status, they may wait until the current CBA expires to implement the additional reforms that would be required of them as "new" plans. We note that this interpretation is not explicit in the guidance, however, and may be clarified in additional guidance on grandfathering. (FAQ added/updated 6-21-10)

B. Waiting Periods

PPACA §§ 1201 (adding PHSA § 2708); 1252

- 57. When will the timeline start for employer groups having 90-day waiting period as the maximum period and does this obligation vary by employer size?**

The requirement takes effect in 2014. It does not vary by employer size.

- 58. In the Senate bill, it states that 30 days is the recommended waiting period and employers could be fined for going to a 60 or 90-day wait. Is this true and if so, what is the penalty?**

The law will now impose a flat prohibition on group health plan/group health insurance coverage waiting periods that exceed 90 days. Under the Public Health Service Act, the fine for imposing a waiting period in excess of 90 days can be as high as \$100 per day per employee who is denied access to coverage for each day over the 90 days that they are denied access. (42 U.S.C. §§ 300gg-22 & -61).

- 59. On the 90-day wait period, most carriers begin coverage the first of the month, what happens when the wait period is first of month following 90 days?**

We interpret the statute to require that coverage begin within 90 days of the date the employee begins work for the employer. If an employer's current procedure is to begin coverage on the first of the month following 90 days, the employer should modify its enrollment process to ensure compliance with the new law or it will face penalties.

C. The New Mandates – General

- 60. Do you have a list of the new requirements with which plans must comply?**

Yes. The following new plan obligations apply to all employers that provide benefits:

- The new coverage summary disclosure rules (PPACA § 1001 (adding PHSA § 2715); PPACA § 1251) (effective in 2012)
- Non-discrimination in favor of highly compensated employees. (See Subsection G

below) (Grandfathered plans are exempted (see Section V below) but this requirement already applies and will continue to apply to self-insured plans)

The following new plan obligations apply to all employer plans:

- No lifetime coverage limits for essential benefits (effective 2010) (PPACA §§ 1001 and 10101 (adding PHSA § 2711); HCEARA § 2301(a))
- No annual coverage limits on essential benefits (from 2010 to 2014, except as may be permitted by HHS; after 1/1/2014, annual limits are completely prohibited) (PPACA § 10101 (a)(2) (adding PHSA § 2711); HCEARA § 2301(a))
- No pre-existing conditions exclusions (only applies to children younger than 19 from 2010 until 2014 and applies to all thereafter). (See Subsection D below)
- A ban on policy rescissions except in cases of fraud (effective 2010) (PPACA § 1001 (adding PHSA § 2712))
- Extension of dependent coverage until the dependent turns 26 years old (from 2010 until 2014, "grandfathered" group coverage need not be extended to a dependent that is directly eligible for employer-provided coverage). (See Subsection E below)
- A bar on imposing waiting periods on plan participation in excess of 90 days (effective 2014). (See Subsection B above)

All non-grandfathered plans also must comply with the following 8 new requirements that only are imposed on new plans under the legislation:

- Mandated offering of free preventative services (effective 2010) (PPACA § 1001 (adding PHSA § 2713))
- Out of pocket limitations (\$5k individuals/\$10k families for new plans) (effective 2014) (PPACA § 1302(c))
- Primary care physician designation right (effective 2010) (PPACA § 10101 (adding PHSA § 2719A))
- Clinical trial participation right (effective 2014) (PPACA § 10103 (adding PHSA § 2709))
- Mandatory appeals process rights/notice (effective 2010) (PPACA § 10101 (adding PHSA § 2719))
- Premium increase reviews (does not apply to self-insured plans at all) (effective 2011) (PPACA § 1003 (adding PHSA § 2794))
- Plan quality reporting obligation to enrollees/HHS (effective 2012) (PPACA § 1001 (adding PHSA § 2717))

And all non-grandfathered small group (<100) and individual plans also must comply with the following 2 new requirements:

- Essential benefits/minimum plan value (effective 2014) (See Subsection F below)
- Community rating/no medical underwriting. (Effective 2014) (PPACA §§ 1201 (adding PHSA §§ 2701 & 2704))

61. Please clarify the change related to Primary Care Physician Right.

The details regarding this new requirement will be addressed in regulations to be issued by HHS, and keep in mind that it will only apply to new plans, not to grandfathered plans. With that said, we interpret the requirement to direct that each participant has the right to designate his or her own primary care provider, although plans can require that this provider be an in-network one.

62. Does the health reform law prohibit experience rating in insured medical plans in the large employer market?

No. The prohibition on medical underwriting applies only to the small group and individual markets.

63. To what extent do the health reform law's market reform provisions (i.e., prohibition of lifetime/annual limits, etc.) or play or pay requirements apply to Health Reimbursement Accounts?

The plan design requirements apply to the benefits offered in conjunction with HRAs, but there are no market forms that change the accounts themselves.

64. I have a self-funded account with a dependent that has met her lifetime max and is now excluded from coverage. The reinsurance company has noted in the new contract that she will not be covered. So here's the question – when the no lifetime max mandate takes effect, will the account have to allow her back on the plan with no maximum?

Unfortunately, we will not be able to answer this question with certainty until there are regulations from HHS concerning the ban on lifetime limits. But if guidance issued so far on other issues is any indication (e.g., guidance on coverage of adult dependents), it is likely that HHS will direct that a person who previously lost coverage due to exceeding a lifetime limit must be allowed the opportunity to enroll in the plan again (if they still meet other eligibility requirements), and will not be subject to a lifetime limit. *(FAQ added/updated 5-17-10)*

D. Pre-Existing Conditions

PPACA §§ 1001 (adding PHSA § 2704) & 10103(e)

65. When do the pre-existing conditions prohibitions go into effect?

They go into effect for plan years that start on or after 2014; for children younger than 19 years of age; the prohibition will go into effect for plan years that start on or after September 23, 2010.

66. In regards to pre-existing conditions, will employees be allowed to come on and off of plans without being subject to waiting periods?

This is another issue on which clarification will be needed, but there does not appear to be any provision

that over-rides the normal IRC § 125 enrollment rules.

- 67. An employer group offers coverage, but the employee declines the coverage and chooses to pay the penalty. However, the employee then gets sick suddenly. Can he or she then enroll in the group coverage at any time? Or will he or she need to wait for the next regular open enrollment period (unless there is a qualifying event)? Or could the employee simply go to an exchange and get individual coverage?**

The employee would have to wait for the next open enrollment period unless there is a qualifying event. As noted above, nothing over-rides the normal IRC § 125 enrollment rules. The employee will have the option to enroll in an Exchange-provided plan.

- 68. Is the removal of the pre-existing condition limitation applicable to self-funded groups?**

Yes.

- 69. If so, we assume that any new hires or existing employees and family members would still be subject to the Sec 125 qualifying event rules and couldn't just enroll in the plan at any time during the year?**

Yes.

- 70. Does the bill eliminate pre-existing conditions for children under age 19 effective within 6 months following the enactment of the bill?**

The best answer to this is – it will. The drafters of the legislation intended to impose this requirement. The final bill text, however, only excludes the application of the pre-existing condition prohibition for children to plan “enrollees”. Therefore, if a child is not already enrolled in the plan, the pre-existing condition requirements can still be used to bar a child from enrolling in the plan at all. HHS has issued a formal statement indicating that it will issue a rule “fixing” this problem.

- 71. Lastly, if an EE or family member with a pre-existing condition can join the employer plan and have that condition covered (even if only due to new hire, life event or annual enrollment), could stop loss carriers limit their coverage of excess claims or laser individuals with known conditions that are required to be covered?**

There is nothing in the legislation that impacts this one way or the other.

- 72. I have an employee of a group (51+ ee's) that has 4 children. Two are young, and two are college age. These children all lost their benefits coverage on Dec. 31st. The employee was not aware that he could sign his children up for his group plan. He now wants to add them starting as soon as possible. The group is with Company X. I know that Company X has an 18-month pre-existing condition look-back period for any and all late entrants. My questions is...would this type of pre-existing condition look back period apply to the children now that there is no more pre-ex for children in 2010? And if it doesn't count toward children, does it count for kids that are full time**

college students? I know the pre-ex limitation on children only applies to those under 19, but not sure if retroactive.

For children younger than 19 years of age (regardless of whether they are students), the ban on pre-existing condition exclusions will go into effect for plan years that start on or after September 23, 2010. It does not apply retroactively. The ban would not go into effect for older dependents until 2014.

E. Dependent Coverage

PPACA § 1001 (adding PHSA § 2714); HCEARA § 2301

73. What are the rules for adding dependents to existing plans?

The legislation dictates that – for plan years beginning 6 months after March 23, 2010 (the date the bill was signed into law) – plans that already allow dependent children to be included in the plan must expand that allowance for dependent children until they become 26 years old. “Grandfathered” plans also are subject to this dependent extension of benefits requirement but, until January 1, 2014, such “grandfathered” plans can exclude any dependent that is directly “eligible to enroll in an eligible employer-sponsored health plan”.

74. Do the provisions extending benefits for dependents to age 26 apply to self-insured plans?

Yes.

75. When does dependent coverage end – age 26 or is it through age 26?

The law requires dependent coverage “until the child turns 26 years of age.” We interpret this to mean it ends at age 26 rather than extending through age 26.

76. When does this go into effect? Does this effective date apply even if a dependent is coming off of COBRA coverage?

The new rules apply to plan years that start after September 23, 2010. HHS regulations specify that this effective date applies even if the dependent is coming off COBRA.

Moreover, dependents currently on COBRA must be given the same special opportunity to enroll in this extended dependent coverage that must be made available to all dependents. More specifically, the special enrollment period must start no later than the first day of first plan year beginning on or after September 23, 2010, and must last for 30 days. Notices must be provided to employees about the special enrollment opportunity. A plan may use its existing annual enrollment period and materials to comply if the annual enrollment fits within the time parameters required by the regulation. Coverage for these newly enrolled dependents must begin no later than the first day of the first plan year after September 23, 2010, even if the request for enrollment is made after the first day of the plan year. Finally, note that if the dependent loses eligibility for coverage due to a qualifying event such as aging out, the dependent will

have another opportunity to elect COBRA.

77. What are the terms/conditions, which a dependent under 26 years of age, under the Health Care reform, can be covered under his parent's health insurance when this law goes into effect?

For plan years beginning after September 23, 2010, the law requires that group plans that are already providing dependent coverage must extend the eligibility for that coverage to dependents until they are 26 years of age. HHS regulations specify that:

- Eligibility criteria based on factors such as student status, financial dependency, or residency, can no longer be imposed by plans or carriers (the only exception being that grandfathered plans can exclude those dependents who are eligible for their own employer-sponsored coverage, until January 1, 2014).
- Qualifying dependents must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status, and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to loss of dependent status.
- A special enrollment period for dependents will be required, to provide eligible dependents previously not enrolled with a chance to enroll. Notices must be provided to employees about the special enrollment opportunity. The special enrollment period must start no later than the first day of first plan year beginning on or after September 23, 2010, and must last for 30 days. A plan may use its existing annual enrollment period and materials to comply if the annual enrollment fits within the time parameters required by the regulation. Coverage for these newly enrolled dependents must begin no later than the first day of the first plan year after September 23, 2010, even if the request for enrollment is made after the first day of the plan year. In subsequent years, dependent coverage may be elected in connection with normal enrollment opportunities.
- No coverage is required for spouses of qualifying dependents.

78. Will dependents be subject to the pre-existing conditions requirements?

Yes. HHS is issuing a rule clarifying that dependent children younger than 19 years of age must be eligible for participation in the plan regardless of whether they have pre-existing conditions and no exclusions on the benefits may be imposed based on pre-existing conditions. This prohibition will extend to all plan participants for plan years that begin after January 1, 2014.

79. Are dependents eligible for COBRA like any other dependent that ages out currently is offered?

Yes.

80. Will the spouse of the child dependent be eligible to join the ER plan?

No. HHS regulations clearly specify that there is no obligation to cover spouses of eligible dependents.

Additionally, note that the legislation specifies that there is no obligation to extend coverage to “a child of a child receiving dependent coverage.”

- 81. In the case of our public sector client, they currently allow dependents to be covered to age 23. Now with the new law effective January 1st they will have to allow dependents to age 26. So, can they legally charge a higher premium for say those who come back on the plan age 24 & 25?**

No. HHS regulations specify that surcharges for coverage of children under age 26 are not allowed except where surcharges apply regardless of the age of the child.

- 82. I'm still trying to confirm whether the coverage terminates at age 26 or, as the Reconciliation Bill states - the end of the tax year in which the child reaches age 26.**

The law requires dependent coverage “until the child turns 26 years of age.” We interpret this to mean it ends at age 26 rather than extending through age 26. However, changes to the tax code allow coverage for dependents to be excluded from income until the calendar year in which the dependent turns age 27. This is intended to give plans the flexibility to offer dependent coverage for a bit more time (e.g., if a calendar year plan wants to state that coverage continues until the end of the calendar year in which the dependent turns 26), without triggering tax consequences for the employee.

- 83. Does it matter if dependent is FT or PT student?**

The employer’s definition of “dependent,” which may turn on whether the dependent is a student, will be irrelevant for purposes of dependent coverage provision of the reform legislation. The only relevant definition is the one issued by HHS, which explicitly states that plans and issuers can no longer impose limits on who qualifies based upon enrollment status, financial dependency, residency, marital status, or other factors.

- 84. Does coverage for dependent between the ages of 19 and 26 have to be the same as what is offered to employee and/or at the same cost?**

The new reform legislation does not affect what rates may be charged for dependents, and it does not specify whether the same coverage that is offered to employees must be offered to dependents. However, HHS regulations specify that qualifying dependents must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status, and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to loss of dependent status.

Also keep in mind that if rates for dependent coverage under a plan are generally expensive, this could trigger the provisions of the employer mandate that can subject employers to penalties for offering “unaffordable” coverage:

After January 1, 2014, employees will have the Exchange option if they have family incomes below 400% of the Federal Poverty Level and –

- If they would pay more than 9.5% of their family income in premiums for the least expensive employer-provided plan or are responsible for more than 40 percent of the cost of coverage of that plan, they will qualify for an Exchange subsidy and the employer will pay a \$3k fine/fee if they do so.
- If they would pay between 8 and 9.5% of their family income in premiums for the least expensive employer-provided plan, they are eligible for the “Wyden” vouchers and can take the employer’s plan contribution and apply it to an Exchange plan on a tax-exempt basis. Under the voucher provisions, if the Exchange plan costs less than the employer’s plan contribution, the employee keeps the difference.

85. Is dental and vision insurance under the same regs with regard to extending coverage to age 26?

The statute requires plans that currently provide “dependent coverage” to provide it to children up to age 26, and does not define the scope of “coverage” in this context. However, HHS regulations specify that dependents up to age 26 must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status, meaning that if a plan currently offers dependents dental and vision, it must offer the same coverage options to those who qualify for dependent coverage under the new law.

86. I’m questioning the response provided by Steptoe & Johnson that a dental or vision plan that is offered to dependents must also be offered to the new higher-aged children. That would seem to be a stretch, considering this is a Health Care Act. If this is true, what is the treatment for FSA, HSA and HRA reimbursements – are they now available for a 25-year old child too? Also do we need to extend dependent life policies, Orthodontia benefits, etc.?

The dependent coverage rules do not require that dental or vision plans be offered to adult dependents per se. What the rule says, is that any health benefit currently offered to dependents must also be offered to those who will become covered as a result of the new law. In other words, there can be no discrimination in the benefits offered one group of dependents versus adult dependents. Accordingly, if a plan now offers dental or vision to dependents, it must offer those same benefits to older dependents that join the plan under the new law.

87. Where it states that a plan may use its annual enrollment to comply with the special enrollment requirement for adult dependents (if it fits within the time parameters); does this mean the time parameters of the first year following open enrollment, *and* that the open enrollment must be 30 days? Or just that it has to be the first plan year after September 23, and open enrollment could still be two weeks?

Existing open enrollment procedures can be used to satisfy the adult dependent special enrollment requirement if the existing annual enrollment period starts no later than the first day of the first plan year beginning on or after September 23, 2010, *and* lasts for 30 days.

F. Mandated “Essential Benefits”

PPACA §§ 1201 (adding PHSA § 2707) & 1302

88. Covered preventive benefits will be defined by regulation. Will there be clarification on non-essential benefits and/or limits?

There will be clarification of what is considered to be an “essential” benefit. No lifetime or annual limits generally will be permitted for such “essential” benefits, including covered preventive services, but limits may be imposed on non-“essential” benefits. (PPACA § 10101 (adding PHSA § 2711)).

89. What are the “essential health benefits”?

The essential health benefits will be the basic benefits that have to be included in all non-grandfathered individual and small group market (less than 100) plans after 2014. The precise list of benefits will be developed by HHS and you can think of it as a basic plan that includes a basic set of benefits along with the free preventative services that must be offered. The categories of benefits outlined in the statute are as follows:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

90. Do the “essential health benefits” vary by group size?

Yes. These requirements apply only to new plans in the individual and small group (<100) markets.

91. What is the minimum employer contribution for a health plan and when does that go into effect?

There is no minimum employer contribution per se; imposing a large burden on employee premium payments could expose the employer to penalties if the employees qualify for Exchange provided plan subsidies as discussed in Section I.A.

92. What are the basic/minimal requirements to be in Bronze, Silver and Gold plans?

There are two basic differences among the levels. First, the premium payments have to cover a higher level of projected coverage costs at the higher levels. Second, additional benefits can (but are not

required to be) offered in conjunction with the higher level plans.

- 93. The timeline referenced employer first-dollar coverage for preventative services. Does that mean that employers must cover with no employee coinsurance or copay dollars spent?**

Yes. For non-grandfathered plans, preventative services will have to be provided with no employee coinsurance or co-pay dollars spent. The list of which preventative services must be provided on this cost-free basis will be developed by regulation.

- 94. When does the free preventative services requirement take effect?**

It takes effect for plan years that start after September 23, 2010 for all non-grandfathered plans.

- 95. The plan says we have unlimited benefits and unlimited annual max effective renewals 10/1/10 and after. Is there anything to prevent us from doing a 50/50 coinsurance plan with unlimited out of pocket?**

A plan could impose these types of payment rules but depending on the plan's specific circumstances, such a change now would cause the plan to lose grandfathered status and subject the plan to an out of pocket cost limitation (that is equal to the out-of-pocket limits for high deductible health plans for Health Savings Accounts), which goes into effect in 2014. The grandfathering rules (discussed in Section V below) provide that any change in co-insurance percentage as compared to what was in effect on March 23, 2010 will cause loss of grandfather status. Furthermore, changes in fixed-dollar amount cost sharing (e.g., deductibles) or in co-pays that exceed the rate of medical inflation plus 15 percent versus what was in place on March 23, 2010 will also cause a plan to lose grandfather status, as would a decrease in the employer contribution rate by more than 5%. (FAQ added/updated 6-21-10).

- 96. Company X is getting ready to send a letter out now announcing the "lower premium" for achieving the BMI goal initiative. Will premiums be able to vary based on BMI and other health status measures? If not, when will the changes take place and should we pull the letter?**

Grandfathered plans are not subject to any new rules on their ability to vary premiums; group plans for employers employing over 101 individuals also are not subject to any new requirements. That said, our understanding is that the current plan non-discrimination rules prohibit varying the premiums for individuals enrolled in an employer's plan based on such factors.

In the individual and small group markets (less than 100 for these purposes), no medical underwriting or premium variation will be permitted at all based on health status for non-grandfathered plans.

- 97. How will the Federal guaranteed issue guideline interface with a State's guideline if the state's guideline is more liberal? For example, in New York, small groups are purely community rated where employee demographics like age, gender, or occupation have no bearing on the rate, yet the Federal guideline does allow the risk to be influenced by employee demographics.**

For new plans in the individual and small group markets (<100), the federal community rating rules will

preempt any more liberal state rules. Although specific regulatory guidance has not been issued on the subject of guaranteed issue and community rating, we note that guidance recently issued on grandfathered plans states that PPACA, though generally not pre-emptive, will supercede state laws that are more liberal than those in PPACA. *(FAQ added/updated 6-21-10).*

98. Does everything in this Federal bill now trump any and all State Mandates? Are State Mandates now obsolete?

State mandates are not obsolete. Regulatory guidance issued on June 14, 2010 advises that PPACA does not supersede state laws that are stricter than PPACA. Conversely, if a state law prevents the application of a requirement of PPACA, such state law is superseded by PPACA.

So unless PPACA specifically states to the contrary in a particular provision, the state laws that are more generous to plan participants and beneficiaries will apply. There may be an issue regarding Exchange plans and state-required mandates, because of a provision requiring States to defray any cost of their additional mandates for any individuals who qualify to receive federal assistance for Exchange coverage. Because of that new cost burden, we expect many States to revisit what they mandate. *(FAQ added/updated 6-21-10)*

99. Does the new law trump other state laws regarding coverage/rating/etc that may be more liberal than the federal law?

For new plans in the individual and small group markets (<100), the federal rules will preempt any more liberal state rules. This is consistent with recent regulatory guidance on grandfathering, which advised that the federal law will not supersede stricter state laws, but would supersede state laws that prevent application of a requirement of PPACA. *(FAQ added/updated 6-21-10).*

100. In California we have to comply with the San Francisco Health Care Ordinance that requires coverage to be made available for any employee who works more than 10 hours per month in San Francisco. Does their ordinance take precedence over the federal act?

An employer who is subject to this ordinance must still comply with the federal employer mandate.

101. Does “actuarial value” mean the total cost charged by the insurer or only a certain portion of it?

There has been a lot of confusion about “actuarial value” of plans. The only place in the legislation where that term has any meaning of significance is with respect to the premiums, deductibles and out of pocket expenses that a plan participant will have to pay under a non-grandfathered individual or small group (<100) plan. Although rules will need to be developed, this is in essence the total anticipated average cost of coverage that is anticipated under that plan.

G. Non-Discrimination

PPACA § 10101 (adding PHS § 2716)

- 102. What if one group that is offered the major medical plan consists of hundreds or thousands of employees that are not Highly Compensated Employees but a good spread of compensation? Yet the other classifications are only offered a limited medical plan (or min-med)? This is very prevalent in the staffing and hotel/motel/restaurant business.**

For all non-grandfathered group health plans, PPACA imposes new benefits non-discrimination requirements that were once only applicable to self-insured plans, starting on September 23, 2010. At the outset, it is important to note that these new requirements do not apply to grandfathered plans that are not self-insured plans.

Going forward, employers that provide health coverage will be prohibited from limiting eligibility for any coverages to highly compensated individuals. (PPACA §10101: PSHA §2716). The employer must not make high compensation an eligibility requirement or provide certain benefits only to those who are highly compensated. (See Sec. 105(h)(2) of the Internal Revenue Code.) Although the details on this may be adjusted during the mandated rulemaking process, generally, to meet this requirement, new plans must benefit 70 % or more of all employees (or 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan). (See Sec. 105(h)(3) of the Internal Revenue Code). Employers may discriminate for employees who have less than 3 years of service, are not 25 years old and work part-time or work seasonally. (See Sec. 105(h)(3) of the Internal Revenue Code). The Secretary may review classifications to determine whether a plan is discriminatory. (See Sec. 105(h)(2) of the Internal Revenue Code.)¹

- 103. Does that mean indirectly that we can no longer offer first day health coverage to directors and above under our "fully insured plan?" Could we still offer different rate structures to the different areas of our organization (long term care vs. acute care, etc.)?**

The offering of the benefits definitely will be subject to the new non-discrimination requirements. On the rate structures, the rules will limit your ability to do that if the lesser-paid employees are paying more than the higher paid employees. For both, however, the rules do not apply to existing plans (other than self-insured plans to which these rules already apply).

- 104. When do these provisions go into effect?**

They go into effect in September for all new plans/benefits but these new non-discrimination rules do not apply to Grandfathered plans.

- 105. Can an employer have separate contribution strategies by class? i.e. – Salaried personnel get 90% contribution and hourly get 95% contribution?**

Yes, as long as those strategies do not favor the more highly compensated personnel.

¹ In this Non-Discrimination provision, PPACA Cites to Sec. 105 of the Internal Revenue Code, available here: http://www.law.cornell.edu/uscode/26/usc_sec_26_00000105----000-.html Specifically, PPACA cites Sec 105(h)(2), (3), (4), and (8); making the non-discrimination provisions already applicable to self-insured plans now applicable to group plans.

106. Are grandfathered plans exempt from the non-discrimination rules?

Yes, unless the plan is self-insured, in which case it is already subject to the non-discrimination rules.

107. If an executive has a special company-provided life insurance policy, is that considered an "excess benefit"?

If the policy is a life insurance policy that pays benefits upon death, it is not a policy that provides medical care or medical reimbursement, so it should not be covered. It clearly isn't covered under the old section 105(h) provisions (as long as it doesn't provide medical care or reimbursement) and should not be covered under the new provision, although we note that guidance under that provision is not very clear. (FAQ added/updated 5-17-10)

108. If an employer creates classes of employees defined by title and provides a higher level of benefits to the higher classes, the plan will in effect be discriminating based on wages. In this scenario, how is the employer held accountable? Will it be fined? Will it lose the tax deduction for the entire plan? Will those employees in the favored classes be taxed on the benefits coverage?

Setting up separate classes by job title is risky, although there may be some cases where it might work. Remember that the rules on nondiscrimination under Internal Revenue Code section 105(h) are old and unclear. There are two alternative nondiscrimination tests: (1) a subjective test that says you have to benefit employees who qualify under a "classification that is reasonable;" or (2) an objective test that says that you have to cover either 70% of all employees or you must benefit 80% of all employees if 70% are eligible to participate in the plan. Let's assume you are talking about the subjective test. Classifying by title will be risky, if you use something like officers, we suspect that will be no good at the start. If you classify by some titles (e.g., "regular employees") that might pass muster but the employer should definitely be ready to show that the classification is not a subterfuge for discrimination by pay, which may be hard to do, so we would advise that employer to make sure it has data backing up such a claim. In any event, we strongly recommend that an employer contemplating creating classes of employees defined by title should seek advice from expert counsel before doing so.

The penalties for failing to meet non-discrimination requirements differ depending on whether a plan is insured or self-insured. If the plan is self-insured, the "old" rules apply and "excess reimbursements" made to a highly compensated employee under a discriminatory self-insured plan are taxed to the employee. The amount of the tax depends on the violation. If there is a benefit made available to a highly compensated individual but not to any others, the total amount reimbursed under the plan is taxable. (This can be a very large amount!). If all the benefits are available to all participants, but where the plan discriminates as to eligibility to participate, then "excess reimbursement" is determined by multiplying the total amount reimbursed to the highly compensated individual by a fraction, whose numerator is the total amount reimbursed to all highly compensated individuals under the plan, and the denominator is the total amount reimbursed to employees under the plan. (In creating the fraction, there are special rules that exclude any discriminatory benefits paid to the highly compensated.)

If the plan is insured, the income tax inclusion rules described above do not apply. Rather, the employer

will be subject to a \$100 per day /per affected participant excise tax (It's not clear what "affected individual" is – it could be the highly paid persons getting the better benefits, but it could also be the lower paid persons who are not getting the same benefits, which in our view is the better reading. There is no guidance on this yet). The maximum excise tax is \$500,000 per year. Civil penalties can also apply. (FAQ added/updated 5-17-10)

109. Some of our clients have carve-out health plans (where they cover only salaried employees). We are getting mixed messages from the carriers and information we receive on how this will be handled: a) Can we set up new plans that are carve-outs? b) Can current clients with carve-outs continue them? c) If they currently have a carve-out are they allowed to modify it? d) How do discrimination laws under healthcare reform apply to carve-outs? e) Does the grandfather clause apply to these plans?

a. and d. It would be risky, but not impossible that you could establish a new salaried only carve-out plan, as long as you could satisfy the nondiscrimination rules that prohibit providing benefits that disproportionately favor the highly paid. These nondiscrimination rules look at the highly paid employees versus the lower paid ones and have objective tests for who is highly compensated that is generally based on pay -- not job title such as "salaried." If you can pass the objective tests (e.g., benefits 70% of all employees, or if 80% of all employees are eligible to participate and 70% actually do participate), you might be able to use a "salaried" classification for eligibility. For example, if you had only one or two high paid persons in the workforce, and you covered all the salaried employees, you might pass (assuming your non-salaried were a small percentage or if they are collectively bargained employees, who are excluded for purposes of the test if they have health benefits that were the subject of good faith bargaining.) If you can't pass that test, there is an "easier" test for coverage that requires a lower percentage of employees covered (the percentage varies with the workforce) but you have to cover a "reasonable classification" of employees. It's possible the IRS would say that a "salaried only" plan is not reasonable in some circumstances, although in the past we believe employers have used a "salaried employee" eligibility requirement.

Please keep in mind, however, that if you limit coverage to only a particular category of employees, you may become subject to the employer mandate penalties (for employers with 51 or more full time and full-time-equivalent employees, \$2000 per full-time employee if you have an uncovered employee who obtains a federal subsidy to purchase coverage through an Exchange) for failing to cover all full-time employees.

b. It depends. The rules prohibiting discrimination in favor of highly compensated employees requirements do not apply to grandfathered insured plans. But these rules already apply to all self-insured plans.

c. Although regulatory guidance was issued on grandfathering (discussed in Section V below), the guidance did not deal specifically with the question of whether, and to what extent, changes could be made to the categories of employees covered or excluded under a grandfathered insured carve-out plan without losing grandfathered status. The rules advise that plans may add new employees (newly hired or newly enrolled) without losing grandfathered status. But there are restrictions on the ability to transfer employees from one plan to another (e.g., transfer must be for a bona fide employment based reason and

not simply to move employees from a high cost plan to a cheaper one). The question of whether changes to a carve-out plan could cause loss of grandfather status is, therefore, fact specific, and employers should seek expert advice before making such changes.

e. Insured carve out plans can be grandfathered. The question of what types of changes can be made to these plans without losing grandfathered status would be governed by the regulatory guidance on grandfathering (discussed in Section V below). *(FAQ added/updated 6-21-10)*

G.1 Non-Discrimination Safe Harbor – Simple Cafeteria Plans

PPACA § 9022 (amending § 125 of the Internal Revenue Code
(Available to “Small” Employers -- <100 Employees)

110. What are Simple Cafeteria Plans and to whom are they available?

A small employer establishing a new plan or offering new benefits qualifies for the “simple cafeteria plan” safe harbor if the employer employs less than 100 employees and makes contributions on behalf of all employees to plan benefits of either –

- a uniform percentage for all employees that is equivalent to at least 2 percent of each employee’s income or
- an amount for each employee which is not less than the lesser of (i) 6 percent of the employee’s compensation for the plan year or (ii) twice the amount of the salary reduction contributions of each “qualified employee”

In addition, all plan benefits must be available to all employees who work more than 1,000 hours in a plan year. The safe harbor is eliminated if the employer makes plan contributions (either directly or through a matching program) at a rate that is higher for highly compensated employees than it is for other employees.

111. Would you please send me information regarding the rules for the new simple cafeteria plans? Specifically, will plans renewing between now and December 31, 2010 have to amend their current plan to remove the OTC benefit on January 1, 2011 or if they will be able to make the changes to their plan at the time of their 2011 renewal?

This is an issue of general application that would not differ for simple cafeteria plans. The plan year is irrelevant; the over-the-counter restriction applies starting January 1, 2011 for money contributed to the account after that date. Administrators may want to consider informing participants of the change now to give them an opportunity to use their funds to purchase non-prescribed over-the-counter drugs before the new restriction goes into effect.

112. The employer contribution requirement – is this a contribution toward premiums, flex dollars or both?

To the extent the premium contribution is made toward general health coverage under a cafeteria plan or that the employee uses flex dollars to purchase such coverage, it appears both would count. A report by the Congressional Joint Committee on Taxation advises that the minimum employer contribution needed to avoid nondiscrimination testing must be available for application toward the cost of any qualified benefit (other than a taxable benefit) offered under the plan. So if the plan offers both premiums and flex dollars, we interpret this as meaning contributions must be provided towards both.

Generally, “qualified benefits” are defined in section 125(f) of the Internal Revenue Code and generally means employer-provided benefits that are not included in gross income under an express provision of the Code (so “qualified benefits” include employer-provided health insurance, group-term life insurance coverage not in excess of \$50,000, and dependent care). Benefits that are expressly excluded from cafeteria plans include scholarships, educational assistance, meals and lodging, and fringe benefits. You can access a copy of the Joint Committee on Taxation’s report via this link: <http://www.jct.gov/publications.html?func=startdown&id=3673>. (FAQ added/updated 5-17-10)

113. Does the new legislation change current law that precludes sole proprietors, limited liability companies, partners in a partnership and two percent shareholders of S corporations from participating in the plan (for Simple Cafeteria safe harbor)?

No. It does not appear to allow these persons to participate because, as under current law, they are not treated as “employees” for this purpose. (FAQ added/updated 5-17-10)

114. Will there be a new test to determine if the eligibility, participation and minimum contribution requirements are being met by the plan (for Simple Cafeteria safe harbor)?

Yes. The “SIMPLE” cafeteria plan nondiscrimination test for small employers has two basic requirements: (1) all employees must have access to the plan, and (2) a minimum employer contribution must be made. This contribution can be either (1) a uniform percentage of at least 2% of each employee’s compensation, or (2) the lesser of (a) 6% of the employee’s pay or (b) twice the amount he elects to contribute. Only a small employer (generally 100 or fewer employees) is eligible to use this test.

If these “SIMPLE” criteria are met, the eligible employer does not have to run the current law nondiscrimination tests for cafeteria plans. The current cafeteria plan test requires that the plan meet an eligibility and benefits test. To meet the eligibility test, the plan must be available to a “reasonable classification of employees,” and there must be a specific percentage of lower paid employees covered (the percentage depends on the size of the employer). Certain categories of employees can be excluded from the test. Also, the plan must give each similarly situated participant a uniform opportunity to elect benefits and the actual election of qualified benefits (i.e., tax advantaged benefits) must not disproportionately favor highly compensated participants. To test this, one must compare the aggregate benefits elected over the aggregate compensation of the lower paid and the highly paid. (There are some safe harbor rules that can be used as alternatives.) Thus, this test requires gathering data on compensation and amounts of benefits elected. Finally, cafeteria plans must satisfy a “concentration test.” The percent of statutory nontaxable benefits provided to “key employees” cannot exceed 25% of the statutory nontaxable benefits for all employees.

If the employer meets the “SIMPLE” nondiscrimination test, it is also exempt from the nondiscrimination requirements for group term life insurance benefits (which must be offered to a specified percentage of non-highly-compensated employees) and dependent care benefits (the average benefits provided to the lower paid must be at least 55% of the average benefits provided to the high paid). *(FAQ added/updated 5-24-10)*

H. Penalties

42 U.S.C. §§ 300gg-22 & -61

115. Are you aware of what the penalties are for employers who have plans with lifetime limits or is this something that the legislation is silent on?

With respect to the market reforms that apply to an employer’s plan, the legislation dictates that they be implemented if those changes apply to your plan. The restriction on lifetime limits applies to all plans. The penalty under the Public Health Service Act is \$100 per day per violation and violations can be defined as being by beneficiary. The penalties therefore can add up quickly. In addition, because plans will have a legal requirement to eliminate lifetime limits for plan years that begin after September 23, 2010, a plan beneficiary may have a legal claim that such limits do not apply to plan years that commence after that date even if the plan has not been revised to reflect the new legal requirement.

116. What is the penalty to the employer for not complying with the “essential health benefits” requirement?

This obligation really applies to carriers but the penalties could be at least \$100 per day per beneficiary during periods of time when the plan is out of compliance with any applicable requirement plus punitive penalties for intentional non-compliance.

117. What is the penalty for canceling coverage altogether, if they decide they can’t afford it? And does that penalty go into effect immediately?

There is no immediate penalty. Employers that do not offer coverage to their employees will be subject to the mandate penalties discussed in Section I above.

I. Employer Notices/Disclosures

118. What new reports/disclosures does an employer have to make under the new provisions?

All employers/plans will have to comply with the following new annual reporting and disclosure requirements:

- 60-Day Advance Notice of Material Plan Changes to Enrollees (likely 2011)

- The W-2 health insurance value report to the IRS (2011)
- The new uniform coverage summary disclosure rules to Enrollees (2012)
- Notice of Exchanges/Subsidies to Enrollees (3/1/2013)
- Data privacy compliance certification to HHS (two times: in 2013 and in 2015)
- Coverage Provided/Who Is Covered Report to Treasury (2014)
- Cadillac Tax Report To Carriers/HHS (2018)

In addition, employers/plans offering new/non-grandfathered plans also will have to provide the following new annual reports/disclosures:

- Plan Appeals Process/State Consumer Assistance Office disclosure to Enrollees (2012)
- Quality of Care Measures/Wellness Programs to Enrollees and HHS (2012)

- 119. Can you define the rules and regulations around the 60-day advance notice of material plan changes? Do we know what “material” plan changes include and could rate changes be included in “material” plan changes? Does this mean that employers will have to have all plan decisions completed, set and announced to the employees 60 days before renewal?**

We do not yet have the rules and regulations that will govern the 60-day material plan changes advance notice requirement, including what will be considered to be a “material” change. We expect rate changes to be included, however, and we believe that this will require all plan decisions to be finalized and announced 60 days or more before renewal.

- 120. Does the 60-day advance notice apply to collectively bargained plans?**

Yes.

- 121. Can you define the Uniform explanation of benefits? Does this include self-funded plans?**

This new disclosure form will be developed by HHS. It is expected to be a standard form for outlining the benefits offered under a plan and their costs. All plans will have to provide this form to plan beneficiaries.

IV. Medical Loss Ratio / Rebating Issues

PPACA § 10101 (adding PHSA § 2718)

- 122. Under the MLR provisions, what defines “medical services”?**

All that the legislation provides is that 80%/85% of the carrier’s costs must be spent on “reimbursement for clinical services provided to enrollees” and “for activities that improve health care.” The statute directs that the details of what will qualify as an expense under those two categories is to be developed by the NAIC but must be adopted by HHS. There will be a lot of focus on how these categories should be constructed.

- 123. Is the 80% & 85% MLR requirement for each group plan separately or is it for the overall pool of all groups or groups segmented by area or products?**

It is clearly intended to apply to pools but implementation of this provision will necessitate extensive rulemaking that will involve both HHS and the NAIC, and this issue will need to be clarified under those rules.

- 124. If it applies to each group buying group insurance, how will insurers ever cover the risk for high loss ratio groups other than to charge a ton more than they really need upfront for all groups and then return the excess for those with lower than the MLR ratios?**

It should apply to pools.

- 125. Are the carrier pool calculations just for the under 100 employee calculations but the over 100 employee plans will have plan-specific MLR requirements?**

Both calculations should be made on an aggregate basis but the details need to be developed by regulation. The expectation is that a carrier will have only two or three calculations to make overall – one for the individual market; one for the <100 employee plan market; and one for the >101 employee plan market (and the first two may be combined). One of the bigger questions is whether these calculations will be made for the company overall or whether they will be done by State.

- 126. Also, does this mean that insurers will have to divulge the claim loss ratio for all sized groups buying insurance from them?**

This will be settled in the rulemaking but they will probably be required to disclose aggregate information at a pool level.

- 127. How would value-added services for claims cost reduction be treated under the bill's MLR provisions?**

This is an issue that will be resolved through the MLR rulemakings that will be undertaken and also will depend on the precise nature of the value-added services. The MLR provisions expressly provide that expenditures “for activities that improve health care quality” will be considered along with other medical care expenses on the “good” side of the MLR calculation.

- 128. Has anyone brought up the issue of carrier rebates and how they are to be distributed? Must they be shared proportionately?**

We expect the rebate process to be addressed in more detail in the rules, but those rules will direct that the rebates be distributed pro rata, and that the rebates will go to enrollees, not to the employer, based on the text of the legislation.

- 129. Will rebates to plan enrollees be taxed?**

This issue is not addressed in the legislation. We expect that if the individual paid the premium through an employer-provided plan that the rebate will be taxable income to the individual but if the individual purchased the plan on an Exchange with post-tax dollars that the rebate would not be subject to income tax for that individual.

130. Do the MLR provisions apply to groups renewing at any point in time in 2011?

The MLR provisions apply at the carrier level only and do not impose any requirements on individual plans.

V. “Grandfathered” Plans/CBAs

PPACA § 1251; HCEARA § 2301

131. What exactly are the grandfathered plans under the Senate Bill, the Reconciliation bill, and is there a quick list of the provisions that grandfathered plans are exempt from or have to comply with, whichever direction is easier?

Regulatory guidance released on June 14, 2010 provides more details about the definition of grandfathered plans. The guidance is available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=Hjj9NK/0/2/0&WAIAction=retrieve>. For group plans, new beneficiaries can be added to the plans without affecting the “grandfather” status. And changes necessitated by PPACA or state law can be made without affecting “grandfather” status.

However, the following types of changes will cause a plan to lose grandfathered status:

- Eliminating benefits – eliminating all or substantially all benefits to diagnose or treat a particular condition;
- Raising co-insurance charges – increasing a percentage cost-sharing requirement (such as coinsurance) above the level it was at on March 23, 2010;
- Raising co-pays “significantly” – compared with the copayments in effect on March 23, 2010, increasing those co-pays by more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation (as of March 23, 2010) plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status;
- Raising fixed-amount cost-sharing other than co-payments “significantly” – compared with the fixed-amount cost-sharing (e.g., deductibles, out-of-pocket limits) required as of March 23, 2010, increasing these amounts by a percentage equal to medical inflation plus 15 percentage points;
- Lowering employer contributions “significantly” – decreasing the percent of premiums or other fixed cost of coverage the employer or employee organization pays toward the cost of any tier of coverage for any class of similarly situated employees by more than 5 percentage points below the contribution rate that was in place on March 23, 2010, relative to the amount contributed by

- employees;
- New or decreased annual limits – adding or tightening any annual dollar limit in place as of March 23, 2010. Plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. Keep in mind that for plan years beginning after September 23, 2010, annual limits must be eliminated until HHS issues regulations on permissible ones;
 - Changing insurance companies – if an employer decides to buy insurance from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when self-insured plans switch plan administrators and it does not apply to collective bargaining agreements;
 - Requiring employees to switch plans to avoid compliance – if an employer requires employees to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing “as a means of avoiding new consumer protections,” grandfathered status will be revoked; or,
 - Sales or merger to avoid compliance – merging with or engaging in a sale to another plan to avoid complying with the law will cause grandfather status to be revoked.

To maintain grandfather status, plans must disclose that they are considered grandfathered in any plan materials provided to participants or beneficiaries, and must provide contact information for any questions or complaints about their grandfathered status. The grandfathering rules provide model language to assist plans with complying with this disclosure obligation. Grandfathered plans will also have recordkeeping obligations with respect to the information necessary to verify grandfathered status (e.g., records documenting the terms of the plan that were in effect on March 23, 2010) and must make such records available for examination by participants or regulators.

As a general matter, “grandfathered” plans under PPACA were exempt from most of the market reforms included in the bill with just a few exceptions. But the Reconciliation bill subsequently added several more exceptions, meaning that “grandfathered” plans – including those that are self-insured – will be subject to the following new requirements for the first plan year after September 23, 2010 (Reconciliation bill § 2301)–

- No waiting enrollment waiting periods for new employees longer than 90 days (PPACA § 1201 (adding § 2701 to the Public Health Service Act));
- No lifetime coverage limits for essential benefits (PPACA § 1001 (adding § 2711 to the Public Health Service Act));
- No annual coverage limits on essential benefits except as may be permitted by HHS (PPACA § 1001 (adding § 2711 to the Public Health Service Act));
- Extension of dependent coverage until the dependent turns 26 (until 2014, however, group coverage need not be extended to a dependent that is directly eligible for his own employer-provided coverage) (PPACA § 1001 (adding § 2714 to the Public Health Service Act));
- The new uniform coverage disclosure rules (PPACA § 1001 (adding Section 2715 to the Public Health Service Act) and § 1251);
- The medical loss ratio/rebating-related requirements (does not apply to self-insured plans) (PPACA § 10101 (adding Section 2718 to the Public Health Service Act));
- A ban on policy rescissions except in cases of fraud (PPACA § 1001 (adding Section 2712 to the

- Public Health Service Act); and
- No pre-existing conditions exclusions for children up to the age of 19 (applies to all in 2014) (PPACA § 1001 (adding § 2704 to the Public Health Service Act) and § 10103(e)).

See Section III for more in-depth discussion of these requirements except for the new MLR requirements, which are discussed in Section IV. *(FAQ added/updated 6-21-10)*

132. Conversely, with what new requirements must a new plan comply that a Grandfathered plan does not?

Grandfathered plans are exempt from mandatory compliance with the following 10 new requirements imposed on new plans under the legislation:

- Mandated offering of free preventative services
- Out of pocket limitations (\$5k individuals/\$10k families for new plans)
- Primary care physician designation right
- Clinical trial participation right
- Mandatory appeals process rights
- Essential benefits/minimum plan value (applies to new <100 group plans and individual plans only)
- Community rating/no medical underwriting (applies to new <100 group plans and individual plans only)
- Premium increase reviews (does not apply to self-insured plans at all)
- Non-discrimination in favor of highly compensated employees (already applies and will continue to apply to self-insured plans)
- Plan quality reporting obligation to HHS

See Section III for more in-depth discussion of these requirements.

133. By making the mandatory changes described above, does an existing plan lose its grandfathered status meaning that there will be no grandfathered status or does making the mandated changes not affect grandfathered status?

Rules issued on June 14, 2010 on grandfathering (available at this link <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=Hjj9NK/0/2/0&WAIAction=retrieve>) confirm that making the mandated changes will not jeopardize a plan's "grandfather" status, since plans are required to make those changes by PPACA. Additionally, the rule notes that making changes required by state law also will not cause loss of grandfathered status. *(FAQ added/updated 6-21-10)*

134. Section 1251 of the bill provides "grandfather protection" to existing group plans from many of the mandated benefits and similar provision. The manager's amendment and reconciliation carve out a number of exceptions, leaving a handful of provisions (most notably the nondiscrimination rule applicable to fully insured plans) apparently subject to the grandfather rule. Yet, Section 1562 of the bill rolls all these benefit mandates and similar provisions into ERISA, wholesale, without reference to a grandfather rule. Question is, does the wholesale incorporation of these items into

ERISA effectively trump whatever was left of the grandfather protection, insofar as ERISA plans are concerned?

First, the Section 1562 to which you refer was amended in the law to be Section 1563. That technical issue aside, the regulatory guidance on grandfathering issued on June 14, 2010 indicates that the manner in which the PPACA reform provisions were incorporated into ERISA does not render grandfathering inapplicable to ERISA plans (although the manner of incorporation did create some confusion about the more fundamental applicability of PPACA to certain types of plans, such as retiree-only plans. The guidance clarified that particular issue by confirming that the PPACA reforms do not apply to retiree-only plans or to “excepted benefits”). (FAQ added/updated 6-21-10)

- 135. I am a broker for East Ohio Methodist Church self-funded medical plans. Is there anything in the new requirements that would not apply since the church is not subject to ERISA – does this play any part in the Federal Rules?**

Whether a plan is an ERISA plan does not have any significance under the new requirements.

- 136. Employer who has a January 1, 2011 health plan renewal makes a plan change (either mandated by the carrier or by choice) effective April 1, 2010. On January 1, 2011, when health reform would be effective, has the employer lost its grandfathered status because a plan change was made after March 23, 2010 the signing date of the legislation?**

Not necessarily. The answer to whether the plan loses grandfather status depends on the type of change that was made, when the change was made, and whether the plan decides to revoke the change as permitted by the recently issued rules governing grandfathered status. First, there is now guidance (available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=Hjj9NK/0/2/0&WALSaction=retrieve>) specifying the types of changes that cause grandfathered status and the types of changes that do not affect grandfathered status. Assuming the change is of the variety that could cause loss of grandfathered status, the second inquiry should concern precisely when the change was made, as the grandfathering rules state that changes made after PPACA’s enactment pursuant to a binding contract “entered into” before enactment will not cause loss of grandfathered status. This question states that the “effective date” of the changes is April 1 but there is not sufficient information here to determine whether this is the same date the contract was “entered into.” Assuming the contract was entered into before March 23, 2010, the grandfathering rules allow for plans to revoke post-enactment changes that would cause them to lose grandfathering status (changes that were made before the grandfathering rules were issued, however), so long as the changes are revoked and the plan is modified effective as of the first day of the first plan year beginning on or after September 23, 2010. (FAQ added/updated 6-21-10)

- 137. Are collective bargaining agreements, reached before the enactment of the act on March 23, 2010, subject to ‘grandfathering’ with respect to the insurance reforms or other components of the new law?**

Yes. But the biggest concern for CBA plans had been when they would need to implement the reforms

applicable to grandfathered plans. Specifically, PPACA Section 1251(d) contains a special implementation rule for coverage maintained under CBAs, which is widely interpreted to direct that any changes that apply to such coverage need to be implemented only when the “last of the CBAs relating to such coverage” terminates. However, this special implementation rule appears to have been rendered meaningless by the regulations issued on grandfathering. Those regulations provide that 1) the special implementation rule applies to insured, but not self-insured, CBA coverage, and 2) grandfathered CBA plans (i.e., ones under CBAs ratified prior to March 23, 2010) must implement the reforms applicable to grandfathered plans at the same time as non-CBA plans. This latter rule means that grandfathered CBA plans, whether insured or self-insured, must implement the required reforms their first plan year after September 23, 2010 regardless of whether, or when, the CBA expires.

The only remaining significance of the special implementation provision may be for grandfathered insured CBA coverage that make changes causing loss of grandfathered status – the provision can be interpreted to give such plans until the termination of the current CBA before they must implement the reforms applicable to non-grandfathered coverage, rather than requiring them to implement the additional reforms immediately upon making the change. This is an issue that may be clarified by further regulatory guidance on grandfathering. *(FAQ added/updated 6-21-10)*

138. Do those CBAs have to have been in place before the enactment of the law or is it enough that they are in place before the earliest of the reforms go into effect on 9/23/2010?

To be grandfathered, the CBA must have been in place prior to March 23, 2010. *(FAQ added/updated 6-21-10)*

139. To the extent that a plan covers both union and non-union members, is it correct that the grandfathering benefit applicable to a CBA applies only to union members?

The answer to this question remains unclear despite the issuance of regulatory guidance on grandfathering, because that guidance did not address the question of grandfathering coverage of union versus non-union workers. Keep in mind; however, that the grandfather rule narrowed the significance of the special CBA implementation rule such that grandfathered CBA plans (insured or self-insured)_ must implement the reforms applicable to all grandfathered plans at the same time as non-CBA plans. The result is that there would not be a time difference in implementing these reforms for union versus non-union employees.

The only possible difference may be the implementation of reforms that would apply to grandfathered, insured CBA coverage if there is a decision to make changes that would cause loss of grandfathered status. It appears that such plans would have until the expiration of the current CBA to implement the reforms required of non-grandfathered plans, rather than being required to implement these additional reforms immediately upon making the change.

And the question then becomes whether such a delay could apply to both non-union as well as union employees. While there is no regulatory guidance on this precise issue, we note that the delayed implementation provision in the statute applies to plans “maintained” pursuant to one or more CBAs. Historically, two different tests have been used to establish whether a plan is maintained pursuant to a

CBA. One test holds that if at least 25% of those covered by the plan are union employees, the plan would be considered to be maintained pursuant to the CBA (thus, the special CBA implementation rule would apply to this plan and all employees, union and non-union). The second test essentially holds that the plan is “bifurcated” between the union and non-union employees, so the special CBA implementation rule would apply only with respect to the union employees. It is possible that further regulatory guidance from HHS regulations will resolve this question. *(FAQ added/updated 6-21-10)*

- 140. If there are multiple CBAs with the same employer, i.e. different trade unions with different termination groups, would they be grandfathered on an individual basis, i.e. when each CBA comes up for general or when the last one with the employer comes up?**

First, keep in mind that while plans under CBAs that were ratified before March 23, 2010 are considered grandfathered, regulatory guidance on grandfathering requires all grandfathered CBA plans to implement the reforms applicable to grandfathered plans the first plan year after September 23, 2010 regardless of whether and when the CBA expires. (The definition of a “plan year” for a CBA plan will depend on how this term is defined in the plan documents, and those documents and the plan’s advisors should be consulted to determine what the plan year is for a particular CBA plan.) In the event that changes are made to grandfathered insured coverage that would cause loss of grandfathered status, note that the special CBA implementation provision provides that the reform provisions will not apply until the last CBA relating to the “coverage” expires. We interpret this to mean the assessment needs to be done on a plan-by-plan basis instead of a CBA-by-CBA basis – for each plan, any changes that must be instituted due to loss of grandfathered status can be delayed until the last CBA related to that plan has terminated. Note further, however, that we do not have definitive guidance concerning this latter interpretation from HHS. *(FAQ added/updated 6-21-10)*

VI. Limited Benefits (e.g. “Mini-Med”) Plans

- 141. Our division administers about 110,000 limited medical lives. For these groups it is their PRIMARY coverage. There are many internal limitations and there are NO catastrophic benefits. I have attached a brochure as an example of some of the plan types. I know that Company X and Company Y have about a 500 Million block of this business as well. Do we have any idea how limited medical is going to be affected?**

This is a good question. Until the Health Reconciliation Act, all existing coverage plans were “grandfathered” and were thus insulated from mandatory compliance with most of the new requirements. That would have allowed such limited benefit plans to remain in place. The Reconciliation Act mandates that many of the key market reforms – including the elimination or restriction of lifetime and annual insurance coverage limits for essential benefits and the mandatory offering of free preventive services, for example – will apply to any plan year that begins after September 23, 2010 (or so) to all health insurance coverage. (H.R. 4872 § 2301(a)). We are still evaluating this issue and we will seek regulatory relief/clarification, but those provisions may essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward.

142. Do we know what role, if any, mini-med plans will have moving forward?

This is an issue that we are still evaluating and regulatory relief/clarification is needed, but those provisions may essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward.

143. Since mini-med plans are not considered traditional health plans, would people of such plans be subject to the penalty for not having credible coverage?

The individual mandate is satisfied if an individual is enrolled in any employer-provided health coverage. Mini-med plans – to the extent that they will still exist after the mandates take place in 2014 – would satisfy this requirement.

144. Do you have any summaries regarding the impact on limited benefit plans and what can be offered?

The impact will turn on how HHS interprets the application of the annual benefits to limited benefits plans. HHS has the discretion to allow annual limits until 2014; after 2014, it appears that limited benefit plans will not be permitted but we are working through the regulatory process in an effort to address that issue. For existing plans, there is no requirement regarding the scope of benefits that must be offered; the issue is that – for the benefits that are offered, the legislation imposes the prohibitions on annual and lifetime limits.

145. One of our clients is concerned by the "annual limits" language as they are all over mini-med plans. The annual limits language is outlined in Sec. 2711, but can you clarify how it relates to mini-medical plans.

This is an issue that we are still evaluating and regulatory relief/clarification is needed, but this provision may essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward. Please see above responses for more details.

VII. Issues Regarding Self-Insured Plans

146. Section 1301(b)(1)(B) of the PPACA contains provocative language that could literally be read to exempt self-funded group plans from all of Title I of the bill...all the mandated plan benefits and design changes, for example. Yet it doesn't seem to make sense that this would be the case. I wonder what Steptoe's take is on any self-funded vs. fully insured distinction to be made, based on that section. My sense is that the language merely means a self-funded plan can't play in the Exchanges, as offering qualified health benefits. But I am scratching my head.

We read the Section 1301(b)(1)(B) self-insured plan exception to only – in that provision at any rate –

exempt self-insured plans from eligibility to participate in the Exchanges. Section 1301 is outlining parameters for “qualified health plans” that are “qualified” to participate in Exchanges. The specific provision exempts self-insured plans from being considered to be “health plans.” The Subtitle A market reforms and other reforms folded into other portions of the Act generally apply to “group health plans” from which self-insured plans are not excluded under this definition. Again, this is an area in which regulatory clarification/verification will be sought at the earliest opportunity.

147. Do all provisions of the healthcare reform measure that address health insurance coverages apply to self-insured groups? If not, which do/do not?

By and large, almost all of the provisions included in the bill apply to self-insured plans on the same terms and conditions as they do to other similarly situated group plans. The primary exceptions are that self-insured plans are exempt from the Medical Loss Ratio provisions and from the premium increase review provisions (although they do have to make information filings listing their costs under the MLR provisions). Self-insured plans also have an independent obligation to file a new report with HHS.

148. Can you please confirm that a self-funded plan will be required to pay 60% of an employee’s coverage and the employee can’t be required to pay more than 9.5% of their salary?

There are a few things to be aware of regarding self-insured employers’ contributions toward coverage. First, a large employer may be penalized for providing “unaffordable” coverage to its employees, if it has an employee that ends up obtaining a federal subsidy to buy individual coverage from the Exchange. Starting in 2014, “unaffordable” coverage will be defined as employer coverage for which the premium costs more than 9.5% of family income for the least expensive plan or a plan for which the employer is responsible for less than 60% of the total cost of coverage, if the employee has a family income below 400% of the Federal Poverty Level. While an employer is free to provide coverage that is “unaffordable” by this standard, the employer will face a \$3,000 penalty for each employee offered such unaffordable coverage who obtains a federal subsidy to buy coverage through the Exchange.

Also keep in mind that if employees with family income below 400% of the Federal Poverty Level are offered coverage by an employer that would cost between 8 and 9.5% of their family income in premiums for the least expensive employer-provided plan, such employees are eligible for the “Wyden” vouchers and can take the employer’s plan contribution and apply it to an Exchange plan on a tax-exempt basis. Under the voucher provisions, if the Exchange plan costs less than the employer’s plan contribution, the employee keeps the difference.

Second, for non-grandfathered plans in the small group market (100 or fewer employees) starting in 2014, the reform law will cap the amount of out-of-pocket expense (e.g., coinsurance, copayments, deductibles, but not premiums, balance billing for non-network providers or spending for non-covered services) for employees at an amount equal to the high deductible health plan out-of-pocket limits for health savings accounts, and will also cap deductibles at \$2,000 for self-only coverage and \$4,000 for any other type of coverage, which amounts will be subject to indexing tied to growth in average nationwide premiums. *(FAQ added/updated 5-17-10)*

149. Is a self-funded account subject to this mandate if they made no changes to their plan at renewal?

This should mean they are "grandfathered"?

If the question refers to the market reforms, a plan that was in existence on March 23, 2010 and made no changes at plan renewal is considered to be grandfathered. Grandfathered plans are required to implement some of the new market reforms, specifically:

- No lifetime coverage limits for essential benefits (effective 2010) (PPACA §§ 1001 and 10101 (adding PHSA § 2711); HCEARA § 2301(a))
- No annual coverage limits on essential benefits (from 2010 to 2014, except as may be permitted by HHS; after 1/1/2014, annual limits are completely prohibited) (PPACA § 10101 (a)(2) (adding PHSA § 2711); HCEARA § 2301(a))
- No pre-existing conditions exclusions (only applies to children younger than 19 from 2010 until 2014 and applies to all thereafter).
- A ban on policy rescissions except in cases of fraud (effective 2010) (PPACA § 1001 (adding PHSA § 2712))
- Extension of dependent coverage until the dependent turns 26 years old (from 2010 until 2014, "grandfathered" group coverage need not be extended to a dependent that is directly eligible for employer-provided coverage). And,
- A bar on imposing waiting periods on plan participation in excess of 90 days (effective 2014).
(FAQ added/updated 6-21-10)

VIII. Taxes, FSAs, HSAs, HRAs

PPACA Titles IX and X

A. General

150. Can you please provide a list of all of the new taxes imposed under the new law and when they take effect?

- 10% sales-type tax on indoor tanning services (2010) (PPACA §10907; IRC §5000B)
- MLR/Carrier Rebates (2011) (PPACA §1001, §10101; PHSA §2718)
- Increase to 20% of tax on distributions from HSAs and MSAs (2011) (PPACA §9004)
- Tax on pharmaceuticals, and increase fee by \$4.8 billion (2011) (PPACA §9008; HCEARB §1404)
- Executive Compensation deductibility limit of \$500,000 (2013) (PPACA §9014; IRC §162(m))
- New 3.8% Medicare Investment Tax on high-income individuals (2013) (PPACA §9015)
- 0.9% increase the hospital insurance tax on High Income Individuals (2013) (PPACA §9015)
- 2.3% excise tax on Medical Devices (2013) (PPACA §9009; HCEARB §1405)
- Annual limitation on contributions to a health FSA of \$2,500 (2013) (PPACA §9005; IRC §125; HCEARB §1403)

- Elimination of deduction for expenses allocable to Medicare part D subsidy (2013) (PPACA §9012; HCEARB §1407)
- \$2 (per covered beneficiary) tax to fund the Patient-Centered Outcome Research Trust Fund (2013) (PPACA §6301, §10602)
- Employer Mandate – fine of \$2,000/employee (2014) (PPACA §1511-1515; HCEARB §1003)
- Individual Mandate – penalties equal the greater of \$95/individual or 1% of family income in 2014; \$325/individual or 2% of family income in 2015; \$695/individual or 2.5% of family income in 2016, and rise in accordance with cost-of-living adjustments thereafter. (2014) (PPACA §1501; HCEARB § 1002)
- Three year tax on TPAs and insurers to fund a transitional reinsurance program (2014) (PPAHCA §1341(b))
- Annual fee imposed on all health insurers (excluding self-insured plans), based on their market share (2014) (PPACA §9010; HCEARB §1406)
- 40% Excise Tax on certain “Cadillac Plans” (2018) (PPACA §9001; IRC §4980l; HCEARB §1406)

B. FSAs, HSAs, HRAs

151. With regard to FSAs, I've seen 2011, 2013 and 2014 as the date that FSAs will be capped at \$2,500. Which one is correct?

The cap will take effect in 2013 (HCEARA § 1401(a)(2)(E)) (amending PPACA § 9005(a)(2)).

152. How are flex plans used for dependent care cover affected by the bill?

There is no impact.

153. Are prescription drugs the ONLY thing that HSAs/FSAs/HRAs are permitted to reimburse, or can they still cover other qualified expenses like glasses, contacts, dental expenses, etc.?

The legislation only affects the status of drugs; it does not affect the other qualified expenses for which reimbursement may be sought, so these accounts will still cover vision, dental expenses, etc.

154. When does the HSA Reimbursement become limited to prescription drugs?

January 1, 2011.

155. If our FSA plan year begins July 1, 2010, will the \$2500 max apply at that time or the following plan year?

The plan year is irrelevant; the \$2500 maximum will apply to the individual over the course of the calendar year, starting in 2013.

156. What if your plan expires mid-year in 2011 will the over-the-counter drug reimbursement continue

through your plan end date?

The plan year is irrelevant; the over-the-counter restriction applies starting January 1, 2011 for money contributed to the account after that date. Administrators may want to consider informing participants of the change now to give them an opportunity to use their funds to purchase non-prescribed over-the-counter drugs before the new restriction goes into effect.

157. There is a FSA contribution limit of \$2500 in 2011. Does this also apply to HSA accounts?

No, the new \$2500 contribution limit applies only to health FSAs.

158. The response to one of the FAQs above states that the FSA cap goes to \$2,500 in 2013, but the question immediately above reads “There is a FSA contribution limit of \$2,500 in 2011. Does this also apply to HSA accounts?” Is it 2013 or 2011 and does the H.S.A. ever have the \$2,500 cap?

The \$2500 cap on health FSAs goes into effect in 2013. The questioner above is mistaken in asserting that the new health FSA limit starts in 2011 (we generally replicate the questions as asked). The \$2500 cap does not apply to HSAs. *(FAQ added/updated 5-28-10)*

159. Does the \$2,500 health FSA cap apply per individual, so that for a married couple each spouse could take the \$2,500 max, or does the cap apply per family?

The health care reform legislation does not change existing law in this regard, therefore, the \$2500 cap applies per individual employee, and each spouse could take the \$2500 maximum. *(FAQ added/updated 5-28-10)*

160. Is the \$2,500 cap regardless of covering an individual or a family?

Yes. The same health FSA maximum applies regardless of whether the employee is covering only themselves, or covering their family. *(FAQ added/updated 5-28-10)*

161. If a family has an H.R.A. of \$2,100 through one parent and an F.S.A. through the other parent what is the cap for the F.S.A. - \$2,500 per person, \$2,500 for the family or \$400 because you already gave \$2,100 in the H.R.A?

Our understanding is that HRAs are contributions of employer monies only and are to be treated separately from FSAs. Therefore, the contribution to the HRA does not affect the amount of the health FSA cap. And as previously noted, the health FSA cap is per employee.

C. Cadillac Plan Taxes

PPACA § 9001 (adding IRC § 49801); HCEARA § 1401

162. Will an employee-paid voluntary plan (i.e. critical illness, cancer, accident health, hospital

indemnity, etc.) that supplements their employer's plan be included when calculating if the value of their health plan warrants the "Cadillac" excise tax? Will it depend on whether the employee pays for it with pre-tax or post-tax dollars?

Any benefit that pays for medical claims will be included in the calculation. Contributions to HSAs, HRAs and Medical FSAs also will be included. The only medical expense exception is for stand-alone Dental and Vision coverage. Economic benefits that pay the beneficiary upon the occurrence of an event but that do not go directly to pay for medical care are also excluded from the scope of this calculation.

In the list of examples, it appears that both types of benefits are included but only the benefits that pay directly for medical care would be included in the Cadillac tax calculation. That calculation does not depend on whether the employee uses pre- or post-tax dollars to purchase the benefit.

163. Will the "Cadillac" excise tax be based on the entire cost of the plan regardless of how much of the cost is paid by the insured?

Yes.

164. For purposes of calculating the "Cadillac" plans excise tax - would the value of these plans subject to the tax include our executive health reimbursement plan like Exec-U-Care?

Yes. Contributions to such plans made by both the employer and the employee would be included in this calculation.

165. What are the final threshold amounts for the Cadillac plan provisions that take effect in 2018?

The threshold amounts in 2018 will be \$10,200 for an individual and \$27,500 for a family. Employees in "high risk professions" will have these threshold amounts increased by \$1650 for individual coverage and \$3450 for families. The thresholds will be increased after 2018 in accordance with the increase in the cost of living.

166. Are these amounts the total gross premium or the net employer contributed amounts?

Total gross premiums.

167. What is the excise tax level?

40%.

168. Who pays the excise tax in fully insured plans?

The benefit provider.

169. Is there a minimum benefit threshold that needs to be met to be considered a "Cadillac Plan"?

No. It is based strictly on cost.

- 170. What happens in small group plans age banded rates where an employee is in a high age bracket and their rate is over the “Cadillac Plan” threshold, but the rest of the group is not because they are younger?**

The calculation is made separately for each employee; it is not made on a group basis.

- 171. Will the "Cadillac" benchmark limit also be used for health insurance deductions for self employed people or employees using a Section 125 POP for pre-tax deductions?**

The benchmark applies to all employer plans.

- 172. Are union members excluded from the taxes imposed on "Cadillac" plan?**

No, the Cadillac tax provision does not distinguish between union and non-union employees.

D. Other

(i) W-2 Tax Reporting (PPACA § 9002 (amending IRC § 6051(a))

- 173. With respect to the employer obligation to report the value of health benefits on employees' W-2s, are the employees taxed on this?**

This reporting is to effectuate the Cadillac tax provisions; it will not subject the employees to any new tax obligations.

- 174. We are a construction company paying a rate per hour into a multi-employer trust for health insurance. Do we have to report amount paid in on the W-2 and how do we know if the insurance they are getting is in compliance?**

We will not have a definitive answer to this question until the rules are issued on W-2 reporting, but we anticipate that the amounts paid by an employer into a trust toward an employee's health insurance would be among the amounts required to be reported on the W-2. With respect to compliance responsibility, if the plan is sponsored by an entity other than the employer, we believe it will be that entity's responsibility to ensure compliance.

- 175. For W-2 reporting purposes, does this include medical, vision, dental, FSA premium dollar amounts paid?**

Keep in mind that the purpose of the new W-2 reporting is to effectuate the Cadillac tax, so the items to be reported are tied to the Cadillac tax provisions. The Cadillac tax provisions exclude standalone vision and dental from the definition of “coverage,” so the value of such items will not be reported on the W-2.

Contributions to HSAs, HRAs, and health FSAs are included in the definition of “coverage” under the Cadillac tax provisions, so those amounts will need to be reported on the W-2 to the extent that they are not currently reported on the W-2. The IRS will issue regulations on this to (we hope) fully clarify exactly what will be required to be reported on the W-2 and how that information will be reported.

In addition, note that anything that is already being reported on a W-2 (like HSA account contributions) need not be reported again.

(ii) Medicare Part D Subsidy (PPACA § 9012 (amending IRC § 139A))

176. We have been noticing that a number of companies are taking hits on their P&L referencing the healthcare reform. Will the new law affect us any?

This is a Medicare Part D subsidy issue for retiree prescription drug plans. If your company does not offer this program to your Medicare-eligible retirees, the change will not affect you. If your company does provide the benefit, the law will have two impacts. First, employers currently qualify for a tax subsidy if they provide this benefit to their employees. Under the original law establishing the subsidy, employers were permitted to both exclude the subsidy from their income and to deduct the total cost of the plan contributions on their tax returns. Effective in 2013, the expense deduction must now net out the subsidy. Second – and this is the P&L issue you are seeing – the accounting rules require the immediate recognition of an increased expense equivalent to the increase in the net present value of the total projected cost of offering this retiree benefit going forward. This accounting impact combined with the real increased cost of providing the benefit is leading many employers to reconsider whether they are going to continue to offer the benefit.

(iii) Individual Mandate Penalties

(PPACA §§ 1501 (adding IRC § 5000A) & 10106(b); HCEARA § 1002)

177. For the Individual Requirement Tax Penalty: how will the government collect the taxes?

Theoretically, from the employees as part of their tax return burden. There has been a lot of attention focused on the fact that the IRS has been given no resources to use to try to collect these penalties however. There is no employer burden to deal with this issue.

(iv) Medicare Wage Tax

PPACA §§ 9015 and 10906 (amending IRC § 3101(b))

178. How could an employer collect +.9% Medicare tax on couples earning >\$250K? How would an employer know?

An employer is responsible only for collecting the additional Medicare wage tax for its own individual employees who earn more than the \$200,000 threshold.

IX. Fees

A. Comparative Effectiveness Fees

PPCA § 9511 (adding IRC §§ 4375-77)

- 179. For the Comparative Effectiveness Fee, is the fee per member per month or per year? If per year, is it based on the average number of covered lives for the year? When does it take effect and what are the fees?**

The fee is based on the average number of covered lives under the plan for the prior year. For plans that end during the federal fiscal year 2013 (between October 1, 2012 and September 30, 2013), the fee will be \$1 per covered individual; for plan years that end thereafter, the fee will be \$2 per plan beneficiary.

- 180. Does this include dependents or is it a per employee fee?**

It is a per covered life fee and therefore includes dependents.

(B) Fees for High Risk Reinsurance Pool

PPACA § 1341(b)

- 181. You mentioned the new fees for TPAs and Carriers at \$25 billion; can you go over this issue again or clarify.**

The legislation provides for establishment of a temporary high risk reinsurance pool in each state to help individuals with pre-existing conditions obtain coverage in the individual market between now and the time that the Exchanges are operating and these individuals presumably will be able to obtain coverage through Exchange plans. To fund these high risk pools, fees totaling \$25 billion will be assessed on carriers and third-party administrators, on a pro rata basis taking into account each entity's fully insured commercial book of business for all major medical products and the cost of coverage administered by each issuer as a third party administrator. The calculation method will be determined in more detail by HHS. The total fees collected will be \$12 billion in 2014, \$ 8 billion in 2015, and \$5 billion in 2016.

X. Long Term Care Insurance

PPACA § 8002 (adding Title XXXII to the Public Health Service Act)

- 182. CLASS ACT – what is an employer's responsibility for collecting the premiums?**

Employers will have the option to participate by automatically enrolling and collecting premiums on behalf

of the new federal long-term care insurance program under rules that will be promulgated by the Department of Health & Human Services, but employers will not be required to participate in the program. (PPACA § 3204(a))

183. CLASS ACT – when is the effective date of the LTC opt-out program and will it offset with private purchased plans?

The CLASS Act has an effective date of January 1, 2011, but it is not exactly clear when the program must be up and running. Based on some of the statute's specific directives to HHS, however, we anticipate that the program will be established and running by 2012. Individuals will have the right to opt out of the coverage at any time. It is unclear how the federal coverage will integrate with private coverage; that will be something that must be addressed under the rules that will be written for the program.

184. If an employer chooses not to participate, then the employer will not process payroll deductions. Does this imply all employees will be “dis-enrolled” from the program by the employer?

No. The statute directs HHS to set up a mechanism for individuals to enroll and pay premiums independently. This will facilitate enrollment and premium payments for employees of non-participating employers and for individuals who are not employed.

185. If an employer chooses to participate does this mean all of those employees are enrolled unless the employees choose to opt-out?

We will not have a definitive answer to this question until HHS issues rules to implement the program. We do note that the statute requires HHS to establish a procedure for auto-enrollment by participating employers. However, it is unclear whether the auto-enrollment feature is mandatory for participating employers.

186. Is the employer responsible for collecting the LTC premium and sending to the government?

Yes, if the employer chooses to participate in the program. An employer who does not participate will not have premium collection responsibilities.

187. Are there any reporting or reconciliation requirements of the employer if the employer participates?

We will not have an answer to this question until implementation rules are issued by HHS.

XI. Wellness Premium Subsidies

PPACA § 1201 (adding PHSA § 2705(j))

- 188. I have read that there is now going to be (in 2014) an increase to 30% for wellness incentives and regulators have the authority to raise the cap to 50%. I would like some clarity on how this dynamic works/ what this will mean as compared to how things work now (where the wellness incentive is 20% I believe), simply an increase in the amount of incentive or further changes in how the wellness incentive works. In one of the original bills (I cannot remember which one), there was some proposal regarding tax credits for Wellness Programs. Does the final bill have any regulation surrounding wellness programs?**

The final law does increase the permissible allowance for participation in wellness programs to 30% (up from 20%) and it also authorizes HHS to increase the permissible allowance to as much as 50% by regulation. The legislation, however, does not otherwise change any of the current legal regime that applies to wellness programs.

XII. Reinsurance Program for Early Retirees

(PPACA § 1102)

- 189. Your Steptoe timeline referenced employers providing reinsurance to early retirees in 2010. What exactly does that mean and how will the program work?**

The legislation establishes a reinsurance program that will be administered by HHS and that is available to employers that offer health coverage to their early retirees (those between the ages of 55 and 64) and dependents of those retirees. HHS has issued interim regulations to implement the program, and indicates that it expects to start accepting applications for the program by June 30, 2010. Congress appropriated \$5 billion in funding for this reinsurance program, and the program will end when all funding has been consumed, or January 1, 2014, whichever is sooner.

Any sponsor of a qualifying retiree health benefits insurance plan is eligible to participate in the reinsurance program. The reinsurance reimbursement is 80 percent of the cost of all of the claims paid by the plan and the participant for each plan participant that are between \$15,000 and \$90,000 for the plan year. To be eligible for those reinsurance payments, a sponsor will be required to file a single application demonstrating plan eligibility and then, after the sponsor is approved for the program, the sponsor will file for claims reimbursement as claims are incurred.

Among other items, the application requires the plan sponsor to demonstrate or describe the following to establish its eligibility for reinsurance under the program:

- How the reinsurance reimbursement will be used to reduce premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs for plan participants, to reduce health benefit or health benefit premium costs for the sponsor, or to reduce any combination of these costs.
- How the reinsurance reimbursement will be used to help the plan sponsor maintain its current level of contribution to the applicable plan.

- The procedures and/or programs it has in place that have the potential to generate cost savings with respect to plan participants with chronic and high-cost conditions.
- The policies and procedures in place to detect and reduce fraud, waste, and abuse. And,
- The existence of a written agreement in place with the health insurance issuer of self-insured plan allowing disclosures to be made to HHS as required.

Potential plan sponsor-applicants should begin assembling the information that will be needed to apply for and participate in the program as soon as possible. This information collection should include data on the dollar amount of claims paid for each such retiree plan participant from January 1 to June 1, 2010, as this data will be necessary to initiate the claims process once a plan sponsor is certified to participate in the program.

It should be noted that certain matters will be the subject of further guidance that HHS plans to issue at a future unspecified date, including details on the mechanism HHS will use to monitor plans' use of reimbursements in accordance with the statutory limitations, and the process for revising reimbursement amounts due to post-claim changes. *(FAQ added/updated 6-21-10)*

190. Reinsurance for early retirees would involve the employer maintaining coverage for non-employees. Does this not violate most carrier contracts?

The new reinsurance program does not require any changes to the coverage an employer is offering now – if an employer does not cover retirees, it is not required to start doing so. The reinsurance program is simply a new benefit that employers may wish to apply for.

191. Would the reinsurance money apply to a situation where the early retiree pays most or all of the monthly cost for the coverage? Or just to situations where the employer pays the pre-65 premium?

HHS regulations state that reimbursement may be obtained for costs expended by the plan and by the retiree for the cost of health benefits, excluding premiums.

XIII. Miscellaneous Issues

192. Since there are no individual mandates until 2014, the number of insureds might go up drastically if these plans are outlawed between now and then?

Seems true.

193. How would the NY requirement that 75% of eligible employees sign up for a plan be affected by the bill?

I think that this is a rating issue and the federal legislation would have no legal effect on such a

requirement although there could, of course, be marketplace ramifications for the requirement.

194. What impact will the new healthcare laws have on the individual health insurance market?

This is, of course, difficult to predict but new policies offered in that market after 2014 (including any policies offered through the Exchanges) will be required to satisfy the entire spectrum of new benefits and cost requirements. The elimination of medical underwriting in the individual market should stabilize premiums but the rest of the requirements will probably lead to an overall increase in premium magnitudes.

195. Come 2014, I've read where insurance agents "may" be included to sell QHBPs available through the State Exchanges but how would we be eligible? Would we have to be approved by the State, or would we simply be permitted to sell Exchange products available by the carriers that are approved by the Exchange?

The Exchanges will not have the authority to approve carrier-broker relationships. Those will be maintained as they always have been – any carrier offering coverage through the exchanges will retain the right to contract with agents to help place and service those plans.

196. Based on the latest health care reform, what will happen to COBRA?

The legislation does not address this issue but you would expect the need for the COBRA regime would be eliminated after 2014.

How does the provision that mandates "employers must provide a 1099" for all corporate service providers receiving more than \$600 per year for services or property affect a broker's commissions or consulting fees?

This new reporting provision should not directly affect whether commissions or fees can be received, but only whether such commissions or fees are reportable by the entity that pays them.

197. How does the provision that mandates "employers must provide a 1099" for all corporate service providers receiving more than \$600 per year for services or property affect a broker's commissions or consulting fees?

This new reporting provision should not directly affect whether commissions or fees can be received, but only whether such commissions or fees are reportable by the entity that pays them.