THE COUNCIL
The Council of Insurance Agents & Brokers

Updated July 14, 2011
Version 21

Health Care Reform – FAQs

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 on a weekly basis. Starting with the May 17, 2010 version, the date a question was added or updated is indicated in parentheses at the end of the response. In addition, if regulatory guidance has been published on a particular topic, there will be a "Fed. Reg." citation to the guidance in the section heading.

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.

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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)(4))) and because citizens living abroad will be ineligible to purchase coverage through any individual plan offered through an Exchange (*see* PPACA § 1312(f)(1)(A)(ii)).

4. **Does PPACA apply to an international medical plan written out of the United Kingdom for a U.S. based employer with employees that are U.S. citizen expatriates on assignment outside of the United States with dependents living inside the United States?**

The employer mandate provisions of the statute do not explicitly address this issue, and in the absence of regulatory guidance on the mandate, a definitive answer to this question cannot be provided. What is relatively clear at this point is that the market reforms cannot be imposed on a U.K. carrier unless that carrier is doing business in the United States. The question then becomes whether the U.S. employer is required to extend health care benefits to U.S. expatriates living abroad. We believe the answer to this question is probably "no," in part because the individual mandate exempts U.S. citizens living abroad (*see* PPACA § 1501 (adding IRC § 5000A(f)(4)), and because an employer is not penalized for failing to offer coverage unless an employee goes to the Exchange to buy coverage, which is something U.S. expatriates cannot do since they will be ineligible to buy coverage through an Exchange (*see* PPACA § 1312(f)(1)(A)(ii)). Additional details and facts would be necessary to do any further analysis of such an arrangement, and we recommend consultation with counsel for guidance regarding concerns about the status of expatriate employees. *(FAQ added 9-24-10)*

5. **Does PPACA apply to U.S. Citizens that are Expats working outside the U.S. meaning would they be eligible to purchase insurance through the newly established Exchanges (once they are established)?**

No. U.S. citizens living abroad will be ineligible to purchase coverage through any individual plan offered through an Exchange (*see* PPACA § 1312(f)(1)(A)(ii)). *(FAQ added 9-24-10)*

6. **Do the PPACA employer mandate penalties of $2,000 per employee apply to U.S. Expatriate Employees (U.S. Citizens working outside the U.S.) if the U.S. based employer does not offer any medical plan for the U.S. Expatriate Employees?**

As previously discussed, the employer mandate section does not explicitly address this issue, and it is one that should be clarified through rulemaking. However, we believe that employers should not be penalized under the mandate provisions for employees living abroad 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)). *(FAQ added 9-24-10)*

7. **If a U.S. based employer offers a U.S. based international medical plan like Cigna International which is subject to PPACA but does not contribute 60% of the premium, will the employer need to pay the $3,000 per employee penalty for each employee that enrolls in an individual plan on the Exchange?**

The answer to this question will depend on several factors. Assuming that a U.S. employer is involved and the question concerns employees in the United States (because U.S. citizens living abroad will be ineligible to purchase coverage through the Exchanges); and assuming further that an employee's family income is below 400% of the federal poverty line; and assuming that the employee would be responsible for more than 40% of the "cost of coverage" (a term that has not yet been defined but will likely encompass more than just premiums), we anticipate that such an employer could be penalized for each employee who obtains a federal subsidy to purchase coverage on the Exchange. Since regulatory guidance has not yet been issued regarding the employer mandate, a more definitive answer cannot be offered until guidance becomes available. *(FAQ added 9-24-10)*

8. **I have a prospect with about 100 employees, many who are not US citizens. If they work F/T, do they need to be offered coverage? Many of them will not take the coverage so that will kill participation. If the group did not offer coverage in 2014, would they be subject to the penalty because of these non-US citizens?**

The employer mandate provisions of the statute do not explicitly address this issue, so there will be no definitive answer until rules are issued on the employer mandate. We note, however, that it is possible that regulators will interpret the statute to penalize large employers that do not offer coverage to their full-time employees located in the U.S. even though some of those employees are not U.S. citizens. Such an interpretation is a possibility because neither the text of the employer mandate provision nor that of the individual mandate provision exempts foreign employees who are working in the U.S. for U.S. companies. It follows that, in the absence of regulatory guidance, large employers should not assume that there will be no consequences for failure to offer coverage to non-U.S. citizen employees working in the U.S. *(FAQ added 11-18-10)*

9. 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). While the IRS has not yet announced its plans concerning timing to finalize rules on this and related issues, we note that on May 3, 2011 the IRS initiated the rulemaking process by issuing a request for public comment on matters including how to calculate whether an employee is full-time or part-time, and who qualifies as an "employee" (the IRS proposes to use existing federal definitions for "employee" and "employer"). Comments are due June 17, 2011. *(FAQ updated 5-27-11)*

10. 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 will 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.

11. What is the definition of an "employee" for purposes of the mandate?

The statute does not include an independent definition and we had anticipated that it would, therefore, incorporate the current standard definitions for who qualifies as an "employee" under existing federal law. On May 3, 2011 the IRS initiated the rulemaking process on this and related issues by releasing a request for public comment, in which it proposes to use existing federal definitions for "employee" and "employer." Comments are due June 17, 2011. *(FAQ updated 5-27-11)*

12. 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.

13. 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.

14. 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.

15. Are domestic partners covered by the mandate?

Only if they qualify as a "dependent."

16. 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 (as discussed below). *(FAQ updated 4-28-11)*

17. 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)

18. 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.

19. 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, however, employees will have the Exchange option and can can obtain a subsidy to purchase coverage on the Exchange if they have family incomes below 400% of the Federal Poverty Level and their premiums for the least expensive employer-provided plan would amount to more than 9.5% of their family income or they are responsible for more than 40% of the cost of that coverage (i.e., the employer's plan is "unaffordable"). In this case, the employer will pay a $3k fine/fee for each employee who qualifies for and purchases subsidized Exchange coverage. 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.

Note that a second provision of PPACA that would have made vouchers available to employees in an amount equal to the employer's contribution toward coverage if certain other criteria were met was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*

20. 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.

21. To determine household income, isn't there a privacy issue here?

Regulations must be finalized by HHS to define the procedures for seeking a federal subsidy to buy coverage through Exchanges, but the operational procedures proposed by the agency contemplate that those rules will task the Exchanges with collecting and evaluating information on family income, rather than employers. *(FAQ updated 7/14/11)*

22. 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.

23. 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?

PPACA's voucher provision, which would have made vouchers available to employees in an amount equal to the employer's contribution toward coverage if certain other criteria were met, was repealed by Congress as part of the budget-cutting measure that was signed

into law on April 15, 2011. This development should mitigate the adverse selection concerns that were prompted by the voucher program. *(FAQ updated 4/28/11)*

24. 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.

25. 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.

26. I have a question regarding the impact of health care reform. I have a family owned construction company based in Kansas City, Missouri. They have 15 full time, non-union employees who have their own group plan. In addition, the company pays into the union health plan based on hours worked. They have 60-80 union employees throughout the course of the year. Would they be treated as under 50 or more than 50 for the health care reform? If they would be treated as over 50, is there any way they can stay as an under 50 group and avoid the PPACA employer mandate?

If an employer has at least 50 employees, counting full-time employees (i.e., those working an average of 30 or more hours per week) and full-time equivalents (i.e., adding up all the hours worked in a month by any part-time employees and dividing that number by 120), the employer would be considered a "large employer," to whom the employer mandate will apply. The fact that some employees may be non-union, and some may be union employees, does not factor into the calculation of employer size for purposes of the

employer mandate. The one caveat to the 50 employee benchmark is if the employer only exceeds 50 employees due to employment of seasonal workers, which applies if the workforce is more than 50 full-time employees for 120 or fewer days in a calendar year. "Seasonal" employees are ones who work fewer than 120 days per year for the employer and who also meet the definition of "seasonal" employee that the DOL is expected to issue in future regulations. *(FAQ added 8-20-10)*

27. 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)*

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

A: 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.

29. 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.

30. 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.

31. 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.

32. If an employer of +50 employees does not offer health insurance in 2014 and is required to pay the $2000 annual penalty, for those employees that have other coverage (military retiree, Medicare, spouse coverage, individual, etc…) will the employer be penalized for them?

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. *(FAQ added/updated 5-24-10)*

33. 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.

34. 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)."

35. Will health plans still be able to exclude "any individual who begins active

service in the armed forces of any country, unless coverage is continued as provided under USERRA" as many do now?

The guidance regulators have issued thus far does not address this specific question, so it cannot be said with certainty that group health plans may continue to impose such eligibility restrictions. However, it could be argued that when an employee is on a leave of absence, they would not meet the definition of "full time employees" (i.e., ones who work thirty or hours per week) to whom the mandate/penalty regime will apply, but this position is one that needs to be verified by the regulatory agencies. *(FAQ added/updated 7-9-10)*

36. 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. *(FAQ added/updated 7-9-10)*

37. 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.

38. If our plan has fewer than 50 employees, will we be required to comply with the reporting requirements, non discrim 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, small employers (those that filed fewer than 250 W-2 forms in the preceding

calendar year) who provide coverage to their employees are temporarily exempt from reporting the value of that health coverage on W-2s, but we anticipate that this small employer exemption will expire at some point after the 2012 calendar year.

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. *(FAQ updated 4-28-11)*

39. 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 is addressed in regulations described in Section V below) *(FAQ added/updated 6-21-10)*.

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.

40. How do employees that are covered under a spouse's plan affect things for a small group?

Employees covered under a spouse's plan are still counted for purposes of determining employer size for the employer mandate. Whether and where an employee obtains health insurance is not relevant to the employee count. *(FAQ added/updated 7-27-10)*

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

In regulatory guidance on grandfathered plans (discussed in detail in Section V below), HHS advises that the market reforms do not apply to "retiree-only plans." We note, however, that this guidance does not provide specific details regarding the definition of "retiree plans" so the question of whether an arrangement must be the subject of a separate DOL Form 5500 filing for example, or whether it can be part of a single plan filed under Form 5500 that includes active employees but has options available only to retirees, remains unclear. In any event, we anticipate that HHS would not consider a single plan that covers both active employees and retirees and that makes all options available to both to be a "retiree-only" plan that is exempt from compliance with the market reforms. *(FAQ added/updated 6-16-10)*

42. 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)*

43. Would an employer be penalized by PPACA's employer mandate if the employer does not offer health coverage to current employees who are Medicare-eligible?

Before addressing implications under PPACA, it is important to be aware that there is a US Department of Labor regulation under the Age Discrimination in Employment Act that requires employers to offer current employees who are Medicare-eligible the same benefits, under the same conditions, as are offered to current employees who are not Medicare-eligible. See 47 CFR sec. 1625.32 (A7 in Q&A section following the text of the regulation). For this reason, it appears that the ADEA requirements would present a more fundamental obstacle to the approach being contemplated here, and employers should explore the age discrimination issue with their counsel before proceeding with such an approach.

Even if the ADEA did not present an obstacle, note that there is no clear cut language in the statute prohibiting Medicare enrollees or Medicare-eligible people from buying coverage on the Exchange. But because the employer mandate is set up such that a penalty is only assessed against the employer when an employee goes to the Exchange and gets a subsidy, and Medicare enrollees are ineligible to receive Exchange subsidies under the statute, it is easy to see why an employer might read the employer mandate to the effect that an employer would not be penalized for not covering a Medicare-enrolled employee.

But again, we think that viewing the question this way is too narrow. The ADEA issues need to be considered, as well as the way that employer mandate penalties would work as a practical matter. On this latter point, suppose that the employer devises a regime that avoids the ADEA problem by basing coverage eligibility on some factor other than age or

Medicare eligibility, and succeeds in excluding all its Medicare-eligible employees, plus a few in some other category that does not raise an ADEA issue. The fact that a Medicare enrollee cannot obtain a penalty-triggering Exchange subsidy does not mean the employer is off the hook, because if just one full-time employee from the non-ADEA/Medicare category goes to the Exchange and gets a subsidy, an employer mandate penalty is triggered and is calculated based solely on the total number of full-time employees (i.e., regardless of whether those employees are enrolled in Medicare, ineligible to go to the Exchange, etc). So, going through the process of excluding these two categories of employees still would not shield the employer from employer mandate penalties, and it will probably be difficult as a legal matter for the employer to exclude just Medicare enrollees/ Medicare-eligible employees. *(FAQ added/updated 2-25-11)*

44. How would an employer handle a COBRA situation in an exchange environment? (ie, the employee chose to go to the exchange for their coverage rather than take the employer's plan, and the employer was paying the penalty/subsidy for the employee going to the exchange.)

Unfortunately, PPACA does not address this question, and employers should assume for now that the Exchanges will not affect COBRA obligations. In theory, once Exchanges are operating and individuals presumably have access to more robust individual insurance markets, there would be no need for COBRA, and HHS officials have expressed such a view informally.

However, PPACA did not repeal COBRA. Accordingly, we suggest that employers not change the way they handle their COBRA obligations unless and until there is further legislative activity with respect to COBRA or regulatory guidance on this issue. *(FAQ added 4-28-11)*.

B. Vouchers

PPACA § 10108 (Repealed)
(Apply to any Employer Contributing to Group Coverage)

45. Can you explain how the vouchers work?

The provision of PPACA that would have made vouchers available to employees in an amount equal to the employer's contribution toward coverage if certain other criteria were met was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*

46. 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. But the voucher provision was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*

47. 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 finalize rules concerning the Exchanges and eligibility determinations, but the operational framework HHS has proposed contemplates 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. *(FAQ updated 7/14/11)*

48. 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?

The voucher provision was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*

49. 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 voucher provision was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*

50. 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.

51. Voucher Eligibility for Group Plans (not individuals):

1. **An employee is eligible if the family income is less than 400% of FPL and**
2. **The employee's contribution is between 8% and 9.8% (Should this read between 8% and 9.8% and more?)**

For example:
Employee (family of 4) household income is $88,200.
8% - 9.8% in contributions would be between $7,056 - $8,379.
If that employee paid $9,000 in contribution are they eligible for an Employer Voucher?

The voucher provision was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. In any event, note that in this example, assuming the employee's family income is less than 400% of FPL, if that employee's premium would be greater than 9.5% of his family income or the plan requires him to pay more than 40% of the cost of coverage, that employee would be eligible for a federal subsidy to buy coverage on the Exchange, rather than a voucher. *(FAQ updated 4/28/11)*

52. 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?

The voucher provision was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*.

53. One of our folks has asked if there is a typo in one of the responses above related to the "Wyden" vouchers. Can you please check to see if the 9.5% should be 9.8%?

The voucher provision was repealed by Congress as part of the budget-cutting measure that was signed into law on April 15, 2011. *(FAQ updated 4/28/11)*

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

54. 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.

55. When does this requirement take effect?

In guidance issued on December 23, 2010, regulators advised that the auto-enrollment requirement will not take effect until the Secretary of Labor issues rules to implement it. DOL has been vague about when it expects to issue these regulations, stating only that they will do so "by 2014." However, DOL has begun to examine issues related to the auto-enrollment requirement; on April 8, 2011, the agency held a public forum to give employers an opportunity to discuss questions, concerns, and suggestions about how to implement the auto-enrollment requirement. *(FAQ updated 4/28/11)*

56. 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).

57. 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)

58. 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.

59. 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.

60. 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.

61. 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.

62. Is this credit available to employers that already offer group plans?

Yes.

63. 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.

64. 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.

65. 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.

66. 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.

67. Can you tell me if we have several hundred "small" under 50 employers under an association plan, if under HCR these small employers are eligible for the small business tax credit on their insurance or will they be considered under the association a large group plan and not eligible for tax credits. Also, how would the excise tax work for an association plan. We have several plans that are offered and each employer chooses their options. Will there be any benefits for being an association?

To determine employer size for purposes of the small business tax credit, the current IRS rules apply. Those rules generally provide 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 association plan are commonly controlled. The same common control rule applies for purposes of the excise tax that would be imposed as a penalty under the employer mandate for employers who fail to provide coverage. In determining whether each entity's employees are counted separately, or whether all entities in the association are combined, the determinative factor is whether the entities are under common control. *(FAQ added/updated 7-9-10)*

III. MARKET REFORM/PLAN DESIGN REQUIREMENTS

A. Implementation/Timing

68. 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 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). Regulatory guidance further advises that insured grandfathered CBA plans that make changes which would cause loss of grandfather status can wait until expiration of the last CBA that was in place on March 23, 2010 before they must adopt the reforms required of non-grandfathered plans. *(FAQ updated 11-18-10)*

69. If an employer has a 3 year contract for their health plan, could the compliance date be 3 years from this Sept.?

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)*

70. If a plan is effective on 4/1 of each year and yet the 5500 reporting form is filed on a calendar year basis, what is the applicable date of the plan? I would suppose that the plan year controls; that is all we have seen from the materials. In other words, the data is reported to the IRS on a calendar year beginning January 1 basis. Is that relevant at all?

While regulatory guidance has not directly addressed this issue, we note that in the one instance so far where the definition of "plan year" was relevant to an analysis in HHS guidance (with respect to rules for claims under the Early Retiree Reinsurance Program), HHS directed that the plan's "plan year," as it is defined in the plan documents, would control. We would expect HHS to take a position consistent with this with respect to other issues related to health care reform. *(FAQ added/updated 7-9-10)*

71. We file our Form 5500 on an 11/1 basis for Plan #501 which includes the medical as well as life and disability benefits. Because our medical is self-funded, there is really nothing to report on it (no Schedule A). We have historically made all medical plan design changes on a 1/1 basis. Must we use our Form 5500 plan year (11/1/10) as the effective date for the initial set of changes, or can we delay the changes until 1/1/11? Is there any room for interpretation?

While regulatory guidance has not directly addressed this issue, we note that in the one instance so far where the definition of "plan year" was relevant to an analysis in HHS guidance (with respect to rules for claims under the Early Retiree Reinsurance Program), HHS directed that the plan's "plan year," as it is defined in the plan documents, would control. We would expect HHS to take a position consistent with this with respect to other issues related to health care reform, so the answer to this question depends on how the "plan year" is defined in the plan documents. If plan years are defined as commencing every January 1, the plan would not need to implement the relevant design changes until January 1, 2011. *(FAQ added/updated 7-9-10)*

72. I have a client whose plan year is 8/1 and they also file their 5500 based on 8/1. They make plan design changes 1/1 and premium changes 1/1. Based on the new law I think that they should not have to make any of the HCR changes until 8/1/2011. Their insurance company is telling them that they have to make the changes 1/1/2011. Can you please tell me what your opinion is on this?

The answer to this question depends on how the plan's "plan year" is defined in the plan documents. If the "plan year" is defined as starting August 1 of each year, the plan would need to implement the design changes mandated by the statute for the plan year starting August 1, 2011. But if the "plan year" is defined as starting January 1 each year, the changes must be implemented by January 1, 2011. *(FAQ added/updated 7-9-10)*

73. The regulations on plan design that have been issued so far are "interim final regulations." What does the term "interim final" regulation mean?

Typically, regulatory agencies issue "final" regulations only after a period of public comment on a regulatory proposal, and the regulations go into effect after they are issued in "final" form. But in urgent circumstances, agencies can use a procedure that involves issuing regulations that go into effect immediately (or almost immediately), hence the use of the term "final," but the agency opens a public comment on these "final" regulations and reserves the right to amend them after the comment period, hence the use of the term "interim." The version of the regulations issued after the comment period would typically be labeled "final." Thus, "interim final" regulations are ones that go into effect immediately and prior to a public comment period, but are subject to subsequent amendment before the agency issues them as "final." Note that "interim final" regulations are still considered as binding, meaning compliance with such regulations is still required notwithstanding their "interim" nature. *(FAQ added/updated 7-9-10)*

74. On Section 1302, page 62 of the bill, in (2), the Annual Limits on Deductible section, does not explicitly reference an effective date for the $2,000 / $4,000 amounts. When does this limitation become effective?

This question references the annual limitations on deductibles for employer-sponsored coverage in the small group market (100 or fewer employees) in Section 1302 (c)(2) of PPACA. No effective date is specified in the statute for this provision, which makes the answer to this question unclear. However we would anticipate, based on the appearance

of this provision in the Subtitle dealing with Exchanges and the fact that the indexing mechanism for the provision references calendar years after 2014, that regulators would interpret this limit on deductibles as being effective in 2014. Keep in mind, though, that there is presently no definitive answer in the absence of specific regulatory guidance. *(FAQ added 8-20-10)*

B. Waiting Periods
PPACA §§ 1201 (adding PHSA § 2708); 1252

75. 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.

76. 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)

77. 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.

78. Per the most recent FAQs (V12), question 64 states that the 90-day max waiting period takes effect 2014. However, question 143 states that the 90 day max waiting period applies, per grandfathered rules, 9/23/10 (see below). If we are interpreting something incorrectly, please let us know.

You are correct – 2014 is the effective date of the 90 day maximum waiting period. The response to Question 143 (now numbered Question 185) has been revised to specify that the waiting period provision is among the reforms that go into effect in 2014 rather than plan years starting after September 23, 2010. *(FAQ added 8-20-10)*

C. The New Mandates – General

79. 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)
- For insured plans, 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) (effective date will be announced by IRS)

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)

(FAQ updated 2-25-11)

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

Regulatory guidance was issued on this requirement on June 22, 2010 and is available at http://edocket.access.gpo.gov/2010/2010-15278.htm. Briefly, the guidance will require non-grandfathered plans to do the following with respect to access to primary care physicians:

- if a plan requires or provides for designation of a primary care provider[1], the plan must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary; and,

- if a primary care provider can be designated for a child, the plan must allow the designation of any participating pediatrician who is available to accept the child. The general terms of the plan regarding pediatric coverage are otherwise unaffected.

- In both cases, the plan must provide notice to participants of the terms of the plan regarding designation of a primary care provider or pediatrician, and the regulatory guidance provides model language for such notices.

Keep in mind that these new requirements will only apply to new plans, not to grandfathered plans. *(FAQ added/updated 7-9-10)*

[1] The regulatory guidance advises that the provider choice rules do not apply to plans that have not negotiated with any provider for the delivery of health care, but that merely reimburse covered individuals for their receipt of health care.

81. 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.

82. 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 annual/lifetime limit rules clearly apply to any health benefits offered in conjunction with HRAs. Regulatory guidance also states that the annual/lifetime limit rules do not apply to retiree-only HRAs (since retiree-only benefits are exempt from the market reforms). What is unclear is whether these rules, particularly the prohibition on annual limits, apply to "stand-alone" HRAs. The implementing agencies recognize that this is a significant question left unresolved by the statute, and they requested public comment on this matter in the interim final rule on annual limits, which was issued in June 2010. In the meantime, there is no guidance on whether or how the annual limit rule would apply. We note that some stand-alone HRAs are applying for waivers of the annual limits rule using the procedures established for mini-med plans, and HHS is granting these waivers (without offering any analysis as to whether the waivers are, in fact, necessary for stand-alone HRAs). There will not be a definitive answer to this question unless and until the agencies issue guidance on the matter. (*FAQ added/updated 2-25-11)*

83.I have a self-funded account with a dependent who 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?

Regulatory guidance issued on June 22, 2010 regarding the lifetime limit prohibition directs that individuals who reach a lifetime limit prior to the ban becoming effective (i.e., plan years beginning before September 23, 2010), and who are otherwise still eligible under the plan, must be provided with a notice that the lifetime limit no longer applies, and if the individual is no longer enrolled, must be given a special enrollment opportunity that continues for at least 30 days. The notices and special enrollment

opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010, and coverage must be effective no later than the first day of the first plan year beginning on or after September 23, 2010. Significantly, those enrolled through this special enrollment opportunity cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit. *(FAQ added/updated 7-9-10)*

84. If an individual has already exhausted their lifetime maximum under the current employer plan. Will the requirement to eliminate lifetime maximums bring this individual back under her employer's plan with an unlimited maximum?

Yes. Under the rules recently issued to implement PPACA's ban on lifetime limits, such limits on essential benefits will be prohibited beginning with plan years starting on or after September 23, 2010, and individuals who reached a lifetime limit prior to the ban becoming effective (i.e., plan years beginning before September 23, 2010) and who are otherwise still eligible under the plan must be provided with individual written notice that the lifetime limit no longer applies, and if the individual is no longer enrolled, must be given a special enrollment opportunity that continues for at least 30 days. See the discussion above for additional details. *(FAQ added/updated 7-9-10)*

85. Is there a requirement that a benefit plan with in and out of network benefits [PPO –style] provide full compliance with benefit requirements [Preventive, Essential, Annual and Lifetime] both in network and out of network? Or, is the availability of compliant benefits on an in-network basis considered compliance?

The statute generally does not distinguish between in-network and out-of-network benefits plans with respect to the market reforms. So, for example, the prohibitions on annual and lifetime limits appear to apply regardless of whether the participant is using in-network or out-of-network benefits. The specific instances we are aware of in which a distinction is made between in-network and out-of-network benefits relate to the requirement that participants be given the right to designate a primary care physician – in that case, the plan can require that the primary care physician a participant designates be an in-network physician; the special rules on access to out-of-network emergency services; the rule on coverage of participation in approved clinical trials; and the requirement that non-grandfathered plans provide free preventive services – the requirement of first dollar coverage in that case is limited to in-network services, and

plans are not required to cover preventive services that are provided by an out-of-network provider, or they may impose cost-sharing on such out-of-network services. *(FAQ updated 9-24-10)*

86. If an employer bundles/packages health, dental and vision coverages and offers the eligible employee the option to either enroll in the package (all three coverages) or decline the package versus allowing an independent selection for each coverage, are all the benefits in the bundled offering subject to the annual and lifetime unlimited benefit requirements? For example, would the dental plan no longer be able to have an annual dental maximum or a lifetime orthodontia limit?

The restrictions on annual and lifetime limits apply to "essential benefits." Although there is limited regulatory guidance on the precise definition of essential benefits, the categories of essential benefits set forth in the statute (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; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care) do not appear to encompass dental and vision coverage, with the exception of "pediatric oral and vision care." Until regulators provide a more specific definition of the essential benefits including "pediatric oral and vision care," the agencies have directed plans to use good faith efforts to comply with a "reasonable" interpretation of the definition of essential benefits. A "reasonable" interpretation may be, for example, that dental and vision coverage are not essential benefits except for children, and on that basis, a plan could decide to continue to have an annual dental maximum or lifetime orthodontia limit but only for adults. *(FAQ added 9-24-10)*

87. Dependent coverage is in Section 2714 of the PPACA (as amended). Section 2714 should be codified at 42 U.S.C. Section 300gg-14, which is in subpart 3. Subpart 3 is applicable "with respect to group health plans only -- ... (B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan)." Section 300gg-21(b)(1)(B). Because the plan is self-insured, it does not offer health insurance coverage in connection with a group health plan. Therefore, the plan is most likely exempt from the dependent coverage provisions of PPACA. Lifetime

limits are in Section 2711 of the PPACA, which should be codified at 300gg-11, which is also in subpart 3. The above analysis should also apply to lifetime limits, so the plan most likely is exempt from the lifetime limit provisions of PPACA.

Nice try. PPACA amended 42 USC Section 300gg-21(b)(1)(B) to make the provisions in Subpart 3 – essentially all the market reforms that will apply to the group market – applicable to "group health plans" as well as health insurance coverage provided by issuers (i.e., insured plans). See PPACA Section 1563 (a) (entitled "Conforming Amendments" – due to a statutory drafting error there are presently two Section 1563s in PPACA). In addition, the regulatory guidance emphasizes that the term "group health plan" includes both insured and self-insured group health plans for purposes of the market reform provisions in PPACA. See, e.g., the rules on grandfathering published in 75 Fed. Reg. 34538, 34539 (June 17, 2010). *(FAQ added/updated 7-27-10)*

88. If an employer fails to provide answers to a health carrier's risk questionnaire even though such employer indirectly knows of medical conditions, would this omission be acceptable grounds for rescission?

PPACA prohibits rescissions except in cases of fraud or intentional material misrepresentation, and the regulatory guidance concerning rescissions specifically states that fraud and intentional misrepresentations prohibited by the rules include can include omissions. *(FAQ added/updated 7-27-10)*

89. What exactly is the effective date of prohibition on rescissions? Immediately in 2010 i.e., now, or effective new plan year, e.g., 1/1/2011?

The new rule on rescissions goes into effect for plan years starting on or after September 23, 2010. *(FAQ added 9-24-10)*

D. Pre-Existing Conditions
PPACA §§ 1001 (adding PHSA § 2704) & 10103(e)
75 Fed. Reg. 37188 (June 28, 2010)

90. 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.

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

Regulatory guidance on the pre-existing condition provision was issued on June 22, 2010 but does not specifically address this question. With that said, there is no indication either in the statute or in the regulations that the new pre-existing condition requirements over-ride the normal IRC § 125 enrollment rules. *(FAQ added/updated 7-9-10)*

92. 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.

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

Yes.

94. 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.

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

Yes. While a lack of clarity in the statutory text led to some confusion regarding application of the pre-existing condition exclusion for children under age 19, the regulatory guidance on this matter clarifies that the new ban on pre-existing condition exclusions applies to children under age 19 starting with the first plan year after September 23, 2010. The regulations further provide that the ban on pre-existing condition exclusions applies to current enrollees as well as those who apply for enrollment, meaning plans cannot deny enrollment, and they cannot deny specific benefits, based on pre-existing conditions. *(FAQ added/updated 7-9-10)*

96. 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.

97.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.

98. Now that insurers can no longer consider pre-existing conditions in underwriting policies, how would an employer handle the HIPAA requirement for certification of creditable coverage?

Keep in mind that the ban on pre-existing condition exclusions for those age 19 and older does not go into effect until 2014, and regulators have not yet issued guidance on how the certification process would work after that point, so employers should continue to handle certifications for the 19 and over age group as they currently do. We note that regulators also have not yet updated the certification regulations for the under 19 age group even though the pre-existing condition exclusion ban went into effect for this age group for plan years starting September 23, 2010. Unless and until the creditable coverage certificate regulations are revised or other guidance is issued on this subject, we suggest that employers continue to comply with those regulations as they are currently written. *(FAQ added 4-27-11)*

E. Dependent Coverage
PPACA § 1001 (adding PHSA § 2714); HCEARA § 2301
75 Fed. Reg. 27122 (May 13, 2010)

99. 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."

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

Yes.

101. 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.

102. 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.

103. 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 children until they are 26 years of age. HHS regulations specify that:

- For these purposes, a "child" can only be defined in terms of the relationship with the participant, and eligibility criteria based on factors such as student status, financial dependency, or residency, can no longer be imposed by plans or carriers for coverage of a "child." Examples of

permissible definitions of "child" are biological child, adopted child, or stepchild. Regulatory guidance also states that use of the IRS definition of "child" (son, daughter, adopted child, child placed for adoption, and stepchild) will comply with the law. For individuals who do not meet the IRS definition of child, regulatory guidance states further that additional eligibility requirements such as residency or IRS dependent status are permissible. Note further that grandfathered plans can exclude those dependents who are eligible for their own (or a spouse's) 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.

(FAQ updated 9-24-10)

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

Yes. HHS has issued 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. *(FAQ added/updated 7-9-10)*

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

Yes.

106. 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."

107. 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.

108. 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 end of the tax year so long as the dependent is under 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.

109. Does it matter if dependent is FT or PT student?

The employer's definition of an eligible "child," which may turn on whether the child is a student, will be irrelevant for purposes of dependent coverage provision of the reform legislation. The only relevant criteria is what has been issued by HHS, which explicitly states that for purposes of the rule governing coverage of children to age 26, plans and issuers can no longer impose limits on who qualifies as an eligible "child" based upon enrollment status, financial dependency, residency, marital status, or other similar factors; an eligible child may only be defined in terms of the relationship between the participant and the child (e.g., biological child, adopted child), and the Departments have advised that plans defining "child" by reference to the IRS definition of "child" (biological child, adopted child, child placed for adoption, and stepchild) will be in compliance with the rule. Further, the Departments have advised that for individuals who do not meet the IRS definition of "child," plans may continue to impose other requirements for eligibility such as residency or "dependent" status under the IRS rules. *(FAQ updated 9-24-10)*

110. Does coverage for dependent between 19 - 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 that the employer's plan contribution, the employee keeps the difference.

111. 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, the rule could be interpreted to require that it offer the same coverage options to those who qualify for dependent coverage under the new law.

112. 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 age 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, the rule can be interpreted to require the plan to offer those same benefits to older dependents who join the plan under the new law. *(FAQ added/updated 10-26-10)*

113. On CIAB's FAQ document, certain questions reference a requirement to extend dental and vision coverage to over age dependents, if such coverage is offered to other dependent children. However, an employee in one of our other offices posed this question to an attorney they have on retainer, and was given a different answer. As you can imagine, we're now scratching our heads wondering what to tell our clients. Would you pose this to Steptoe to see what they come back with – do they still firmly believe in their original interpretation? Are there specific regs / text they could reference?

We believe the confusion about this issue arises from the intersection of the preamble to the grandfather rules which provides that the PPACA reforms do not apply to "excepted benefits" like stand-alone dental and vision, and the provision in the dependent coverage regulations that prohibits plans from discriminating in the benefits offered to one group of dependents versus the overage dependents. The relevant text of the dependent coverage rule includes the following in the rule's preamble: "for children under age 26, the plan cannot vary benefits based on the age of the child" (75 Fed. Reg. 27122, 27124 (May 13, 2010)), and "the child [eligible for the rule's special enrollment relief] must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status" (*id*. at 27125). And in the regulations themselves: "Uniformity irrespective of age. The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older)" (*id.* at 27134, 27136, 27138, to be codified as 54 C.F.R. § 54.9814T (d); 29 C.F.R. § 2590.715-2714 (d); and 45 C.F.R. § 147.120 (d)); and "the child [as a special enrollee] must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package." (75 Fed. Reg. at 27135, 27137, 27139 (to be codified as 54 C.F.R. § 54.9814T (d); 29 C.F.R. § 2590.715-2714 (f)(4); and 45 C.F.R. § 147.120 (f)(4)).

In attempting to harmonize the exemption for excepted benefits and the non-discrimination aspect of the dependent coverage rule, reasonable minds can certainly

differ. The most important point to be aware of is that this issue has not been addressed in regulatory guidance, and there is some risk should plans elect to interpret the dependent coverage rule as not requiring them to offer older dependents dental and vision if such coverage is offered to younger ones. The conservative approach, of course, would be to offer the same benefits to all dependents under 26 until the question is resolved by regulators. But it is up to plans and their advisors whether they wish to take this approach. *(FAQ added 8-20-10)*

114. We had a client ask whether HCR applies to dental and vision. Everything I've read up to this point says no. But when reading one of the responses above, it states otherwise.

There is confusion on this point because the regulatory guidance is contradictory. On the one hand, guidance in the grandfather rule advises that the market reforms in the health care reform law do not apply to "excepted benefits," which includes stand-alone dental and vision. But the age 26 rule states that a plan cannot offer different benefits to those who become eligible for coverage under the age 26 rule than are offered to other dependents. This raises the question of whether plans that offer dental and vision to dependents under age 19 (or that meet whatever eligibility criteria the plan had in place before health care reform), must also offer dental and vision to those who now qualify due to the age 26 rule. At present, there is no regulatory guidance that answers this question, but of course, plans still must decide whether or not they will offer dental and vision to adult children, and this decision will depend on how plans decide to interpret what regulatory guidance we do have. Obviously, some plans will be more comfortable with what we have characterized as a "conservative" approach – offering dental and vision to children up to age 26, and other plans will be comfortable with taking the approach of not offering dental and vision to adult children until there is guidance that clearly articulates that there is an obligation to do so. Each plan will need to make its own decision in consultation with its advisors, as to the approach it will take. *(FAQ added/updated 10-26-10)*

115. 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 <u>and</u> that the open enrollment must be 30 days? Or just that it has to be the 1st plan year after Sept 23 and open enrollment could still be 2 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. *(FAQ added/updated 5-28-10)*

116. My understanding is that if you decided voluntarily not to enroll your child for whatever reason, this is NOT an opportunity to add them now UNLESS they WERE originally enrolled and lost coverage due to ageing out of the plan or no longer being FT students. Please confirm.

The special enrollment opportunity is only for those children who had been excluded from coverage because of age before the effective date of the rule – that is, for a child whose coverage ended, or who was denied coverage, or who was ineligible for coverage, because the availability of coverage under the plan ended before age 26. *(FAQ added 8-20-10)*

117. If an under 26 dependent is on COBRA after getting laid off from his or her former employer, would they be eligible to enroll through their parent's employer even though they remain eligible for another employer sponsored plan (which is what COBRA through their former employer really is)?

Unfortunately, the HHS interim regulations on dependent coverage do not address this question, although they do advise that dependents under age 26 who are on COBRA through their parents plan would be eligible to enroll in the plan again. Hopefully this issue will be addressed when HHS issues a final rule. *(FAQ added/updated 7-9-10)*

118. Under the interim final regulations released in May, Plans are required to offer an enrollment opportunity (transitional relief) to: "a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group's health plan…because, under the terms of the plan, the availability of dependent coverage ended before the attainment of the age 26." My first Question relates to this provision - Are Plans required to offer this enrollment opportunity to all non-covered dependents under the age of 26, or only to those who were specifically barred from the Plan because their age exceeded the maximum allowed? In other words, if a 2 year old dependent was denied coverage in 2006 because he did not reside with the employee and was not claimed on taxes, should this dependent be given the enrollment opportunity? Second question is more general – Under the new law, a Plan is not required to provide coverage to dependent children, but if it does, the Plan cannot restrict eligibility based on residence or financial support. My question is – does the reference to "children" include only biological children or does it apply to step children as well? In other words, can a Plan continue to apply residence or support requirements to step children?

The response to the first question, when viewed in isolation, is no. The special enrollment period provided in the rules must be provided only to a child who lost coverage, was denied coverage, or was ineligible "because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26" and who would become eligible because of the new rules requiring coverage up to age 26. (this regulation will be published at 45 C.F.R. § 147.120 (f)(1)). We interpret this to mean that a child who was ineligible, lost, or was denied coverage for reasons other than aging out under the plan's prior age criteria, is not entitled to the new enrollment opportunity. *(FAQ updated 7-9-10).*

As to the second question, the regulation provides that a plan may not establish eligibility criteria based on "whether a child is a tax dependent or a student, or resides with or receives financial support from the parent." The only eligibility criteria a plan may use is the relationship between the child and the participant. So a plan may define an eligible dependent child as a biological or adopted child, or it may include step-children, or even other family members, so long as the plan is defining eligibility solely based on the relationship with the employee. In sum, a plan can decide whether stepchildren are in or out, but must do it based on the relationship with the employee and not based on

residence or support. Regulatory agencies have advised that if a plan does exclude stepchildren from eligibility for coverage as a "child" of the employee, the plan may still offer dependent coverage to stepchildren or other individuals (think of them as being in an "other" category of dependents a plan may opt to cover), and in that case, the plan can impose residency or financial support conditions on coverage of such "other" dependents.

And turning back to the first question, this means that if a plan defines biological children as eligible for dependent coverage, it will no longer be able to deny coverage to the two year old in the first example, although the parent could be required to wait until the next open enrollment to put the child on the plan. *(FAQ added/updated 10-26-10)*

119. For a school consortium plan, the Plan Year starts July 1, with an open enrollment September 1-30. A Special Enrollment Opportunity letter will be sent June 1 to allow a 30 day special enrollment for dependents with effective date July 1. Can any dependents that did not come on during the special enrollment opportunity come on during the normal scheduled open enrollment in September?

Yes. The new age 26 regulation does not change the procedural rules with respect to open enrollments. "Open" enrollment generally means a participant can make any change he or she desires for the plan year so long as a permissible option is being selected. Dependent coverage to age 26 is now a permissible option. So a participant should be able to enroll a dependent during open enrollment even if they chose not to do so during the special enrollment period. *(FAQ added 5-27-11)*

120. I believe there is a contradictory statement provided in the most recent version of the FAQ document from Steptoe. As part of the answer for the preceding question, it states:

> *In sum, a plan can decide whet her stepchildren are in or out, but must do it based on the relationship with the employee and not based on residence or support. Regulatory agencies have advised that if a plan does exclude stepchildren from the definition of a "child" who is eligible for coverage (which they are allowed to do), the plan may impose residency or financi al support condit ions on c overage of stepchildren.*

The first sentence states plans may not determine eligibility of stepchildren based on residence or support. The second sentence then states that the plan may impose residency or financial support conditions on coverage of stepchildren.

This issue is confusing many people because of the convoluted way that the age 26 rule was written. (We recognize that the response to the preceding question was not as clear as it could be, so we have revised the response in an attempt to clarify it.) The rule directs that plans must cover "children" up to age 26, but does not provide a definition of "child." Rather, the rule provides only that for age 26 purposes, an eligible "child" cannot be defined by reference to residence, support, student status, etc. So the plan is still responsible for defining the categories of dependents that are eligible for coverage, but in a sense, two categories of eligible dependents can be created. The first category are those the plan covers without any financial, student, or residency conditions, e.g., biological and adopted children, and children placed for adoption with the employee. This category must be offered coverage to age 26. A plan can opt to include other individuals in this category, such as stepchildren, children for whom the employee is legal guardian, or children of a domestic partner – but the plan must keep in mind that if it counts these individuals as "children" of the employee, the plan cannot also impose financial, student, or residency conditions on those "children."

The other category of dependents the plan could cover – again, at its option – are those who will only be covered if they meet whatever conditions the plan decides to impose, such as residency, financial support, student status, etc. Therefore, if a plan decides not to treat stepchildren as "children" of employees – that is, if a plan decides that it does not want to cover stepchildren with no conditions on residency, student, or financial status, it

could include stepchildren in this "other" category of eligible dependents. *(FAQ added/updated 10-26-10)*

121. Who is considered a "dependent" in regards to extending coverage to age 26? For example, if an employee has a stepdaughter who is 24, is the plan required to offer her coverage? A response above gave the permissible definitions (including stepchild) but then later states a plan can decide whether stepchildren are in or out. That seems to contradict itself…

The plan still gets to determine who is eligible for coverage as a "child" of the employee, with the caveat from the age 26 rule that eligible "children" can only be defined by reference to relationship with the employee. The example of stepchildren was cited as being *permissible* to include within the definition of an eligible "child" of an employee, but it is not mandatory under the federal health care reform law that plans cover stepchildren (keep in mind that this discussion is limited to the requirements of the federal health care reform law, and there may be other laws, such as state law, that affect the question of which dependents must be offered coverage). Therefore, a plan may opt to cover a stepchild as a "child" of the employee, but plans should bear in mind that if the plan does so, it must offer coverage to the stepchild to age 26 and cannot impose other conditions such as residency, financial dependency, student status, etc. on the stepchild's eligibility. A plan's other two options, if it does not want to offer unconditional coverage to stepchildren as a "child" of an employee, are to offer coverage to stepchildren as an "other" category of eligible dependents – in which case, the plan can impose conditions for eligibility such as residency or financial dependency; or the plan can decide not to offer coverage to stepchildren at all. *(FAQ added/updated 10-26-10)*

122. Client has an employee who is currently not enrolled in the group benefits plan. (Waived coverage). However, he has a daughter who is now eligible, as a result of the age 26 provision, to join his plan. Can he enroll during the special open enrollment period in order to add both he and his daughter to the coverage, and as an employer, is our client required to accept him?

Yes, the rules governing coverage of adult children require that an unenrolled employee be given the opportunity to enroll during the special open enrollment, along with the employee's eligible adult child. *(FAQ added/updated 7-27-10)*

123. This did not necessarily have to do with eg any distinctions between a 23 year old and new 26 year old coverage but within the existing definition of dependents, eg 15 or 22 years. One interpretation is that PPACA generally prevents discrimination, so that coverage must be made available in a uniform and nondiscriminatory manner to all within the class. TPA position is that while one cannot differentiate in the cost of coverage to dependents, that does not mean that one cannot differentiate with respect to actual benefits. They believe nothing prohibits a plan from using medically necessary or other standards to make (what I would characterize as) a medical benefit determination or perhaps claim settlement decision depending on different age or characteristic of the dependent. We talked specifically about Retin-A coverage and instances in which there is medical documentation based on studies etc, to support a particular age limit for the coverage. I think we may be talking about two different things with the distinction being that a plan must offer coverage package, the same to everyone, but that it can make rational distinctions dependent on dependent age etc. Some procedures or Rx may be more medically necessary for young children vs. teenagers etc.

Regulatory guidance issued on December 23, 2010 does not answer this particular question, but does shed some light on how the agencies might view this situation, and indicates that the agencies would likely deem such an arrangement to be in compliance with the age 26 rule. In a set of Frequently Asked Questions issued by the agencies (available at http://www.dol.gov/ebsa/faqs/faq-aca5.html), a question was posed about whether a plan could maintain its structure of charging a co-payment to those age 19 and older for doctor visits that do not constitute preventive services, while waiving the co-payment for those under 19. The agencies advised that this arrangement was allowed under the age 26 rule. More specifically, the agencies explained that while the age 26 rule generally prohibits distinctions based on age in dependent coverage of children, it "does not prohibit distinctions based on age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children." It follows that where a plan makes an age-based distinction but applies it across the board to all who are covered, the arrangement would not run afoul of the age 26 rule. And under this logic, we believe a plan would be allowed to have a rule such as covering Retin-A only for those under age 18, so long as it applied this limitation consistently to dependents, employees, and spouses. *(FAQ added 2-25-11).*

124. Dependents to age 26: special enrollment and three month waiting period. Ones opinion is that if the 3 month waiting period bumps up against the 1/1/2011 plan effective date, the waiting period is of no force and effect. TPA believes that this is not the case. For example, if an employee started work on 12/1/2010, the three month waiting period applies, it having gotten under the wire so to speak. They state that the 3 month waiting period can apply and that the insured was not denied entry to the plan but is just subject to waiting period rules. If however, the individual was denied coverage on 12/1, eg due to age limitations and want to take advantage of special enrollment, should be entitled to do so.

The regulatory guidance does not address the how to harmonize the special enrollment opportunity with a waiting period. The rule states only that "coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010," which means the answer to this question will depend on the meaning of coverage being "in effect." If a plan imposes a waiting period on other types of "special enrollees" (e.g., those enrolling after a marriage or loss of spousal coverage), a plan could reasonably take the position that coverage of an individual enrolled under the dependent coverage rule is "effective" as of 1/1/2011, but the new enrollee is subject to the same waiting period as anyone else. Be aware, however, that HHS could take a different view, so there could be some risk in following this approach. *(FAQ added 9-24-10)*

125. Can grandfathered health plan exclude (until 1/1/2014) dependent to age 26 from plan if married dependent eligible for coverage under dependent's spouse's employer-sponsored plan?

Yes. HHS staff have indicated in informal discussions that grandfathered plans may exclude children from coverage under this rule if the child has access to employer-sponsored coverage through the child's spouse. *(FAQ added 9-24-10)*

126. Since the new health care law permits "children" up to age 26 and not dependent on the parent/policyholder to remain on their parents' coverage, would the policyholder or child of legal age be the one responsible for any expenses incurred for the child? (i.e.. Ded., co-pay's).

The regulation does not alter requirements with respect to financial responsibility for the coverage, so the plan can continue to follow its present practice or modify its practices, as

it sees fit. *(FAQ added/updated 10-26-10)*

127. If two members of a couple each have single coverage from their respective employers, who is responsible for covering a dependent that now becomes eligible under the new legislation?

Both parents' plans must offer coverage to the child. Neither plan can refuse to offer coverage on the basis that the child has access to coverage through the other parent's plan. *(FAQ added/updated 10-26-10)*

128. In the scenario where both parents have single coverage, can the dependent enroll in both plans? If so, how would coordination of benefits work?

The rules state only that each parent's plan must offer coverage to an eligible child, without discussing whether the child could in fact enroll in both, or how benefits would be coordinated. Note, however, that there appears to be no reason why anything other than current coordination of benefits practices would apply in the event a child did enroll in both parents' plans. *(FAQ added 11-18-10)*

F. Mandated "Essential Benefits" PPACA §§ 1201 (adding PHSA § 2707) & 1302

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

On the issue of preventive benefits, take note that interim regulatory guidance was issued on July 14, 2010 and is available at http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=bgyjU7/1/2/0&WAISaction=retrieve. On the subject of defining what is considered to be an "essential" benefit, regulatory guidance issued to date has provided no further definition beyond the categories outlined in the statute, which are listed below. HHS has advised that it does intend to issue more specific guidance in the future; however, in the meantime, plans are directed to make "good faith efforts" to comply with a reasonable interpretation of "essential benefits." HHS has not offered any specifics in terms of when it might issue the more specific guidance on essential benefits. 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)). *(FAQ updated 7-27-10)*

130. 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 (and also constitute the set of benefits that will be subject to no annual and lifetime limits for plans of all types). 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.

(FAQ updated 7-27-10)

131. 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.

132. 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.

133. 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.

134. 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. Regulatory guidance was issued on July 14, 2010, regarding the preventative services that must be provided on this cost-free basis, and these services consist of:

- Items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and

- With respect to women, preventive care and screening provided for in comprehensive guidelines supported by HRSA and not otherwise addressed by the recommendations of the Task Force. (HHS is in the process of developing these guidelines and expects to issue them by August 1, 2011.)

The specific descriptions of the services in these categories can be accessed at http://www.HealthCare.gov/center/regulations/prevention.html. Also note that HHS advises that this website will be updated on an ongoing basis to capture any changes in the four categories of required preventive services. *(FAQ updated 7-27-10)*

135. For a PPO, is it still allowable to have out-of-network coverage for preventive care and have it go to deductible and coinsurance and not subject to first dollar coverage?

Yes, the regulatory guidance on preventive care states that plans that use a provider network may subject preventive care that is obtained out-of-network to cost sharing. *(FAQ added/updated 7-27-10)*

136. 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.

137. 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)*

138. 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.

139. With respect to the answer immediately above, can they expand on their source, please? "Our understanding" sounds like an assumption? Outside of self funded plans, we're not sure what "current non-discrimination rules" they might be referring to (HIPAA wellness incentive non-discrimination rules are a different topic). This answer also doesn't reference the fact that offering premium discounts and/or benefit enhancements under bona-fide wellness programs are still allowed (even encouraged) despite this prohibition.

Prior to the enactment of PPACA, Public Health Service Act Section 2702 (b) prohibited group health plans and issuers offering group coverage from varying premiums for similarly situated individuals based on an individual's health status, outside the context of a wellness program. PPACA maintains this prohibition in new PHSA Section 2705, and also codifies the regulatory provisions setting forth the requirements for wellness programs to offer premium discounts and the like. Accordingly, there has not been a substantive change in the law – premiums cannot be varied based on BMI or other health status-related factors, unless done in the context of a wellness program that complies with the statute's requirements. *(FAQ added 8-20-10)*

140. How will the Federal guaranteed issue guideline interface with a State's guideline if the state's guideline is more liberal? For example, in NY 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 supersede state laws that are more liberal than those in PPACA. *(FAQ added/updated 6-21-10)*

141. 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, 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 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)*

142. 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)*.

143. 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.

144. 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.

145. Can you (or CIAB) clarify the essential benefits? Question 67 says "plan obligations apply to all employers that provide benefits"…"no lifetime coverage limits for essential benefits" and "no annual coverage limits on essential benefits". Question 60 goes on to say that all non-grandfathered small group and individual plans must also comply with "essential benefits/minimum plan value". Then, on Question 100, it says that "essential health benefits will be the basic benefits that have to be included in all non-grandfathered individual and small group market plans." Therefore, will large employers and self-funded plans (grandfathered and non-grandfathered) be required to offer the essential benefits that the Secretary will later define and not apply annual and lifetime limits on those essential benefits as directed by the Secretary.

This question raises two separate issues – the definition of essential benefits, and the separate question of whether employer-based plans must offer essential benefits. With respect to the definition of "essential benefits" HHS has announced only an "interim" definition of the term so far in its guidance on annual and lifetime limits. Unfortunately, the definition in this guidance does not provide any more detail than the categories of benefits described as "essential benefits" in the statute: 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; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. HHS has not yet provided any more detail on what specific services must be offered within these categories, although it acknowledges that it will need to provide more specific definition. For the moment, HHS has directed that plans make "good faith efforts" to comply with a reasonable interpretation of essential benefits, but warns that plans must apply their definitions consistently, and not define a benefit as "essential" for one purpose but not essential for another.

As to the question of whether employer-based plans must offer a package of essential benefits, non-grandfathered small group plans (100 or fewer employees) must do so starting in 2014, but this requirement does not apply to large employers (101 or more employees), regardless of whether they are grandfathered or self-funded. Instead, large employers must offer "minimum essential benefits," which the statute does not define other than to say "minimum essential benefits" are benefits offered by an employer-based plan. In other words, the definition in the statute is circular and appears to require large employers to offer what they have been offering in the past. Although there is not an explicit requirement that large employer plans offer an essential benefits package, keep in mind that there are some implicit limitations on large employers. For example, large plans must still abide by the prohibitions on annual and lifetime limits on whatever benefits they offer that would fit in the "essential benefits" categories; and if a large employer offers a plan for which it pay less than 60% of the "cost of coverage," (a term yet to be defined by HHS), that employer risks being penalized for offering "unaffordable" coverage. *(FAQ added/updated 7-9-10)*.

146. Can you please clarify that healthcare reform requires that if you offer Rx benefits for mental health then you also need to offer medical benefits for mental health also and vice versa?

Effective in 2014, the healthcare reform law imposes an "essential benefits" package requirement on non-grandfathered plans in the small group (100 or fewer employees) and individual markets, as well as on any plan that is a "qualified health plan" sold via the Exchanges. Note that this requirement will not apply to self-insured plans. While the "essential benefits" will be defined in greater detail in a rulemaking, the general

categories of essential benefits that must be provided will include "mental health and substance use disorder services," as well as prescription drug benefits. In this way, the health care reform law imposes a mandate that certain types of plans provide benefits for treatment of mental health disorders as well as prescription benefits that presumably will include drugs to treat mental health disorders; both will have to be provided by such plans – there is not a "trigger" that only requires provision of benefits for treatment of mental health disorders if a plan offers prescription benefits for mental health. There are "triggers" in the federal mental health parity laws, which are separate from the health care reform law. You may wish to consult your advisors or counsel for more information regarding the federal mental health parity laws and whether those laws apply to your plan. *(FAQ added/updated 10-26-10)*

147. It has been brought to our attention from a Pharmacy Benefit Manager that Tobacco Cessation benefits are considered to be "essential benefits." We currently have a client maintaining GF status and they have a "3 fill maximum per year" for cessation medications. Since this maximum was in place prior to 9/23 we believe per the information below we can keep the annual limit. Or, because a benefit is considered "essential" does that mean the limit must be lifted? Here are the guidelines we have been using (from the grandfather rule):

> **Annual Limits. With respect to annual limits, a grandfathered plan must adhere to the following guidelines to avoid losing grandfathered status:**
>
> **1. Plans that on March 23, 2010 did not impose an annual or lifetime limit on benefits may not impose any annual limit after March 23, 2010.**
> **2. Plans that on March 23, 2010 imposed a lifetime limit, but no annual limit may not impose an annual limit that is lower than the lifetime limit that was in place on March 23, 2010. For example, if the plan had a lifetime limit of $10,000 on March 23, 2010, it could not impose an annual limit lower than $10,000 after March 23, 2010.**
> **3. Plans that on March 23, 2010 imposed an annual limit may not decrease the annual limit below the amount of the limit that was in place on March 23, 2010, regardless of whether the plan has a lifetime limit or the amount of the lifetime limit on March 23, 2010. For example, if a plan had an annual limit of $5,000 on March 23, 2010 and**

a lifetime limit of $10,000, it may not lower the annual limit after March 23, 2010 below $5,000. This is the case even though the lifetime limit is lifted after September 23, 2010.

Can we maintain the "3 fill maximum" on smoking cessation medications?

Although regulatory agencies have not yet provided specific guidance on the particular treatments and services that will be included as "essential benefits," we will assume for the purposes of this response that smoking cessation medications are "essential benefits," perhaps under the "prescription drugs" category identified in the health reform statute, or potentially as a corollary to the "substance use disorder services," or "wellness services" categories.

Second, be advised that the excerpt from the grandfather rule quoted above is irrelevant to this analysis because this excerpt deals with overall annual dollar limits on coverage, not with benefit-specific limits. Moreover, the issue here is not whether the 3-fill limit on smoking cessation medications complies with the grandfather rule, but whether it complies with the restrictions on annual limits for "essential benefits" under the annual limits rule.

In any event, substantively this is a tough question and the answer could go either way. On one hand, HHS has informally advised that benefit-specific limits, including prescription drug limits as a particular example, will not be allowed for essential benefits. On this basis, one could argue that you cannot retain the 3-fill limit on smoking cessation medications.

On the other hand, the argument could be made that what the informal advice pertains to is a ban on limits that apply to prescription drugs as a category, and that plans must be able to put some "medical necessity" parameters around what participants can obtain, or else plans would be obligated to accede to unreasonable requests like giving someone a lifetime supply of smoking cessation products in one year. This "medical necessity" approach would be similar to the rule announced for coverage of preventive services, which allows plans to use "reasonable medical management techniques" to impose limits where the preventive services guidelines do not address limits. Such an approach can also be analogized to HHS informal guidance stating that limits on the number of visits for particular treatments will still be allowed under the annual/lifetime limits rules, so long is

there is not also a limit on the dollar amount that would be covered per visit.

In the absence of specific regulatory guidance on this issue, a plan will have to make a decision, preferably in consultation with its advisors, as to which approach it will adopt, keeping in mind that the regulatory agencies have a stated expectation that plans will make design decisions based on what plans believe is a "good faith reasonable interpretation" of the statute and existing regulatory guidance. *(FAQ added/updated 10-26-10)*

G. Non-Discrimination
PPACA § 10101 (adding PHSA § 2716)

148. 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% or more of all the employees who are eligible to benefit under the plan if 70% 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, 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.)[2]

149. 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).

150. When do these provisions go into effect?

According to the health care reform statute, the go into effect for plan years beginning on or after September 23, 2010 for all new plans/benefits (these new non-discrimination rules do not apply to grandfathered plans). However, the regulatory agencies have not yet issued rules to implement the requirement, and they have advised that compliance will not be required until they have issued these rules (see IRS Notice 2011-1, available at http://www.irs.gov/pub/irs-drop/n-11-01.pdf). *(FAQ updated 2-25-11).*

151. 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.

152. 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.

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[2] 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.

153. 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)*

154. 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, and in many cases, the answers depend on specific facts and circumstances, so our answers here are general in nature based on our current understanding of the law. 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 eligible 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 updated 9-24-10)*

155. 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 does 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 70% of all employees are eligible to participate and 80% 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. It is important to be aware, however, that the nondiscrimination tests are based on very old regulations (see Treas. Reg. § 1.105-11(c)) that often do not reflect changes in health plans over the past 20 years, and in many cases, the answers depend on specific facts and circumstances, so our answers here are general in nature based on our current understanding of the law.

Please also keep in mind 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 updated 9-24-10)*

156. With the non-discrimination rules can a plan offer a different waiting period for an hourly group versus a salary group?

Under the regulations, you would need to indicate in the plan document that the plan covering the hourly group is separate from the plan covering the salary group and would have to test both plans separately to see if they passed the required "coverage" tests. If you are relying on the "reasonable classification test", hourly versus salaried is generally considered a reasonable classification, but then each plan still must pass the coverage portion of the reasonable classification test (this is a bit easier than the general coverage test). Note that for purposes of the test, you can exclude from consideration any collectively bargained employees if their health benefits were subject to the collective bargaining process. The "coverage tests" look at the proportion of highly compensated and non-highly compensated individuals covered by the plan. These tests (as well as the determination of who is highly compensated) are objective, so you need to look at the regulations.

Please keep in mind, however, that the nondiscrimination tests are based on very old regulations (see Treas. Reg. § 1.105-11(c)) that often do not reflect changes in health plans over the past 20 years, and in many cases, the answers depend on specific facts and circumstances, so our answers here are general in nature based on our current understanding of the law. *(FAQ added 9-24-10)*

157. Does a non-grandfathered (fully insured health plan) employer violate the non-discrimination rules under Section 105 if such employer applies the same benefits and contribution requirements to all eligible employees but sets up a 30 day waiting period for all exempt employees and a 60 waiting period for non-exempt employees?

As discussed in the preceding response, the answer to this question will depend on whether the employer sets up two separate plans and can establish a "reasonable classification" for each, in addition to passing the coverage portion of the reasonable classification test (if that's the test framework the employer opts to rely upon). Although the nondiscrimination tests are based on very old regulations, non-grandfathered insured

plans should proceed cautiously with regard to establishing different waiting periods for different employee classifications, as we understand there was a private letter ruling in the 1980s in which the IRS took the position that a plan failed the "benefits" prong of the nondiscrimination test because it made certain highly compensated individuals immediately eligible while imposing a 90-day waiting period on other employees. We highly recommend that plans make such design decisions in consultation with advisors with expertise in nondiscrimination compliance. *(FAQ added 11-18-10)*

158. Relative to 105h's Eligibility Test – lets' say an employer places 10 physicians in one class and all other executives and staff employees (about 50) in a second class will this be considered a discriminatory classification of employees?

You would have to indicate that the two plans are separate plans in the plan document and would have to test the two classes as separate health plans. You cannot tell if the "physician plan" would pass without knowing the compensation/ownership structure of each physician and executives and whether they were highly compensated or one of the highest paid owners or shareholders as defined in the regulations. It would be discriminatory if all physicians were treated as highly compensated under the regulations and everyone else was not. If you have some lower paid physicians and some high paid executives, you might be able to pass the reasonable classification test but that depends on demographics. Make sure you look at the regulations to determine whether the physicians are treated as highly compensated – and keep in mind that this is an objective test. You might also have to make the case that the distinction between physicians and the other employees was a reasonable classification, which could be challenging, depending on the facts. Finally, note that the nondiscrimination tests are based on very old regulations (see Treas. Reg. § 1.105-11(c)) that often do not reflect changes in health plans over the past 20 years, and in many cases, the answers depend on specific facts and circumstances. Accordingly, our answers here are general in nature based on our current understanding of the law. *(FAQ added 9-24-10)*

159. What does it mean under the Benefits Test that all benefits provided to highly compensated employees must be provided to all other participants? Does this mean that the required employee premium contributions MUST be identical for both HCEs and employees?

The benefits test really didn't address premium contributions in the past because it was applied in the context of self-insured plans. The regulations specify that plans will not satisfy the benefits test unless all the benefits provided to participants (and their dependents) who are highly compensated individuals are provided to all other participants (and their dependents) and also essentially require that all options be available on an equal basis. The regulations require that any maximum benefit limits be uniform and prohibit reimbursement that is proportionate to compensation. The regulations also indicate that a plan with options cannot be treated as providing a single benefit unless there are no required employee contributions or the required employee contributions are the same amount.

Because the regulations do not specifically address premiums, it is not clear if premiums have to be identical for all classes of participants (we assume you can have separate premiums for employee only, or family coverage, for example) but we think that if you have separate premium structures, absent any other guidance from the IRS, the plan could specify in plan documents that coverage of each class of employees with a separate premium structure constituted a separate plan, and test each "sub-plan" for coverage and nondiscrimination benefits separately. This may work as a good faith interpretation as long as the employer has established reasonable classifications and has a nondiscriminatory reason for treating the sub-plans separately (e.g., separate divisions, separate geographical areas, eligibility for HMOs, etc.).

It is important to keep in mind, however, that the nondiscrimination tests are based on very old regulations (see Treas. Reg. § 1.105-11(c)) that often do not reflect changes in health plans over the past 20 years, and in many cases, the answers depend on specific facts and circumstances, so our answers here are general in nature based on our current understanding of the law. *(FAQ added 9-24-10)*

160. We have been talking to a lot of clients about the "non-discrimination rules" that apply under HCR and the potential penalties if they are not in compliance. Unfortunately, plans that favor highly compensated employees are fairly common with smaller employers. Recently we have seen information that implies that the penalties for non-compliance to these rules do not apply to employers with less than 50 employees. We have not interpret PPACA that way. Can you advise on this point?

From a practical standpoint, small employers (<100 employees) that are concerned about non-discrimination compliance should consider taking advantage of the "Simple" cafeteria plan described in Section 9022 of PPACA (discussed in Part G.1. below). While the IRS has not yet issued guidance on the Simple plan and its interaction with the non-discrimination rules, the Simple plan appears to be intended to serve as a non-discrimination safe harbor, so that as long as a small employer complies with the Simple plan requirements (very generally, universal eligibility and availability of benefits, with uniform minimum employer contributions) it would be deemed compliant with the non-discrimination rules.

With that said, we disagree with the suggestion that there is no penalty for small employers who fail to comply with the non-discrimination rules, for two reasons. First, employers must keep in mind that the non-discrimination rules have been incorporated not only into the Internal Revenue Code (IRC), but also into ERISA and the Public Health Service Act (PHSA). Thus, while the IRC penalty provision does have an exception for small business, ERISA and the PHSA do not have parallel exceptions, which makes noncompliant small businesses vulnerable to enforcement and penalties by the Department of Labor in the case of ERISA plans, and by states and possibly HHS in the case of insured group plans. Under the PHSA, a plan that knowingly violates the non-discrimination rule could be subject to monetary penalties of as much as $100/day per affected individual (with no $500,000 cap as there is in the IRC). The Labor Department or excluded individuals could also sue to enforce the law (i.e., gain coverage).

Second, even if the IRC penalty framework was the only one that governed small businesses, our understanding is that the small business exception is not intended to give a small business a free pass if it elects to provide better coverage to the highly compensated. The IRC section in question says "no tax is imposed by this section on the employer on any failure (other than a failure attributable to section 8911) [i.e., HIPAA]

solely because of the health insu rance coverage offered by t he issuer." IRC § 4980D(d) (emphasis added). We believe this language reflects an intention to provide relief to the employer if the insurer's coverage package somehow violated some of the requirements covered by IRC section 4980D (which presumably now includes health reform). Our view is confirmed by our understanding that Treasury staff have advised others that the government was likely to read this exception narrowly to only apply where the prohibited discrimination results from the underlying insurance policy itself versus an employer plan design or related employer activities as to eligibility or employer subsidies. Even if an insurance company were to design and market a clearly "discriminatory" insurance policy (which we doubt would occur), we think the government could try to take the position that the selection of such a policy by an employer might violate the non-discrimination rules. In sum, therefore, we believe it would be ill-advised for small employers to assume that they could intentionally design a plan that discriminates in favor of the highly compensated without the risk of a penalty. *(FAQ added/updated 2-25-11)*

161. With respect to law firms' "partner only" plans, have there been any legislative changes to the non-discrimination rules that will allow firms to keep this type of plan?

Since we do not have definitive regulatory guidance on these issues, it would be prudent for insured partner-only plans to assume, at this point, that the non-discrimination rules could apply to them. It follows that to the extent an insured partner-only plan is grandfathered, it should give serious consideration to maintaining grandfathered status, since the non-discrimination rules will not apply to grandfathered plans.

We do note that there are technical arguments that can be made to the effect that "partner-only" plans should not be subject to non-discrimination testing. Such arguments can be based on the definition of "employees" in the basic rule that employer-provided medical care is excluded from gross income, which does not include partners (self-employed individuals). Nevertheless, since PPACA requires the IRS to adopt rules for insured plans that are "similar to those under section 105(h) [for self-insured plans]," the statute likely provides regulators with sufficient flexibility to write rules subjecting insured partner-only plans to the non-discrimination tests.

And considering that these technical arguments, when taken to their extreme, could allow a partnership with employees to avoid the non-discrimination rules and have two sets of

plans -- very rich ones for the partners, and very poor (or none at all) for other employees -- there are doubts that as a policy matter, regulators would seek to adopt such an interpretation. For all of these reasons, we believe the most prudent approach is for non-grandfathered insured partner-only plans to assume that the non-discrimination rules could apply to them, until such issues are resolved by regulators. *(FAQ added April 27, 2011)*

G.1 Non-Discrimination Safe Harbor – Simple Cafeteria Plans PPACA § 9022 (amending § 125 of the Internal Revenue Code (Available to "Small" Employers -- <100 Employees)

162. 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.

163. 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.

164. 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)*

165. 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 a 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 (that 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 nonhighly 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)*

166. 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)*

H. Penalties
42 U.S.C. §§ 300gg-22 & -61

167. 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.

168. 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.

169. 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.

170. What is the penalty if a group chooses not to make the necessary changes to be compliant with the health reform legislation on their first anniversary date after 9/23/2010? What will the penalty be?

With respect to the market reforms (e.g., prohibition on lifetime limits, coverage of adult children to age 26, coverage of participation in government-approved clinical trials) that were incorporated by PPACA into the Public Health Service Act, the penalty for failure to implement applicable changes is $100 per day per violation, and violations can be defined as being by beneficiary. Also bear in mind that because plans will have a legal requirement to make certain changes for plan years starting after September 23, 2010, such as eliminating lifetime limits, a plan beneficiary may have a legal claim that such limits or other non-compliant terms 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. *(FAQ added 8-20-10)*

I. Employer Notices/Disclosures

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

The statute requires all employers/plans to comply with the following new annual reporting and disclosure requirements:

- 60-Day advance notice to enrollees of any material plan changes not reflected in most recently provided summary of benefits (goes into effect after regulators adopt new uniform coverage summary disclosure rules, which most likely will not occur until 2012)
- The W-2 health insurance value report to the IRS (optional for tax year 2011; mandatory starting with tax year 2012 W-2 forms (i.e., the ones that are provided to employees in January 2013, with small employers exempt (ones that file fewer than 250 W-2s in the preceding calendar year) until further notice from the IRS)
- 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)

(FAQ updated 4-28-11)

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)

(FAQ updated 9-24-10).

172. 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. Keep in mind that this requirement applies to material plan changes that are not already reflected in the summary of benefits and coverage most recently provided to employees. While we must await regulatory guidance to confirm this, we believe this requirement can be interpreted to mean this 60 day prior notice requirement would not apply to renewal situations, since a new summary plan description can be provided in conjunction with renewal, and thus, any material changes would be reflected in the "most recent" summary plan description provided to employees. *(FAQ added/updated 2-25-11)*

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

Yes.

174. Regarding the employer notices now required under PHSA Section 2715:

a. Who is responsible for the notices involving fully-insured plans?
b. Does the 60-Day notice need to include a full benefit summary sheet or benefit modification summary explanation the changes? Or a simple notice via email, snail mail or posted in a "conspicuous place" stating "Please be advised there may be material changes to our benefit plan effective "X" date"?

First, please note that the Section 2715 notice requirement is not yet in effect, and will not go into effect until after HHS issues rules on it. In any event, the statute specifies that the notices must be provided by the carrier in the case of insured plans, and that the notices can be in written or "electronic" form (with no further definition of what "electronic" means). There will likely be clarification of the notice requirements when the Sec. 2715 rules are issued. *(FAQ added 5-27-11)*

175. 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)

176. 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 quality." As directed by the statute, the details of what qualifies as an expense under those two categories were developed by the NAIC and then adopted by

HHS. Under the NAIC/HHS definitions, expenses in these two categories include items such as "Direct Claims Incurred," which consists of items such as claims paid for hospital/medical benefits and services of other medical professionals, and "activities that improve health care" include "wellness and health promotion activities." *(FAQ updated 2-25-11)*

177. 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?

Carriers are to report data on a pool basis (i.e., individual market, small group market (100 or fewer employees) and large group market), on a state-by-state basis. (*FAQ updated 2-25-11)*.

178. 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 applies to pools (*FAQ updated 2-25-11)*.

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

Carriers are to report data on a pool basis (i.e., individual market, small group market (100 or fewer employees) and large group market), on a state-by-state basis. (*FAQ updated 2-25-11)*.

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

They will be required to disclose aggregate information at a pool level (i.e., individual market, small group market (100 or fewer employees) and large group market), on a state-by-state basis (*FAQ updated 2-25-11)*.

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

This will depend on the precise nature of the value-added services, but the MLR provisions generally classify activities "designed primarily to control or contain costs" as administrative expenses. In contrast, note that to the extent an activity to improve health care quality also has a cost-reducing or cost-neutral effect, that fact will not preclude the activity from being categorized on the "good" side of the MLR equation, so long as the primary focus of such activities remains on improving health care quality. Examples of such activities described by NAIC are activities that: prevent hospital readmissions; improve patient safety and reduce medical errors, lower infection and mortality rates; enhance the use of health care data to improve quality, transparency and outcomes; and increase wellness and promote health. *(FAQ updated 2-25-11)*

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

Rebates are to be distributed pro rata to whomever paid the premiums, which means there should be a distribution to enrollees and to employers if each contributes toward the premium. *(FAQ updated 2-25-11)*

183. 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.

184. 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
75 Fed. Reg. 34538 (June 17, 2010)

185. 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://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b03a90&disposition=attachment&contentType=pdf. 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;
- 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.

(Note that in regulatory guidance published on November 17, 2010, regulators announced a change to the rule that previously precluded grandfathered insured plans from changing carriers or policies. *See* 75 Federal Register 70114 (Nov. 17, 2010) (available at http://frwebgate2.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=UijJj9/0/2/0&WAISaction=retrieve). Insured plans may now change carriers or policies and maintain grandfather status, so long as no other changes are made that exceed the parameters allowed under the grandfather rule and i) the new coverage is effective on or after November 15, 2010 and ii) the plan provides records to the new carrier (such as a copy of the prior policy or summary plan description) sufficient to determine whether any changes are being made that would otherwise exceed what is permitted under the grandfather rule.)

To maintain grandfather status, plans must disclose that they are considered grandfathered in any plan materials provided to participants or beneficiaries that describe plan benefits, 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 § 2708 to the Public Health Service Act)) (2014);
- 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 updated 11-18-10)*

186. 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 (2010);
- Out-of-pocket limitations (equal to the out-of-pocket limits for high deductible health plans for Health Savings Accounts) (2014);
- Primary care physician designation right for plan participants (2010);
- Clinical trial participation right (2014);
- Mandatory appeals process rights/notice (2010);
- Premium increase reviews (does not apply to self-insured plans) (2011);
- Plan quality reporting obligation to enrollees/HHS (2012);
- A ban on discrimination in favor of highly compensated employees (applies to insured plans only (not effective until rules are issued)).
- And all non-grandfathered small group (<100) and individual plans also must comply with the following two new requirements:
  - Provide "essential benefits" package and 60% minimum plan value (2014); and
  - Community rating/no medical underwriting (2014).

See Section III for more in-depth discussion of these requirements. *(FAQ updated 2-25-11)*

187. 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://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b03a90&disposition=attachment&contentType=pdf) 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)*

188. 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)*

189. 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.

190. 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 (http://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b03a90&disposition=attachment&contentType=pdf) 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 case 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)*

191. I've read Steptoe & Johnson's narrative and most of the 121 pages of the interim "final" rules. With respect to the attached page 3, first bullet, "changing insurance companies…"This does not apply when self-insured plans switch plan administrators…". We had thought that by merely changing stop loss carriers it would not constitute a change and therefore not lose the grandfather status – yet I don't see this addressed – unless I am missing it.

While the text of the grandfather rule does not address the implication of changing stop loss carriers or other back-end arrangements that do not directly affect the benefits provided to participants, informal guidance from HHS advises that a change in stop loss carrier will not affect grandfather status, since stop loss insurance is not the "health plan" that provides benefits to individuals in the plan. With respect to the provision that had precluded plans from changing carriers providing benefits to participants, note that this rule was revised in regulatory guidance published on November 17, 2010. *See* 75 Federal Register 70114 (Nov. 17, 2010). Insured plans may now change carriers or policies and maintain grandfather status, so long as no other changes are made that exceed the parameters allowed under the grandfather rule and i) the new coverage is effective on or after November 15, 2010 and ii) the plan provides records to the new carrier (such as a copy of the prior policy or summary plan description) sufficient to determine whether any

changes are being made that would otherwise exceed what is permitted under the grandfather rule.) *(FAQ updated 11-18-10)*

192. What was the overall medical care component of the CPI on 3-23-10?

The grandfather regulations state that the overall medical care component of the CPI–U (unadjusted) published by the Department of Labor for March 2010 was 387.142. (See 75 Fed. Reg. 34538, 34561 (June 17, 2010)). *(FAQ added/updated 7-9-10)*

193. If an employer has one or more existing benefit plans that are "grandfatherable" and makes only changes within the permitted allowances to those plans such that they are eligible to retain grandfather status, but the employer adds one or more new plans that are intentionally not grandfathered, can an employer offer both grandfathered and non-grandfathered plans at the same time?

Yes. The regulatory guidance on grandfathering advises that the assessment of whether a plan or coverage is grandfathered is to be made separately with respect to each benefit package made available under a group health plan or coverage. It follows that an employer can maintain grandfathered plan(s) as well as non-grandfathered ones. *(FAQ added/updated 7-9-10)*

194. I have a self funded client that wants to change their employer contribution from 2-tier to 4-tier and increase employee portion by the allowable 5%. Is the 5% total cost share? For example, if they pay 90%/10% can they change to 85%/15% or is it 5% of the actual dollar each tier pays? If that is the case, can they change to a 4-tier contribution strategy and not lose their grandfather status?

With respect to reductions in employer contribution, the regulatory guidance on grandfathering states that a plan ceases to be grandfathered if the employer reduces its contribution rate for any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the rate in existence on March 23, 2010. If the contribution rate is based on the cost of coverage, the contribution rate is defined as the amount of contributions made by an employer compared to the total cost of coverage, expressed as a percentage. (Total cost of coverage is to be calculated using the same

process as for calculating the COBRA valuation). The guidance further advises that in the case of self-funded plans, the employer contribution is calculated by taking the total cost of coverage and subtracting the employee contributions toward the total cost of coverage.

Additional regulatory guidance on changes to tiers suggests that such changes can be made without losing grandfather status, but there are some limitations. More specifically, the guidance states that if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier must be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. An example provided by the guidance is as follows: if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (*i.e.*, self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50% (*i.e.*, at least 45 percent).

The guidance further advises that if a plan adds one or more new coverage tiers without eliminating or modifying any previous tiers, and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not need to be tested under the grandfather rule. An example provided in the guidance is as follows: if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status, regardless of what that level is. *(FAQ updated 11-18-10)*

195. If an employer with a July 1 plan year, makes changes to the plan design which violates the interim regs and causes a loss of grandfathered status, is the loss of status effective July 1, 2011 (first plan year after 9/23/10) or is the loss an earlier date i.e. the date the changes impacting GF status were effective?

First, keep in mind that the grandfathering regulations allow plans maintain their grandfathered status by revoking or modifying any changes that were made prior to release of the regulations (June 14, 2010) that would have caused loss of grandfathered status. To take advantage of this safe harbor, the changes must be revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the plan on that date, as modified, would need to be in compliance with the parameters for retaining grandfathered status. Aside from the safe harbor, the

gist of this question is when the plan – which made changes that would cause loss of grandfathered status effective for a plan year starting July 1 – would have to make the changes to comply with the additional plan design requirements that apply to non-grandfathered plans. For requirements that have an implementation deadline in the statute of "the first plan year on or after September 23, 2010," such as the requirement to provide free preventative services, that design change would need to go into effect July 1, 2011. Note that other requirements applicable to non-grandfathered plans may have other implementation deadlines, such as the limitations on out-of-pocket costs, which go into effect in 2014. Attention will need to be paid to the particular plan design requirements in the statute to determine when each requirement must be implemented. *(FAQ added/updated 7-9-10)*

196. Are the restrictions on grandfathered plans reviewed on a per benefit item basis? For example, if an employer increased a copay by a % in excess of the allowable % but adds four new benefits to the health plan, is there an offset or is the GF status still lost?

The restrictions on increasing copays and the like are not assessed on a per benefit item basis; the restrictions are across-the-board limitations. So, if an employer increased a percentage cost-sharing requirement – a change that causes loss of grandfathered status in all circumstances – there is no "offset" for adding new benefits. *(FAQ added/updated 7-9-10)*

197. Do you know if a plan would lose its grandfathered status if it increased the standard contributions by 20% for all tiers of coverage and provided a 20% premium reduction for non-smokers or employees which participant in a smoking cessation program? Or is the plan limited to decrease its contribution (or increase employee contribution) up to 5%?

The rules limiting the ability to increase employee contributions are not tied to the rules for offering premium discounts. If a plan exceeds the grandfather rule's parameters for increasing employee contributions (the limit is 5%), grandfather status is lost regardless of whether it also offers nonsmokers a premium reduction. *(FAQ added/updated 7-9-10)*

198. It is my understanding that if plans remain grandfathered they do not have to comply with the 2014 penalties if an employee goes to an exchange due to the fact that they will have the minimum essential benefits under IRC 5000(a). Can you please confirm?

A plan's grandfather status does not determine whether an employer is penalized for employees who receive a subsidy to buy coverage on the exchange. While the statute does state that a grandfathered plan qualifies as "minimum essential coverage," this is for purposes of satisfying the individual mandate that requires each individual to have a certain level of coverage. Individuals who satisfy the "minimum essential coverage" standard by being covered by a grandfathered plan would not have to pay the tax penalty for individuals. Employers, on the other hand, could be subject to penalty for offering "unaffordable" coverage (for employees with family income below 400% of the federal poverty level, coverage with a premium that amounts to more than 9.5% of family income or that requires the employee to cover more than 40% of the cost of coverage) regardless of whether than plan is grandfathered. *(FAQ added/updated 7-9-10)*

199. I have a client who is considering making a change on covering proton pump inhibitor medications. The revision would limit coverage for PPIs medications to 6 diagnostic conditions and exclude coverage for any other conditions. Would this proposed revision "eliminate all or substantially all benefits to treat a particular condition". I don't believe such decision would based on the examples provided in the interim regs.

This decision could cause loss of grandfather status. The grandfather rule states that "the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition." See 75 Fed. Reg. at 34560. Moreover, while the examples provided in the grandfather rules do not address this specific fact pattern, there is an example that comes close: a plan provides benefits for a mental health condition, the treatment of which is a combination of counseling and prescription drugs. Subsequently the plan eliminates benefits for counseling. The regulatory guidance advises that this plan would lose grandfather status because counseling is an element that is necessary to treat the condition. If the elimination of counseling would cause loss of grandfather status in this example, then the elimination of coverage for the prescription drugs needed to treat the condition would likewise cause loss of grandfather status. We strongly recommend that

plans consult their advisors before making the decision to eliminate prescription drug coverage for any condition. *(FAQ added/updated 7-27-10)*

200. 3) Definitions—(i) Medical inflation defined. For purposes of this paragraph (g), the term medical inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI–U) (unadjusted) published by the Department of Labor using the 1982–1984 base of 100. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI–U (unadjusted) published by the Department of Labor for March 2010, using the 1982–1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142. The problem that we are having is that we can't find the number indicated in the above definition "index amount for any month in the 12 months before the new change is to take effect". I've found the historical CPI for medical care as well as the "387.142" that we are supposed to be subtracting from, but I don't know exactly where to find that number that we subtract from 387.142.

The examples in the grandfather rules indicate that to obtain the "index amount for any month in the 12 months before the new change is to take effect," one needs to locate the figures for the overall medical care component of the Consumer Price Index for all Urban Consumers (unadjusted) (CPI-U) that have been published for the 12 months preceding the change that has been (or will be) made to the plan, and then take the highest of those figures. The CPI-U is published monthly by the Bureau of Labor Statistics within the Department of Labor, and detailed information regarding the CPI-U is available at http://www.bls.gov/cpi. *(FAQ added/updated 7-27-10)*

201. If you are supposed to look back to the 12 months preceding the change that has been or will be made to the plan [to make calculations regarding changes in co-pays, etc. that involve a comparison to the rate of medical inflation] what do you do if the change to the plan is for 1/1/2011 and we are currently discussing changes for 1/1/2011 and obviously we do not have 12 months of prior yet. Do you look at the 12 months prior to when you are deciding what change to make?

There appears to be a slight conflict between what the rule itself states and the examples of calculating medical inflation that are provided in the rule, and we concur that this creates confusion because a plan would be examining the potential impact of cost-sharing increases before the effective date of the change, and thus, before there would be a full 12 months worth of medical inflation data ending on the effective date of the change. Since the actual rule states that the change in the medical inflation rate is to be calculated by subtracting the medical inflation rate published for March 2010 from the index amount "for *any* month in the 12 months before the new change is to take effect," (the italics are ours), a reasonable interpretation of the rule would be to take the highest monthly index amount from the 12 month period preceding January 1, 2011 – that is, from January 1, 2010 up to the time the plan is evaluating the change. *(FAQ added 8-20-10)*

202. The "grandfathering" rules limit co-pay increases to the greater of (a) $5.00 (adjusted annually for medical inflation) or (b) a percentage equal to medical inflation (as of March 23, 2010) plus 15 percentage points. We read these limits to be cumulative and not annual – in other words, our client may increase co-pays over time up to a cumulative amount equal to medical inflation plus 15 percentage points. Is that correct?

Yes. *(FAQ added 7-14-11)*

203. Last plan year our client increased the co-pays on its self-insured medical program by an amount equal to 15% of its then-current co-pays. It did not have any increase for medical inflation. Since the "grandfathering" rule limit is "a percentage equal to medical inflation plus 15 percentage points" we believe our client can increase co-pays this year equal to medical inflation, correct?

Yes, provided that the medical inflation figure that is being used reflects the change in medical inflation since March 23, 2010. For more information on the medical inflation

calculation, see Examples 4 and 5 in the grandfather regulation, which can be found in volume 75 of the Federal Register on page 34561. *(FAQ added 7-14-11)*

204. When determining co-pays for pharmacy – the IFR says to use medical inflation but pharmacy inflation actually fits for pharmacy – and it's about 9% higher – can we use pharmacy inflation instead?

No. The grandfather regulation specifically requires the use of medical inflation. *(FAQ added 9-24-10)*

205. Have you seen whether prescription drug plan changes would affect a group's grandfathered status as medical changes would? Our client is considering $15 copay increase for Non-preferred drugs, which is clearly higher than the allowed co-payment changes.

While the regulatory guidance on grandfathering does not address this precise question, we anticipate that the grandfather rules would be interpreted to provide that an increase in prescription co-pay beyond the amount allowed by the grandfather rule would cause loss of grandfathered status. We note that the regulatory guidance states that the rules limit "the extent to which plans and issuers can increase the fixed-amount and the percentage cost-sharing requirements that are imposed with respect to individuals for covered items and services." 75 Fed. Reg. at 34532. Very likely, regulators would interpret "covered items and services" to include prescription drugs if those drugs were covered by the plan on March 23, 2010. *(FAQ added/updated 7-27-10)*

206. If plan sponsors comply with the mental health parity law and are forced to change their plan design will it cause them to lose their grandfather status?

No. The regulatory guidance on grandfathering specifically states that changes made by plans to comply with federal or state laws will not cause loss of grandfathered status. *(FAQ added/updated 7-27-10)*

207. If a Plan Sponsor applies for the early retirement reinsurance will they lose their "grandfathered status?"

No. The early retiree reinsurance program has no connection with the grandfathering rules. *(FAQ added/updated 7-27-10)*

208. If a currently grandfathered self insured health plan has a dependent child coverage definition to age 30 and is considering revising the definition effective with their January 1, 2011 plan year to meet the health care reform definition at age 26, would this change jeopardize their grandfathered status? The current definition requires the child to be a full time student, unmarried and dependent on the employee for support---so with the exception of the age reduction, the new definition is broader. In addition, isn't there an exception for plan changes required by state or Federal law?

Yes, there is an exception to the grandfather rules for changes that a plan makes to comply with federal and state laws. Keep in mind, however, that plans are permitted to offer coverage that is more generous than the federal standard. Accordingly, so long as the plan changes its rules to cover adult children to age 26 regardless of student or dependent status as required by the law (which is a change that will not cause loss of grandfather status), it may also opt to continue its present policy of covering dependent children from age 26-30 who are full-time students, unmarried, etc. *(FAQ added/updated 7-27-10)*

209. Our client currently offers a plan that is partially self funded, this is their core medical policy. It is currently a $2,500/$5,000 deductible. This plan is <u>not changing</u> at all. However, on top of this plan, the employer offers a 'wellness incentive' giving the employee the option to lower their deductible by meeting certain requirements that are tied to living a healthy lifestyle. This 'wellness incentive' is currently in the form of a fully insured supplemental policy (through BeniComp). The client is considering changing the funding of this 'wellness incentive' to a self-funded arrangement with a new administrator. However, the lifestyle requirements and credits that the employees may earn will not change. With regard to the supplemental plan, will the client lose Grandfathered Status if they decide to a) change carriers, b) change the way they finance it, or c) just eliminate it altogether?

We believe the more fundamental issue here is whether the reforms required by PPACA – and therefore, the grandfather rules – apply to the "supplemental" plan in this example at all. We would argue that the statute does not, because (1) PPACA applies to "group health plans" and "group health insurance coverage," as those terms are defined in the Public Health Service Act; (2) the PHSA provides that "group health plans" and "group health insurance coverage" do not include "excepted benefits;" and (3) very reasonable arguments can be made that supplemental policies like the one in this example are excepted benefits. If wellness incentives such as this supplemental plan are excepted benefits, a change in carrier would not affect grandfather status (and neither would changes in funding arrangements). But since regulators have not directly addressed the status of wellness plan-related benefits or supplemental benefits, we would caution that certain changes may carry risk and should not be undertaken without the advice of the plan's advisors. Note, however, that since the grandfather rule allows plans to change carriers, and allows changes from insured to self-insured arrangements, such changes should not give rise to concern even if this supplemental plan is governed by the PPACA reform provisions. *(FAQ updated 11-18-10)*

210. If a self-insured plan changes provider networks, would the plan lose grandfathered status? A few of my colleagues say they have reviewed articles on the internet that this would cause a loss of status, but there is also a lot of bad information floating around…..please clarify for us.

The interim final rule on grandfathering does not prohibit plans from making changes to their provider networks, although this is an issue for which the regulatory agencies have requested specific comment, which means the regulators' position could change in the final rule. Plans that are considering making changes to their provider networks should monitor the regulatory proceedings on grandfathering to ensure that they are in compliance with any final determination made by the agencies. *(FAQ added 8-20-10)*

211. Does making a Preferred Provider Network (PPO) smaller cause a loss of grandfathering? For example, would grandfather status be lost if an employer is presently covered by a carrier with a national PPO network, and the employer wishes to make changes to the PPO network so that an in-state network must be used to receive the preferred in-network benefits, and use of providers who are in the national network but are not in the in-state network would trigger out-of-network charges?

There is a provision in the grandfathering rule that says a change in network providers, in and of itself, will not cause loss of grandfather status. We would add one caveat, however. The plan should assure itself that these changes will not cause the plan to run afoul of another provision in the grandfather rule that says eliminating all or substantially all benefits for the diagnosis or treatment of a medical condition will cause loss of grandfather status. This may be an extreme scenario, but if the network changes meant that there were no more providers in the network in a particular medical specialty, the plan should be cautious about such a change, keeping in mind that HHS has not addressed this particular question. *(FAQ added 7-14-11)*

212. An employer going through rapid growth due to a temporary contract can not afford to make the same contributions (50% across the board, employee and dependants) to the health plan for the new workers for the temporary contract, and also needs to maintain minimum participation in these lower skilled / paid workers, so they want to grandfather the existing employees as a closed class and pay 75% Single Only, no contribution for dependants <u>on new hires</u>. 1.) Will this change cause them to lose Grandfathered Status under Healthcare Reform? 2). If this takes away grandfathered status, can this arrangement pass the non-discrimination test that the loss of grandfathering will bring at renewal? 3.) Could they open a NEW PLAN, maintain the existing plan and its Grandfathered status, and put the new employees in the new (non-grandfathered) plan at a 75% contribution for employee only in plan 2?

The answers to each question are as follows:

1) If the employer created a new and separate plan for the new hires and made a contribution for that plan different from the contribution it makes to the existing plan, the establishment of such a new plan should not cause loss of grandfather status for the old plan, so long as the employer takes care not to make any changes to the old plan that exceed what is permitted under the grandfathering rules. Close attention should be paid to ensure that only new hires are placed in the new plan, because the act of moving an existing employee from a grandfathered plan with more generous benefits to a plan with less generous benefits can trigger loss of grandfather status for the old plan.

2) The bigger question in this situation would be whether the new plan could pass the Section 105(h) non-discrimination test. (Keep in mind that if the plan is self-insured, it must comply with the rules prohibiting discrimination in favor of highly compensated employees regardless of whether it is grandfathered.) Very generally, the Section 105(h) test require that you cover 80% of all employees (which this arrangement would likely fail given that it probably would not be covering that high a percentage of employees), or you would have to pass the alternative "nondiscriminatory classification test" that is based mainly on facts and circumstances. A general formulation of that test requires that the compensation for non-participants be essentially the same as compensation for participants, that the plan covers employees in all compensation ranges, that lower and mid-level

employees are covered in more than nominal numbers, and that the classification of eligible employees is not discriminatory in favor of officers, shareholders or the highly compensated. The IRS also looks at the relative percentages of high and lower paid employees who are participating. The IRS has not focused on this test for a long time (but will likely have to do so in the future) so it is hard to say what types of evidence they might want an employer to provide.

3) See the answers to the first and second inquiries in this question. *(FAQ added 8-20-10)*

213. A question was asked in a webinar about increasing the deductible from $500 to $4000 (however, to the employee, the deductible is still $500 as the employer is covering the remaining $3,500 (Employer reimburses employee upon submission of EOB). I believe the question was answered that it didn't matter if you increased deductibles on the grandfathering issue, but this is not our understanding. Please clarify.

The grandfather rule does not provide specific guidance on whether such an arrangement would impact a plan's grandfather status. In theory, since the effective increase in deductible to the employee is $0, the arrangement should be consistent with the grandfather rule's limitations on increases in cost-sharing, but the regulatory agencies could adopt a different view and decide that requiring the employee to first pay an additional $3500 and then seek reimbursement would not be consistent with the grandfather rule. HHS has been asked to provide guidance on this particular question, but as of yet, the agency has not offered such guidance. In the meantime, in the absence of any guidance on this question, a plan contemplating such an arrangement should be aware that there is a risk associated with doing so, and should assess the risk in consultation with its advisors. *(FAQ added/updated 10-26-10)*

214. I have a client that with 800 ee's who would like to remain grandfathered. He is planning a TPA change from a private TPA – Wells Fargo to a carrier TPA – Cigna. The network utilized with Wells Fargo is a private, hospital-owned network with poor discounts. The Cigna network is a 98% match to the current network with just a few chiropractors not on the Cigna network. If the plan allows the employees & their dependents access to those providers not on the Cigna network that were on the privately owned network at an in-network level, will their grandfathering status be jeopardized?

The regulatory guidance on grandfathering advises that a change in provider network, by itself, will not cause loss of grandfather status. As for the impact of allowing employees to pay in-network rates to access providers outside the new network, the answer will depend on how the cost-sharing structure for such visits will compare to the cost-sharing requirements that were in place on March 23, 2010, and whether any increase in costs for employees exceeds the parameters set forth in the grandfather rule. *(FAQ added/updated 10-26-10)*

215. Employer (1/1/11 plan anniversary) offers two medical plans in place currently as options for employees. No plan changes will be made 1/1/11, however the employer wants to eliminate one of the two options. If they eliminate the High Option plan and move everyone into the Low Option plan, will the Low Option plan lose grandfathered status? What if the Low Option plan is eliminated?

The grandfather rule (to be published at 26 CFR § 54.9815.1251T (b)(2)(ii), 29 CFR § 2590.715-1251 (b)(2)(ii) and 45 CFR § 147.140 (b)(2)(ii)) states:

> "A group health plan or health insurance coverage (including a benefit package under a group health plan) ceases to be a grandfathered health plan if—
>
> (A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which the employees were covered on March 23, 2010 (the transferor plan);
> (B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it

were an amendment of the transferor plan would cause a loss of grandfather status under the provisions of paragraph (g)(1) of this section; and

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason."

Therefore, the answer to this question will depend on how the terms of the transferee plan compare to the terms of the transferor plan, and upon the reason for eliminating one of the options bearing in mind that dropping one of the options solely because it is more costly is not a "bona fide employment-based reason" for moving employees into the other option. *(FAQ added/updated 10-26-10)*

216. If an Employer who is self-funded and covers Medicare eligible retirees wishes to change from the current RDS (Retiree Drug Subsidy) program and become an EGWP (Employer Group Waiver Plan) under Medicare Part D will they nullify their grandfathered status? Please, assume that the benefits to the retirees do not change.

The grandfather rule does not address the specific issue of changes to drug coverage for retirees. However, an analysis of this particular plan should be done to determine whether the health care reform mandates, and the limitations in the grandfather rule on increases in cost-sharing for prescriptions, apply to the plan at all. Keep in mind that retiree-only plans are not covered by the market reforms in the healthcare reform law. If the plan is not a retiree-only plan, the answer to the question will depend on whether cost-sharing for prescription drugs, and any other changes, will exceed the limitations set forth in the grandfather rule. *(FAQ added/updated 10-26-10)*

217. We just received our client's medical renewal, 12/1/10, and they currently have a Management Class Plan, offered only to Management, and they have a High and Low option offered to all other employees. If the group makes any plan changes effective upon their renewal date of 12/1/10, will the group lose grandfathered status on these plans? If so, will our client be allowed to continue to offer the plan under the Management Class to Management only or will they have to offer that plan to all their employees?

The plan is permitted to make changes that do not exceed the parameters described in the grandfather rule (these parameters are discussed in detail in the response to Question 185 above). If, however, the plan makes a change that exceeds what is allowed by the grandfather rule, and the plan is insured, the loss of grandfather status means the plan will be subject to the rule prohibiting discrimination in favor of highly compensated employees, and the plan design must be tested for discrimination in accordance with the provisions of Internal Revenue Code Section 105(h). The Section 105(h) test is highly fact-specific so we cannot provide definitive guidance on whether this particular plan would pass the test. Note, however, the discussion in Part III.G above of considerations to bear in mind concerning the provision of benefits by classes of employees. *(FAQ added 11-18-10)*

218. Where the Health Insurance and Dental Insurance are offered by the same carrier, or under the same self funded plan, will replacing the Dental with a stand-alone dental plan cause the loss of grandfathering under these scenarios:

- Election is all or none (Medical and Dental or No Coverage) with no separate contribution on the part of the member.
- Member is allowed to choose either coverage alone or together with separate contributions.

While regulatory guidance has not addressed this particular question, it is likely that regulators would conclude that replacing the dental coverage with a stand-alone dental plan would cause loss of grandfather status in the first scenario described here, but not in the second. This could be the outcome because in the first case, the dental benefits are probably considered an integral part of the medical plan – there is regulatory guidance suggesting that where dental benefits are not offered under a separate election with a

separate premium, they are considered integral to the medical plan. In that case, eliminating the integral dental benefits and replacing them with a presumably less generous stand-alone dental plan could cause loss of grandfather status because the grandfather rule precludes the elimination of "all or substantially all benefits to diagnose or treat a particular condition" and limits the ability to make changes in coinsurance and employer contributions toward coverage. (Keep in mind that this analysis depends on a comparison of the old and new dental coverage; if the new stand-alone dental coverage is actually more generous than the integrated dental coverage, then there is an argument that the change does not constitute the elimination of "all or substantially all benefits to diagnose or treat a particular condition" or does not exceed the permitted changes in cost sharing, etc.)

On the other hand, dental benefits that are: i) offered pursuant to a separate election; ii) require payment of an additional premium if elected; and iii) are offered under a separate policy, certificate, or contract of insurance, are considered "excepted benefits" to which the PPACA market reforms do not apply. It follows that the replacement of such excepted benefits, or changes to those benefits, would not affect grandfather status. *(FAQ added 11-18-10)*.

219. In order to keep the grandfathered status for a group, I know that there cannot be significant contribution changes by the employer. Does this also apply to the dependent contribution? Right now, the group pays a portion of the dependent amount. If they were to stop that, would that effect the grandfather status?

The grandfather rule's restrictions on changes to the employer contribution do affect contributions to dependent coverage. Specifically, the rule states that a decrease in employer contribution of more than 5% toward the cost of "any tier of coverage for any class of similarly situated individuals," for example, family coverage, will cause loss of grandfather status. *(FAQ added 11-18-10)*

220. 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 was 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 is for grandfathered insured CBA coverage that make changes causing loss of grandfathered status – such plans can wait until the termination of the current CBA (i.e., the CBA in place on March 23, 2010) before they must implement the reforms applicable to non-grandfathered coverage. *(FAQ updated 11-18-10)*

221. 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)*

222. 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 known difference concerns 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. Such plans would have until the expiration of the last CBA in place on March 23, 2010 before they would be required to implement the reforms required of non-grandfathered plans.

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 updated 11-18-10)*

223. 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
75 Fed. Reg. 37188 (June 28, 2010)

224. 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?

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 to all

health insurance coverage. (H.R. 4872 § 2301(a)). Regulatory guidance to implement this requirement was issued on June 22, 2010. The regulations will phase out annual limits starting with plan years that begin on or after September 23, 2010, as follows –

- For plan years beginning on or after September 23, 2010 but before September 23, 2011, the minimum annual limit is $750,000;

- For plan years beginning on or after September 23, 2011 but before September 23, 2012, the minimum annual limit is $1.25 million; and,

- For plan years beginning on or after September 23, 2012 but before January 1, 2014, the minimum annual limit is $2 million.

As required by PPACA, annual limits will be completely banned for plan years starting January 1, 2014.

The regulations explicitly address concerns about the effect that annual limit restrictions would have on mini-med plans by providing for a "waiver" that such plans can seek to avoid application of the annual limits in the regulations, if compliance with those limits "would result in a significant decrease in access to benefits or a significant increase in premiums." This waiver program has been established by HHS, and details regarding the application process are described in HHS guidance available at: http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf. For plan years that start after November 2, 2010, applications are due 30 days before the start of the plan year. Note that waivers only last one year, at which time, plans must reapply. Regulatory guidance issued December 9, 2010 also advises that HHS will only grant waivers to mini-med plans that existed on March 23, 2010, the date of PPACA's enactment (except in very limited circumstances), which reflects the agency's intention to limit the sale of new mini-med policies going forward. *(FAQ updated 2-25-11)*

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

For the moment, the regulatory guidance on annual limits provides that mini-med plans will be able to apply each year for a "waiver" allowing them to avoid application of the annual limits in the regulations, if compliance with those limits "would result in a

significant decrease in access to benefits or a significant increase in premiums." Information regarding the application process is described in HHS guidance available at: http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf. Also note that with respect to medical loss ratios, HHS has advised that it plans to develop a special methodology that takes into account the special circumstances of mini-med plans in determining how administrative costs are calculated for MLR purposes (and thus how MLR ratios are calculated for such plans). The special methodology for mini-med plans would apply for at least the first year that MLRs are effective (presumably, 2011) and HHS will consider whether to apply it for subsequent years.

Regulatory guidance issued December 9, 2010 advises that HHS will only grant annual limits waivers to mini-med plans that existed on March 23, 2010 (except in very limited circumstances), which reflects the agency's intention to limit the sale of new mini-med policies going forward. Once the complete ban on annual limits goes into effect in 2014, waivers will not be possible, and it is highly unlikely that mini-med plans could be offered by carriers on a basis that is cost-effective while still complying with PPACA. It is expected that mini-med plans will no longer be offered at that point. *(FAQ updated 2-25-11)*

226. 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?

Technically speaking, the individual mandate is satisfied if an individual is enrolled in any employer-provided health coverage, and mini-med plans would satisfy this requirement. However, as discussed above, it is anticipated that mini-med plans would not be available after 2014 when the individual mandate becomes effective. *(FAQ updated 2-25-11)*

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

Although regulations have been adopted to phase out annual limits, mini-med plans will be able to seek waivers to avoid application of the limits, as discussed in more detail above. As for what can be offered, for existing plans, there is no requirement regarding the scope of benefits that must be offered. *(FAQ added/updated 7-9-10)*

228. 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 provision is expected to essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward. Please see above responses for more details. *(FAQ updated 2-25-11)*

229. Mini-med plans filed as indemnity plans do not have to file for the annual limits waiver and are not affected by the regulations until 2014, correct? A waiver is only required for limited benefit plans filed as medical (versus indemnity), correct?

The answer to this question depends on what is meant by "indemnity plan." "Hospital indemnity or other fixed indemnity insurance offered as independent, non-coordinated benefits" is an excepted benefit under the Public Health Service Act, and the PPACA market reforms do not apply to excepted benefits. If the question refers to this type of excepted benefit, this means the annual limit restrictions do not apply at all, even in 2014. *(FAQ added 9-24-10)*

VII. ISSUES REGARDING SELF-INSURED PLANS

230. 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.

231. 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.

232. Can you provide additional detail on how requirements such as MLRs, mandates, and penalties, will apply to self-insured plans versus insured plans?

There are four major points to keep in mind. First, the MLR rebating and premium increase review provisions do not apply to self-insured plans (although self-insured plans will have to do some MLR-type reporting). Second, there can be some differences in treatment in narrow areas. For example, the non-discrimination rule applies to all self-insured plans, but only applies to insured plans that are not grandfathered. In another example, there is a difference in the operation of the special implementation rule for collectively-bargained plans depending on whether the plan is insured or self insured: if an insured collectively-bargained plan loses grandfather status, it does not have to implement the applicable new reforms until expiration of the last collectively-bargained agreement that was in place on March 23, 2010. There are also some tax differences: all coverage, whether insured or self-insured, will be subject to the Cadillac tax if the value of the coverage exceeds the threshold in PPACA. However, there is an annual tax on providers of health insurance that will only apply to carriers and not to sponsors of self-insured plans.

Third, in the over 100 market, self-insured and insured plans are subject to the essentially the same treatment with respect to the market reforms (except for the MLR and premium review issues identified above) and with respect to the employer mandate and penalties.

Fourth, in the under 100 market, non-grandfathered plans will have to provide an essential benefits package that has a minimum plan value, and medical underwriting will be prohibited. But these requirements will not apply to self-insured plans (i.e., plans that are not sold through the Exchanges). *(FAQ added/update 2-25-11)*

233. 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.

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 updated 4-28-11)*

234. 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

235. 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 §4980I; HCEARB §1406)

B. FSAs, HSAs, HRAs

236. 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)).

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

There is no impact.

238. 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.

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

January 1, 2011.

240. 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.

241. 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.

242. 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, not to HSAs or HRAs. And note that the FSA contribution limit goes into effect in 2013, not 2011. *(FAQ*

added/updated 5-28-10)

243. 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)*

244. 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)*

245. 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)*

246. 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 was previously noted, the health FSA cap is per employee.

247. Why can you not use your health FSA or HRA debit card for OTC drugs effective 1/1/11? What is the reason behind this?

In guidance issued September 3, 2010 (available at http://www.irs.gov/pub/irs-drop/n-10-59.pdf), the IRS directs that starting January 16, 2011 these debit cards generally cannot be used to purchase over-the-counter drugs from a provider or merchant regardless of whether the merchant has an inventory information approval system (IIAS). The stated reason is that current debit card systems are not capable of substantiating compliance with the new limitation on use of FSAs and HRAs to reimbursement for prescribed drugs, since the systems are incapable of recognizing and substantiating that the medicines or drugs that are purchased were, in fact, prescribed. Accordingly, participants seeking reimbursement for prescribed over-the-counter drugs must submit substantiation (i.e., a copy of the prescription and the receipt) to their administrator as required by IRS regulations and the plan's rules. There will be an exception that allows for continued use of debit cards to purchase prescribed over-the-counter drugs at pharmacies that do not have an IIAS but meet the "90% test" under the current IRS regulations (i.e., 90 percent of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Internal Revenue Code section 213(d)), so long as the participant provides proper substantiation to the plan. The debit cards can continue to be used for medical expenses other than over-the-counter drugs. *(FAQ added 9-24-10)*

C. Cadillac Plan Taxes
PPACA § 9001 (adding IRC § 49801); HCEARA § 1401

248. 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.

249. 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.

250. 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.

251. 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.

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

Total gross premiums.

253. What is the excise tax level?

40%.

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

The benefit provider.

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

No. It is based strictly on cost.

256. 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.

257. 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.

258. 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))

259. 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.

260. 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?

Guidance issued by the IRS on March 29, 2011 (available at http://www.irs.gov/pub/irs-drop/n-11-28.pdf) states: "[a]n employer that contributes to a multiemployer plan [as "multiemployer plan" is defined in 26 CFR § 54.4980B-2] is not required to include the cost of coverage provided to an employee under that multiemployer plan in determining the aggregate reportable cost. If the only applicable employer-sponsored coverage provided to an employee is provided under a multiemployer plan, the employer is not required to report any amount under § 6051(a)(14) on the Form W-2 for that employee." .

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. *(FAQ updated 4-28-11)*

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

In guidance issued by the IRS on March 29, 2011 (available at http://www.irs.gov/pub/irs-drop/n-11-28.pdf), the IRS advises that the amount of any salary reduction election to a flexible spending arrangement (within the meaning of §§ 106(c)(2) and 125) is not to be included for purposes of reporting the value of health coverage on a W-2 (unless the amount of the health FSA for the plan year exceeds the salary reduction elected by the employee for the plan year). Similarly, the guidance advises that an employer is not required to include the cost of coverage under a dental plan or a vision plan if such plan is not integrated into the group health plan.. *(FAQ updated 4-28-11)*

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

262. 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)

263. 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)

264. How could an er collect +.9% medicare tax on couples earning >$250K? How would an er 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)

265. 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.

266. 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)

267. 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)

268. 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))

269. 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.

270. 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, as the law is presently written. Note, however, that HHS is considering ways to modify the long term program to increase the chances that it will be financially sustainable, and one of the modifications being considered is to limit the program to those who are actively employed when they enroll. *(FAQ updated 2-25-11)*

271. 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.

272. 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.

273. 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

A. Premium Subsidies
PPACA § 1201 (adding PHSA § 2705(j))

274. 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. While the legislation does not explicitly change any of the current legal regimes that apply to wellness programs, we note that recent informal guidance on the grandfather rule cautioned that wellness program penalties, such as cost-sharing surcharges, should be examined carefully to ensure that they do not exceed cost-sharing increases that are permitted in the grandfather rule. We interpret this to mean that cost-sharing penalties imposed in the wellness program context could affect grandfather status, and plans should be mindful of this possibility when designing wellness programs. *(FAQ updated 11-18-10)*

B. Grants for New Small Business Wellness Programs
PPACA § 10408

275. When will HHS give small businesses access to the application process for the PPACA wellness grants?

HHS has not yet developed the grant program for small businesses, and has provided no indication of when it will do so. *(FAQ added 11-18-10)*

XII. REINSURANCE PROGRAM FOR EARLY RETIREES
PPACA § 1102
75 Fed. Reg. 24450 (May 5, 2010)

276. 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 started accepting applications for the program on June 29, 2010. Congress appropriated $5 billion in funding for this reinsurance program, and the program will end when all funding has been consumed. Note that due to overwhelming demand and its prediction that the program will run out of funding in 2012, HHS stopped accepting new applications for the program as of May 6, 2011, although it will continue to pay claims submitted by current program participants until the funding runs out.

Any sponsor of a qualifying retiree health benefits insurance plan was 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 was required to file a single application demonstrating plan eligibility and then, after the sponsor was approved for the program, the sponsor could file for claims reimbursement as claims are incurred.

Among other items, the application required 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.

(FAQ updated 5-25-11)

277. 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.

278. 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.

279. Are there any stipulations that would prevent an employer who offers early retirement options only to their officers from being able to apply for funding via the Early Retiree Reinsurance Program?

The Early Retiree Reinsurance Program does not restrict program eligibility based on the categories of employees who are offered early retirement. *(FAQ added 8-20-10)*

XIII. MISCELLANEOUS ISSUES

280. 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.

281. 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.

282. 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.

283. **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?

Proposed rules issued by HHS on July 11, 2011 would implement Section 1312(e) of PPACA (which confirms the right of states to allow agents and brokers to play a role in the Exchanges), by providing that states "may choose to permit agents and brokers to (1) enroll qualified individuals, qualified employers or qualified employees in any QHPs in the individual or small group market as soon as the QHP is offered through an Exchange in the State; and (2) assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs." (The Proposed Rule is available at

www.ofr.gov/OFRUpload/OFRData/2011-17610_PI.pdf.) Furthermore, states are allowed to provide information regarding licensed agents and brokers on the website that states must develop as a portal to the Exchange. Agents and brokers are also among the types of persons or entities that can be eligible to serve in the "Navigator" programs for the Exchanges. The Navigator program is a separate and distinct mechanism for providing education and assistance to consumers concerning the Exchanges. Navigators would be funded by grants from the Exchanges, but there are several conditions on participating such as a prohibition on compensation from carriers in connection with QHP enrollments. . *(FAQ added/updated 7-14-11)*

284. 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.

285. 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 1099 reporting provision was repealed in April 2011. In any event, it did not directly affect whether commissions or fees could be received, but only whether such commissions or fees would be reportable by the entity that pays them. *(FAQ updated 4-28-11)*.