San Joaquin Valley Insurance Authority

Meeting Location:
Fresno County Employee Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
January 14, 2011
9:00 AM

AGENDA DATE: January 14, 2011

ITEM NUMBER: 11

SUBJECT: Receive and File Health Care Reform Information

REQUEST(S): That the Board receives the attached packet of Health Care Reform Informational Items.

DESCRIPTION: Health Care Reform, also referred to as the Patient Protection and Affordable Care Act (PPACA), has become a topic of conversation heard almost everywhere over the past year. New regulations continue to be issued regularly as this new law is interpreted. The attached packet contains documents prepared by Gallagher Benefits Services legal compliance department.

Documents attached are:

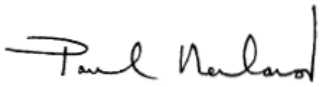
- Legislative Brief – Health Care Reform Timeline
  - Overview of the PPACA and timeline of mandatory changes to health plans through the year 2018.
- Healthcare Reform (PPACA) Year End Review
  - Brief Summary of the Mandatory Changes for the end of 2010 and into 2011.
- Advantages and Disadvantages of Retaining Grandfathered Status Under Healthcare Reform
  - Article outlining the pros and cons of retaining a plan's grandfathered status.
- Healthcare Reform Question and Answer
  - Comprehensive document covering all aspects of PPACA in a question and answer format updated December 15th, 2010 and arranged by topic.

AGENDA: San Joaquin Valley Insurance Authority

DATE: January 14, 2011

FISCAL IMPACT/FINANCING:
None.

ADMINISTRATIVE SIGN-OFF:



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Paul Nerland
Fresno County Employee Benefits Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Receive and File Health Care Reform Information

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board received and filed the attached Health Care Reform Informational items.

Gallagher

Legislative Brief

Health Care Reform Timeline

On March 23, 2010, President Obama signed into law the health care reform bill, the Patient Protection and Affordable Care Act. This legislation, along with the Health Care and Education Reconciliation Act of 2010, makes sweeping changes to the U.S. health care system. These changes will be implemented over the next several years.
This Legislative Brief provides a timeline of the implementation of key reform provisions that affect employers and individuals. Please read below for more information and contact Gallagher Benefit Services with any questions about how you can prepare for health care reform.

2010

Expanded Insurance Coverage
The health care reform law contains some provisions designed to provide improvements in access to health care coverage this year.

- **Extended Coverage for Young Adults.** Group health plans and health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children must make coverage available for adult children up to age 26. There is no requirement to cover the child of a dependent child. This requirement will apply to grandfathered and new plans.

  The Reconciliation Act added a new tax provision related to health insurance coverage for these adult children. Effective March 30, 2010, amounts spent on medical care for an eligible adult child can be excluded from taxable income.

  Note: a "grandfathered plan" is one in which an individual was enrolled on March 23, 2010, and to which there is no change to existing coverage. Many requirements of the new law do not apply to grandfathered plans and nothing in the law requires individuals terminate coverage in which they were enrolled when the law was passed. A plan can still be a grandfathered plan even if family members or new employees are allowed to join.
- **Access to Insurance for Uninsured Individuals with Pre-Existing Conditions.** The health care reform bill provides for the establishment of a temporary high risk health insurance pool program to provide health insurance coverage for certain uninsured individuals with pre-existing conditions. The program will end when the health insurance exchanges, set to be established in 2014, are operational.
- **Identifying Affordable Coverage.** The Secretary of Health and Human Services is required to establish an Internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website will also include information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits, and other information of interest to small businesses. So-called "mini-med" or limited-benefit plans will be precluded from listing their policies on this website.
- **Reinsurance for Covering Early Retirees.** The new law requires the establishment of a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program will end on January 1, 2014.

Health Insurance Reform
The new law also imposes requirements on health insurance issuers to reform certain insurance practices and improve the coverage available.

- **Eliminating Pre-Existing Condition Exclusions for Children.** Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children. This provision will apply to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.

Legislative Brief

Health Care Reform Timeline

- **Coverage of Preventive Health Services.** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive services. These plans also may not impose cost sharing requirements for preventive services.
- **Prohibiting Rescissions.** The health care reform law is designed to prohibit abusive rescissions of coverage by insurance companies when an individual gets sick as a way of avoiding covering the cost of the individual's health care needs. Group health plans and health insurance issuers offering group or individual insurance coverage may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be cancelled without prior notice to the enrollee. This provision applies to all new and existing plans.
- **Limits on Lifetime and Annual Limits.** In general, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or impose unreasonable annual limits on the dollar value of benefits for any participant or beneficiary. This requirement applies to all plans. Annual limits will also be prohibited beginning in 2014.

Health Plan Administration
In addition to any administrative changes required by the coverage improvements described above, health plans will be subject to increased administrative duties under health care reform.

- **Improved Appeals Process.** Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, plans and issuers must:
    - have an internal claims process in effect;
    - provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes; and
    - allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

  The internal claims process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001. Plans and issuers must also implement an external review process that meets applicable state requirements and guidance that is to be issued.
- **Nondiscrimination Rules for Fully-Insured Plans.** Fully-insured group health plans will now have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This section does not appear to apply to grandfathered plans.

Medicare/Medicaid
The health care reform law will further affect individuals by making certain changes to Medicare and Medicaid.

- **Rebates for the Medicare Part D "Donut Hole."** Currently, there is a coverage gap, or "donut hole," in most Medicare Part D plans. Once the plan and participant have paid $2,830 in total drug costs, the participant is in the coverage gap. The coverage gap ends when the participant has spent $4,550 (in 2010) out of pocket for drug costs in a calendar year. Health care reform provides a $250 rebate check for all Medicare Part D enrollees who enter the donut hole. Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020.
- **Medicaid Flexibility for States.** States are given a new option under the health care reform law to cover additional individuals under Medicaid. States will be able to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL).

Fees and Taxes

Legislative Brief

Health Care Reform Timeline

With a total estimated cost of over $900 billion dollars, the reform of the nation's health care system comes with additional costs and fees. These fees will also be implemented over the next several years. However, health care reform also includes some subsidies, in the form of tax credits, to help individuals and businesses pay for coverage.

- **Small Business Tax Credit.** The first phase of the small business tax credit for qualified small employers begins in 2010. These employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. When health insurance exchanges are operational, tax credits will increase, up to 50 percent of premiums.
- **Indoor Tanning Services Tax**. One additional tax imposed by the health care reform law is a 10 percent tax on amounts paid for indoor sun tanning services.

2011

Expanded Insurance Coverage

- **Voluntary Long-Term Care Insurance Options.** The health care reform law creates a long-term care insurance program for adults who become disabled. Participation will be voluntary and the program is to be funded by voluntary payroll deductions to provide benefits to adults who become disabled.

Health Plan Administration

- **Improving Medical Loss Ratios.** Health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.
- **Reporting Health Coverage Costs on Form W-2.** Beginning in 2011, employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2.
- **Standardizing the Definition of Qualified Medical Expenses.** The health care reform law conforms the definition of "qualified medical expenses" for HSAs, FSAs and HRAs to the definition used for the itemized tax deduction. Amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses. Costs for over-the-counter medications obtained without a prescription would not qualify.
- **Cafeteria Plan Changes.** The new law creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This plan is designed to ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees.

Medicare/Medicaid

- **Medicare Part D Discounts.** In order to make prescription drug coverage more affordable for Medicare enrollees, the new law will provide a 50 percent discount on all brand-name drugs and biologics in the "donut hole." It also begins phasing in additional discounts on brand-name and generic drugs to completely fill the donut hole by 2020 for all Part D enrollees.
- **Additional Preventive Health Coverage.** The new law provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminates cost-sharing for preventive services beginning in 2011.

Fees and Taxes

- **Increased Tax on Withdrawals from HSAs and Archer MSAs.** The health care reform law will increase the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.

2013

Legislative Brief

Health Care Reform Timeline

Health Plan Administration

- **Administrative Simplification.** Beginning in 2013, health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.
- **Limiting Health Flexible Savings Account Contributions.** The new health care law will limit the amount of contributions to health FSAs to $2,500 per year, indexed by CPI for subsequent years.

Fees and Taxes

- **Eliminating Deduction for Medicare Part D Subsidy.** Currently, employers that maintain prescription drug plans for their Medicare Part D eligible retirees are entitled to a tax deduction. This deduction will be eliminated in 2013.
- **Increased Threshold for Medical Expense Deductions.** The health care reform law increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- **Additional Hospital Insurance Tax for High Wage Workers.** The new law increases the hospital insurance tax rate by 0.9 percentage points on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).
- **Medical Device Excise Tax.** The law also establishes a 2.3 percent excise tax on the first sale for use of a medical device. Eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use are excepted from the tax.

2014

Coverage Mandates

- **Individual Coverage Mandates.** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at $95 per person for 2014 and increase each year. The penalty amount increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of $2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
- **Employer Coverage Mandates.** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if one employee receives a government subsidy for health coverage. The penalty amount is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.

Health Insurance Exchanges

The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. Large employers with over 100 employees are to be allowed into the exchanges in 2017. Workers who qualify for an affordability exemption to the coverage mandate, but do not qualify for tax credits, can use their employer contribution to join an exchange plan.

Health Insurance Reform

Additional **health insurance reform** measures will be implemented beginning in 2014. Specifically, health insurance companies will not be permitted to:

- Refuse to sell or renew policies due to an individual's health status;

Legislative Brief

Health Care Reform Timeline

- Exclude coverage for treatments based on pre-existing health conditions;
- Charge higher rates due to heath status, gender or other factors (premiums will be able to vary based only on age (no more than 3:1), geography, family size, and tobacco use);
- Impose annual limits on the amount of coverage an individual may receive; or
- Drop coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

Fees and Taxes

- **Individual Health Care Tax Credits.** The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.
- **Small Business Tax Credit.** The second phase of the small business tax credit for qualified small employers will be implemented in 2014. These employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
- **Health Insurance Provider Fee.** The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2018

High-Cost Plan Excise Tax

A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance (also known as a "Cadillac tax"). The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider" which can be the insurer, the employer, or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

This Gallagher Benefit Services Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

ES 4/10

November 2010

Healthcare Reform (PPACA) Year End Review

The Patient Protection and Affordable Care Act (PPACA) enacted in March 2010 is one of the most significant pieces of legislation affecting health insurance and employer-sponsored health plans since the passage of ERISA in 1974. While many of the more far-reaching reforms will not become effective for several years, some significant provisions began taking effect for some plans as early as September 23, 2010. PPACA affects far more than group health plans. It includes major changes for insurance companies selling individual health insurance, governmental plans such as Medicare, and health care providers. This year end review focuses on how PPACA affects employer-sponsored group health plans.

Following is a quick look at PPACA provisions affecting group health plans that became effective in late 2010 or will become effective in 2011. This review focuses first on changes that affect all employer-sponsored health plans. Then it summarizes guidance on determining if a plan is "grandfathered," followed by a summary of additional changes that apply to plans that do not meet the requirements to be "grandfathered." Finally, we discuss developments of special interest to employers that provide retiree health coverage, non-federal governmental plans and small employers that provide health coverage to employees.

Almost all of the regulations implementing PPACA's requirements have been developed jointly by three federal Departments: Health & Human Services (HHS), Labor (EBSA), and Treasury (IRS). Guidance as of November 01, 2010 consists of numerous sets of regulations along with additional guidance posted on the Departments websites on a regular (in some cases daily) basis.

REQUIREMENTS FOR ALL PLANS

Six major requirements apply to all employer-sponsored group health plans that are not "HIPAA excepted" (generally stand-alone dental and vision plans and most health care FSAs are "excepted"). A separate retiree health plan that covers fewer than two current employees is considered to be a "small group" which is exempt from PPACA. A plan that covers both actives and retirees is not exempt. *(see the "Special Group Health Plans" section for additional comments about non-federal governmental plans)*. Plans subject to PPACA are required to comply with the new rules starting with the first plan year than begins on or after September 23, 2010 (January 1, 2011 for a calendar year plan). Following is a summary of those six requirements:

Adult Child Coverage

Group health plans that provide coverage for dependent children must extend eligibility until the child's 26th birthday. The plan may not condition eligibility on requirements such as dependency on the employee, residency, tax status or student status for children who are the employee's:

- Natural child
- Adopted child (includes placement)
- Stepchild
- Foster child

Grandfathered plans *(see "Grandfathered Plans – Definition" section)* are not required to extend coverage to a child who is eligible for employment based coverage such as coverage as an employee or as a spouse (until 2014, when that exception expires). Plans may not make a separate charge for this coverage. Additional contributions are permitted only where the additional coverage of the adult dependent child results in a change in the coverage tier. For example, if an employee has employee + spouse coverage, the plan may charge the family rate when an older child is added. Coverage for these children may be provided on a tax-free basis (for Federal tax; state tax laws vary) until the end of the calendar year in which the child reaches age 26.

Children whose coverage ended (or were not enrolled) because of an age will have a special enrollment right when the group health plan is changed to provide coverage until the child's 26th birthday (i.e. on the first plan year after September 23, 2010, or earlier if the plan and carrier have amended to plan to extend coverage before the official effective date). These adult children must be given a notice and at least 30 days to enroll and permitted to select from the available options. Model notice language is available on the EBSA website at http://www.dol.gov/ebsa

Plans are not required to cover the child's spouse or a grandchild. If other children are eligible, such as the employee's grandchildren or the children of a domestic partner, the plan may impose additional requirements.

A more detailed discussion is available in our Healthcare Reform Update Newsletters: April 23; May 24; and September 21.

Over-the-Counter (OTC) Drugs

Beginning in 2011, group health plans -- major medical (e.g., PPO, HMO, indemnity), health reimbursement arrangements (HRAs), health care flexible spending accounts (FSAs), Archer medical savings accounts (MSAs) and health savings accounts (HSAs) -- may not reimburse drugs or medicines except:

- Drugs/medicines that require a prescription under Federal law;
- Drugs/medicines that do not require a prescription under Federal law, but only if the individual obtains a prescription for the drug; and
- Insulin.

Coverage of medical supplies such as bandages, crutches and blood sugar test kits continue to be reimbursable expenses. The new rule applies to drugs or medicines purchased in 2011. Over-the-counter drugs purchased in 2010 may still be reimbursed without a prescription. A special transition rule until January 16, 2011 applies to debit cards used by HRAs, FSAs, MSAs and HSAs.

A more detailed discussion is available in our Healthcare Reform Update Newsletter: September 21

W-2 Reporting

Employers must report the value of employer-sponsored health care coverage on the employee's W-2 form. The value must be calculated using the COBRA cost of coverage (minus 2%) and include the cost for major medical, prescription drug, EAP, and any health care FSA contributions other than salary reduction. Stand-alone dental and vision plan costs do not need to be included. The cost of dental or vision packaged with medical must be included. The new requirement applies beginning with the 2011 tax year. However, the IRS has deferred mandatory reporting until 2012. Reporting may be done in 2011 using code DD in Box 12 on a voluntary basis. The amount reportable is for informational purposes; it is not taxable and should not be included in taxable compensation which is reported in Box 1.

A more detailed discussion is available in our Healthcare Reform Update Newsletters: June 10; Oct. 14

Lifetime and Annual Dollar Limits

Lifetime dollar limits on "essential health benefits" are prohibited and restricted annual dollar limits permitted only until 2014. Plans may exclude benefits for a specific condition and/or use other types of limits such as day or visit limits. Regulators have not yet provided guidance on the scope of what constitutes "essential health benefits," but PPACA includes the following general categories:

- 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 service
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Individuals whose coverage ended because of the exhaustion of a lifetime maximum will have a special enrollment right when the group health plan is changed to eliminate the lifetime maximum. These individuals must be given at least 30 days to enroll and permitted to select from the available options. Model language is available on the EBSA website at http://www.dol.gov/ebsa.

Restricted annual dollar limits are permitted, but only until 2014 as follows:

Plan Year Beginning	Annual Dollar Limit Must be at Least
9/23/10 through 9/22/11	$ 750,000
9/23/11 through 9/22/12	$ 1,250,000
9/23/12 through 12/31/13	$ 2,000,000
1/1/14 or later	None Permitted

In order to ensure that individuals covered under certain existing limited benefit plans such as "mini med" plans do not lose coverage or face a substantial premium increase, HHS has instituted a waiver process. A group health plan or insurance company is permitted to apply for a waiver from the restriction on annual dollar limits. The waiver, if approved, is valid for one year. Plans and carriers may make a separate application for the waiver each year until 2014.

A more detailed discussion is available in our Healthcare Reform Update Newsletters: July 8; Sept. 13; and Oct. 8

Rescission

Group health plans (insured or self-funded) may rescind coverage only if: (1) the terms of the plan permit rescission and (2) the individual performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact. Rescission is defined as the retroactive cancellation or discontinuation of coverage. Rescission does not include cancellation for failure to pay premiums or contributions even if retroactive. Rescission does not include prospective cancellations. The plan must provide at least 30 days advance notice to each affected participant before coverage is rescinded.

A more detailed discussion is available in our Healthcare Reform Update Newsletter: July 8

Pre-existing Conditions Prohibited Under Age 19

Group health plans are not permitted to apply a pre-existing condition limitation to any enrollee (employee, spouse or dependent child) under age 19 starting with the first plan year beginning on or after September 23, 2010. Pre-existing condition limitations will be prohibited at any age beginning in 2014. The prohibition applies to both coverage and benefits. Self-funded non-federal governmental plans will no longer be permitted to opt out of this requirement *(see the "Special Group Health Plans" section).*

A more detailed discussion is available in our Healthcare Reform Update Newsletter: July 8

"GRANDFATHERED" PLANS – DEFINITION

The requirements above apply to all group health plans. A number of additional PPACA requirements apply only to plans that do not qualify as "grandfathered" plans. All employer-sponsored health plans were grandfathered plans on March 23, 2010 when PPACA was signed. Grandfathered status is lost only if the employer changes insurance contracts* or makes any of the following six changes:

1. Eliminate all or substantially all benefits for a specific condition.
2. Increase any percentage cost-sharing requirement (e.g., raise the employee's coinsurance from 20% to 25%).
3. Increase a deductible or out-of-pocket limit maximum that exceeds medical care inflation plus 15 percentage points. *Note: Medical care inflation is measured using the CPI, not insurance company trend. The CPI medical care inflation rate for the period August 2009 to August 2010 was 3.2%.*
4. Increase a dollar copayment by an amount that exceeds medical care inflation plus 15 percentage points (or $5 plus medical inflation if greater).
5. Decrease an employer's contribution rate toward the cost of coverage by more than 5 percentage points (e.g., change the employer's share of the cost from 80% to 70%).

6. Add an annual dollar limit** or reduce an existing annual dollar limit** (e.g., decrease a $2 million per year limit to $1 million per year for 2011).

**regulators have stated that they are reviewing this rule and anticipate providing guidance on under what circumstances a carrier change would not result in the loss of grandfathered status.*

*** to the extent permitted by PPACA.*

Plans that want to maintain grandfathered status must provide notice to participants (model language available on the EBSA website at: http://www.dol.gov/ebsa) and must maintain the documentation needed to substantiate the coverage and contributions in effect on March 23, 2010. Transitional guidance is provided for plans that made changes before March 23 that are effective after March 23 and plans that made changes after March 22, but before regulatory guidance first became available on June 14.

Two special rules apply to group health plans maintained pursuant to a collective bargaining agreement. First, an insured plan does not lose grandfathered status until the collective bargaining agreement expires (this special rule does not apply to self-funded plans). To determine if grandfathered status is retained or lost the insured plan must compare the benefits and contributions in effect at the expiration of the bargaining agreement with those in effect on March 23, 2010. Second, a change in carrier made before the collective bargaining agreement expires does not cause the loss of grandfather status.

REQUIREMENTS FOR NON-GRANDFATHERED PLANS

Of the requirements applicable to non-grandfathered plans only, one requirement applies only to a non-grandfathered health plan that is insured. Three additional requirements apply to all non-grandfathered group health. Plans are required to comply with all of these new rules starting with the later of the first plan year that begins:

- on or after September 23, 2010; or
- the first plan year that begins after the date grandfathered status is lost.

A more detailed discussion is available in our Healthcare Reform Update Newsletters: June 29; July 8; Sept 21 and Oct. 14.

Nondiscrimination Rule for Insured Health

Prior to PPACA, Internal Revenue Code Section 105(h) prohibited self-funded group health plans from discriminating in favor of highly compensated individuals. There was no similar requirement for insured group health plans (however, insured health plans included in a cafeteria plan were subject to cafeteria plan nondiscrimination requirements under IRC 125.). PPACA added a new nondiscrimination rule for insured plans that is to be "similar to IRC 105(h)." The 105(h) rules prohibit discriminating in favor of highly compensated individuals which is generally defined as the 25% highest paid "non-excludable" employees. Employees who may be excluded when testing the plan are limited to:

- part-time employees – generally defined as under 35 hours, but may be as low as 25 hours under certain circumstances;

- seasonal employees – generally defined as less than 7 months during the year, but may be as long as 9 months under certain circumstances;
- union employees where the benefits were the subject of collective bargaining;
- employees under age 25; and
- employees who are non-resident aliens with no U.S. source of income.

Plans are not permitted to discriminate either in terms of eligibility to participate or with respect to the benefits/contributions available under the plan.

The most significant difference between the rules for self-funded and insured group health plans is the penalty for discriminating in favor of the highly compensated. When a self-funded health plan is discriminatory, some or all of the benefits provided to highly compensated individuals become taxable. If an insured plan is discriminatory, the penalty is an excise tax of $100 per day for each person "to whom the failure relates." IRS Notice 2010-63 makes it clear that the penalty is $100 per day times the number of non-highly compensated individuals who are discriminated against. There is a limit of 10% of the cost of the group health plan or $500,000, whichever is less, for "unintentional" failures. Unfortunately, the IRS has not yet defined "unintentional" or provided guidance on how these penalties will be applied. The IRS Notice included a request for comments (by November 4, 2010).They are expected to provide additional guidance once they have had an opportunity to review comments submitted.

A more detailed discussion is available in our Healthcare Reform Update Newsletters: Sept. 21 and Oct. 8

Preventive Care

Group health plans are required to provide benefits for certain recommended preventive services without the application of typical cost-sharing requirements such as a deductible, coinsurance or copayments. Plans using a network model are permitted to apply cost-sharing requirements for preventive services obtained from non-network providers or to limit coverage of the required preventive services to network providers. The services that must be covered are:

- Services recommended by the United States Preventive Services Task Force with a rating of A or B.
- Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Screenings of infants, children and adolescents from the guidelines supported by the Health Resources and Services Administration.
- Preventive care and screenings for women (beyond those that would be covered in the two bullets above) which are currently under development by the Department of Health and Human Services.

Plans are permitted to apply a copay to an office visit (but not to preventive services) if the provider bills separately for the office visit and preventive services. If the office service is not billed separately, the plan may not apply an office visit copay if the primary reason for the office visit was for a preventive service. Detailed information on the required covered services is available on the HHS website at:

http://www.healthcare.gov/learn/index.html

A more detailed discussion is available in our Healthcare Reform Update Newsletter: July 23

Patient Protections

Group health plans must follow three sets of rules intended to provide patient protection:

- *Choice of a Primary Care Provider* – if the group health plan requires (or provides for) the designation of a primary care provider by adult enrollees, the plan must permit each adult enrollee to designate any participating primary care physician if the provider is available. For a child, the plan must permit the child's parents to designate any participating provider (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider. The plan is not required to permit designation of a specialist or non-participating provider.
- *Access to Obstetrical/Gynecological Care* – group health plans are not permitted to require a female enrollee to obtain pre-authorization or a referral from her primary care physician in order to receive obstetrical and gynecological care from a participating health care provider who specializes in obstetrics of gynecology. Plans are permitted to require pre-authorization or referral for a non-participating provider. The plan may require the participating provider to notify the primary care physician and may require adherence to the plan's normal rules for obtaining authorization for specified services.
- *Services in an Out-of-Network Hospital Emergency Department* – if the plan provides services in a hospital's emergency department, it must provide coverage for emergency services without the need for prior authorization (in or out-of-network) and without regard to whether the provider is a participating provider. In addition, if the emergency services are provided by an out-of-network hospital emergency department the plan: (1) may not impose any limitation more restrictive that for in-network services; (2) may not apply any other term or condition - except COB, exclusions that also apply to in-network services, or a permitted waiting period; and (3) generally must limit the enrollee's copayment and coinsurance to the in-network levels. Plans must calculate the eligible expense for the out-of-network service using the greatest of the median in-network reimbursement amounts, the amount calculated using the plan's normal payment for out-of-network services (such as reasonable and customary) or the amount that Medicare would pay for the service (Part A or B.)

Notice requirements apply and model language is available on the EBSA website.

A more detailed discussion is available in our Healthcare Reform Update Newsletter: July 8

Claims and Appeals

PPACA adds new claim and appeal requirements for all non-grandfathered health plans. It made three very significant changes to the ERISA claim rules issued in late 2000: (1) it expanded and strengthened the existing internal claim protections; (2) it added an external appeal requirement; and (3) it extended the ERISA rules to non-ERISA entities such as non-federal governmental and church plans.

Internal Appeals

The new rules expand the existing ERISA rules in several ways:

- The definition of an "adverse benefit determination" now includes a rescission of coverage or determination of eligibility to participate. It also includes any decision that a service is experimental, investigational, not medically necessary or not covered and the application of a pre-existing condition or source-of-injury exclusion.

- The maximum time frame for making an urgent care claim decision is decreased from 72 hours to 24 hours. *Note: the decision must be rendered as soon as possible which may be less than 24 hours.*
- Group health plans must take steps designed to ensure the independence and impartiality of the individuals making claim and appeal decisions.
- Notices of claim decisions (e.g., EOBs) must include more specific information such as the meaning of the diagnosis and treatment codes, the reason for the denial, and a description of the standard the plan used in denying the claim. For example, a description of a medical necessity standard used by the plan in making the determination. Under certain circumstances notices must be provided in a non-English language.

What may be the most significant change is the compliance standard which will be applied to the plan. Substantial compliance will no longer be sufficient. If the plan fails to adhere strictly to all of the rules, the claimant is deemed to have exhausted the internal appeal process and may proceed to either an external appeal or court.

External Appeals

Group health plans must have a compliant external appeals process. Responsibility for compliance with the Federal requirement depends on the funding arrangement. The insurer is responsible for insured plans; the group health plan is responsible if the plan is self-funded (even if an insurer is acting as the claims administrator). Insured and some self-funded non-ERISA plans may already be subject to state external review laws.

Self-funded ERISA plans which have historically not be required to have an external review process must now comply with the new Federal external review process. Self-funded non-ERISA plans must use the Federal external review process if their State does not have an external review process that meets certain minimum Federal standards or if that State review process is not binding on the plan.

The Federal external review process includes rules for:

- Selecting and contracting with Independent Review Organizations (IROs) to conduct the reviews. The safe harbor includes the use of at least three IROs with an impartial method of assigning reviews to each IRO.
- A four-step review process: (1) request for external review: (2) preliminary review by the plan and referral to an IRO; (3) review by an IRO; and (4) IRO decision. Each step has specific procedure to follow and maximum time frames. The IRO's decision is generally binding on the plan.
- Additional requirements for an expedited review in situations involving urgent care claims. The steps are similar to non-urgent care reviews with two differences. First, the maximum time frame is shortened and second, the external review may be conducted before the internal appeal process has been exhausted.

Regulatory guidance includes three new model notices for communicating the claim and appeal decisions which are available on the EBSA website.

A more detailed discussion is available in our Healthcare Reform Update Newsletters: Aug. 23, Sept 13 and Sept. 21.

SPECIAL GROUP HEALTH PLANS

Some of the provisions of PPACA apply only to certain group health plans or apply somewhat differently to those plans. Three special situations are: (1) early retiree health plans; (2) non-federal governmental plans; and (3) small employer plans.

Early Retiree Health Plans

PPACA added an Early Retiree Reinsurance Program (ERRP) to encourage employers to provide retiree medical coverage to pre-Medicare retirees. The law provides for reimbursement of a portion of the employer's claims cost for eligible early retirees and their dependents. The amount of reimbursement available is 80% of the cost of claims for qualified health expenses for eligible early retirees that exceed $15,000 but are less than $90,000.

Reimbursement is available only for early retirees (and their dependents) under an employment-based plan. Early retirees are defined as individuals who are age 55 or older, not eligible for coverage under Medicare, and not active employees of the employer maintaining or contributing to the retiree health plan. Plans must use the funds to reduce either the plan's or participant's costs or both. Plan sponsors may not treat the funds as general revenue for the plan sponsor. Plans are also required to have in place certain programs such as a program to detect and prevent waste and fraud and a program designed to generate cost-savings for participants with chronic and high-cost conditions.

Application for participation and claim reimbursement are done entirely on-line on a designated website using procedures similar to the Retiree Drug Subsidy program. Additional information is available on the special ERRP website at: http://www.errp.gov

A more detailed discussion is available in our Healthcare Reform Update Newsletters: April 23, May 17, June 29, Sept 13 and Oct 8.

Non-federal Governmental Plans

One other significant change made by PPACA was the elimination of an opt-out option for non-federal governmental plans such as state, county and city plans from some of the HIPAA portability requirements. Prior to PPACA non-federal governmental plans could opt out of up to seven HIPAA requirements:

1. Limitations on preexisting condition exclusions periods.
2. Requirements for special enrollment periods.
3. Prohibitions against discriminating against individual participants and benefits based on health status.
4. Newborns and mothers protection standards.
5. Mental health and substance use disorder parity.
6. Required coverage for reconstructive surgery following mastectomies.
7. Coverage of dependent students on a medically necessary leave of absence.

Non-federal governmental plans – including those who previously opted out --will no longer be permitted to opt out of the first three requirements. They may continue to opt out of requirements four through seven subject to the existing notice requirements. There is a delayed effective date for some collectively bargained plans and a special transition rule.

A more detailed discussion is available in our Healthcare Reform Update Newsletter: Oct 8

PPACA Application to Non-federal Governmental Retiree Health Plans

Prior to PPACA, separate retiree health plans that covered fewer than 2 current employees were considered to be a "small group" which was exempt from most of the HIPAA portability requirements. A plan that covered both actives and retirees was not exempt. This "small group" exemption was retained in ERISA and the tax code, but not the Public Health Service Act (PHSA) when PPACA was enacted. Under a literal reading of the PHSA, the small group exemption would not be available to retiree only plans sponsored by non-federal governmental entities. However, HHS has stated that it does not believe that it was Congress' intent to eliminate this exemption for non-federal government plans while retaining it for private sector plans. As a result, HHS has announced a non-enforcement policy with respect to stand alone retiree health plans maintained by non-federal government employers. *Note: while HHS will not enforce the PPACA requirements, there is some potential for an enrollee to sue the plan.*

Small Employer Tax Credit

Small employers that provide qualifying health care insurance to their employees may be eligible for a tax credit to offset some of the employer's cost. The maximum credit available is 35% (25% for tax-exempt employers) of the employer's portion of the premium. The credit is available to an employer with fewer than 25 full-time equivalent employees and annual average wages under $50,000. The maximum credit is available to an employer with 10 or fewer full-time equivalent employees with average annual wages under $25,000.

To be eligible for the credit, the small employer must maintain a "qualifying arrangement." In order to be a "qualifying arrangement" the employer must pay a uniform percentage of premiums with a minimum of 50% of the employee only cost for each employee enrolled in the employer's health insurance plan. A "health insurance plan" for this purpose generally includes medical, prescription drugs, dental and vision. The amount of premium eligible for the credit is limited to the average premium for the small group market in the employer's State.

The credit is available only to help offset the cost of providing coverage for employees who are not related to the owner(s). Non-employee owners such as individuals who are partners are not eligible. In addition, coverage for "family members" of the owner(s) is not eligible for the credit. Family member is broadly defined to include relatives such as aunt, nephew, in-laws, step parents and siblings, grandchildren and others.

The tax credit is available for tax years beginning in 2010 and is claimed on the small employer's annual tax return. The IRS has posted additional information about the credit on its website at:

http://www.irs.gov/newsroom/article/0,,id=223666,00.html

A more detailed discussion is available in our Healthcare Reform Update Newsletters: April 8, June 10, and Sept 13.

ADDITIONAL GBS RESOURCES ON HEALTHCARE REFORM

GBS has a number of other resources available to help employers trying to keep up with all of the changes and new requirements that are part of PPACA. In addition to our Healthcare Reform Update newsletter, we have a health care reform primer written with employers in mind, FAQs that are updated regularly, and seven (so far) recorded webcasts on healthcare reform. These materials can be accessed by using the links below.

A Primer for Employers	**http://ajg.na6.acrobat.com/p80277614/**
FAQs	**http://ajg.acrobat.com/hcr_qa/**
Recorded Webcasts: • Immediate Impact (April 8) • The Big Picture (May 3) • Initial Regulatory Impact (May 20) • Grandfather Rules (June 28) • Patient Protections (July 19) • Preventive Care & Claim Appeals (Aug 18) • Federal External Review (Sept 15)	Please use the following links to register to listen to a webcast: http://ajg.na6.acrobat.com/hcr_1/event/registration.html http://ajg.na6.acrobat.com/hcr/event/registration.html http://ajg.na6.acrobat.com/hcr_3/event/registration.html http://ajg.na6.acrobat.com/hcr_4/event/registration.html http://ajg.na6.acrobat.com/hcr_5/event/registration.html http://ajg.na6.acrobat.com/hcr_6/event/registration.html http://ajg.na6.acrobat.com/hcr_7/event/registration.html

Please contact your Gallagher Benefit Services Representative with any questions.

December 2010

Point Counter Point

Advantages and Disadvantages of Retaining Grandfathered Status Under Healthcare Reform

Under Healthcare Reform, plan sponsors have the option to maintain the health plans coverage in effect on March 23, 2010 with grandfathered status. Maintaining grandfathered status permits plan sponsors to avoid complying with some, but not all, Healthcare Reform provisions. The importance of maintaining grandfather status is a plan-by-plan consideration. For some plan sponsors there will be obvious value if their plan(s) is exempt from certain mandates. For others, the "cost" of maintaining grandfathered status will outweigh the value.

The following chart provides a quick summary of some of the advantages and disadvantages of retaining grandfathered status.

Issue	*Advantages*	*Disadvantages*
Design – Plan Provisions	• Plan is not required to provide coverage of all preventive care services listed by the US Preventive Service Task Force • Plan is not required to provide preventive health at no cost sharing – plan may still apply cost sharing provisions • Plan is not required to provide access to out-of -network emergency care without increased cost sharing or a pre-authorization requirement • Plan is not required to allow participants to designate any available PCP (or pediatrician) as their PCP • Plan is not required to allow female participants to access OB/GYN services without a referral • Plan can continue to exclude coverage for services solely because they are part of a clinical trial • Plan is exempt from cost-sharing limits effective in 2014	• Coinsurance percentages paid by participants may not be increased at all • Copayments may only be increased by the greater of: $5 (plus medical inflation) or 15% (plus medical inflation) • Fixed cost sharing arrangements such as deductibles and out of pocket maximums may only be increased by 15% (plus medical inflation) • Plan cannot eliminate or reduce benefits for the diagnosis or treatment of a condition • Ability to change insurance carriers is limited unless carrier can provide coverage that doesn't violate one of the rules to maintain grandfathered status
Eligibility	• Prior to 2014, plan may exclude adult dependent children who are eligible for other employer sponsored group health coverage	• Prior to 2014, plan must administer dependent eligibility in determining whether dependent has other employer sponsored health coverage
Claims and Appeals	• Plan is exempt from requirements to establish revised internal claims and review processes and add external review process	
Employer Contributions		• Employers cannot increase employee contributions for any tiers by more than 5 percentage points
Administrative	• Fully insured plans are not subject to new nondiscrimination tests • Plans are not required to provide certain annual reports to HHS (actual effective dates of reporting requirements have yet to be determined) • Plans are not required to provide certain notices relating to plan design	• Plan must maintain records documenting plan as in effect on 3/23/2010 including information regarding cost as of that date • Plan must maintain records of plan changes occurring after 3/23/2010 • Plan must make records available upon request of participants, beneficiaries and federal/state officials • Plan must provide notice of grandfathered status in benefit materials • Plan must provide contact information for comments and complaints
Cost	• Depending on plan design, may avoid increased costs for coverage of preventive care, certain dependents, and modification of claims and appeals process including external review.	• Prohibits management of plan costs by eliminating ability to redesign plan and/or shift costs to employees

The intent of this analysis is to provide you with general information regarding the provisions of current healthcare reform legislation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.

Healthcare Reform

Questions & Answers for Employers

Updated December 15, 2010

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

Contents

BACKGROUND

On Tuesday, March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590) ("the Act"). On Thursday, March 25, 2010, the House and Senate passed The Health Care and Education Reconciliation Act of 2010 (H.R. 4827) (the "Reconciliation Bill") which amends several provisions of the Act. Together, the bills comprise the overall healthcare reform legislation package. President Obama signed the Reconciliation Bill into law on March 30, 2010.

EMPLOYER RESPONSIBILITIES

General

1. Is there anything we have to do immediately?

Although the Act was effective on the date the President signed it, most of its provisions are not effective immediately. For example, certain coverage mandates don't take effect until the first plan year starting on or after September 23, 2010. Other provisions are phased in between 2011 and 2018.

2. Will I be required to offer health insurance coverage to my employees?

No. However, if you have at least 50 full-time employees, and you don't offer coverage, you will owe a penalty starting in 2014 if any full time employee is eligible for and purchases subsidized coverage through an exchange. This penalty is called the "free rider" penalty.

3. Our plan is self-funded. Will we have to do anything as a result of this new law?

Self-funded plans are generally treated the same as fully-insured plans under the Act. You should be analyzing the coming changes for the impact they will have on your self-funded plan.

4. We are a governmental entity. Do we have to comply with this legislation?

Yes. There are no exceptions for nonfederal governmental plans so you should be analyzing the coming changes for the impact they will have on your plan.

5. As a self funded non-Federal governmental plan, can we still opt out of the requirements of HIPAA including Mental Health Parity?

Self funded governmental plans can still opt out of some requirements including Mental Health Parity, but the opt out election will no longer be available for other requirements.

PPACA made several significant changes to the Public Health Service Act (PHSA) which resulted in changes to HIPAA's opt out provision. Prior to enactment of PPACA, sponsors of self-funded nonfederal governmental plans could elect to "opt out" of all 7 of the following requirements:

1. Limitations on preexisting condition exclusion periods.

2. Requirements for special enrollment periods.

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the Genetic Information Nondiscrimination Act of 2008).

4. Standards relating to benefits for newborns and mothers.

5. Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act of 2008).

6. Required coverage for reconstructive surgery following mastectomies.

7. Coverage of dependent students on a medically necessary leave of absence.

Under the revised PHSA, you can no longer choose to exempt your plan from categories 1 through 3 listed above, but may continue to exempt the plan from requirement categories 4 through 7. This change is effective for plan years starting on or after September 23, 2010.

6. We are a church plan and our plan is not subject to ERISA. Do we still have to comply with this legislation?

Yes. There are no exceptions for church plans so you should be analyzing the coming changes for the impact they will have on your plan.

7. Do I only have to "offer" the coverage, or do I also have to pay for the coverage to avoid the "free rider" penalty? If so, how much do I have to contribute?

Not necessarily. You are not required to offer coverage nor pay any part of the coverage if you offer it. However, employers with at least 50 full time employees who don't offer coverage or whose employee contributions exceed a certain percentage of the employee's income could be subject to a penalty starting in 2014, if any full time employee receives a premium tax credit towards purchasing their own coverage through an exchange.

If you have at least 50 full time employees and you do not offer coverage, and at least one full time employee receives a premium tax credit, you would have to pay an annual fee of $2,000 per full time employee (excluding the first 30 employees). Employees eligible for a premium tax credit are those whose household income is less than 400% of the federal poverty level.

If you have at least 50 full time employees and you offer coverage, but at least one employee receives a premium tax credit for purchasing coverage in the exchange, you would be assessed the lesser of an annual $3,000 penalty for each full-time employee who declines your coverage and instead purchases subsidized individual coverage through an exchange, or $2,000 per full-time employee. An employee who is offered coverage will only be eligible for subsidized coverage if the employee's contribution exceeds 9.8% of the employee's household income or if

the plan's share of the total allowed cost of benefits is less than 60% and the employee's household income is less than 400% of the federal poverty level.

8. I have heard we may have to provide "vouchers" which the employee can use to buy insurance through an exchange. Is that true?

Yes, in some circumstances. If you provide coverage to your employees but the employee contribution exceeds more than 8% but less than 9.8% of the employee's household income, and the individual's household income is less than 400% of the federal poverty level, you must provide "free choice" vouchers – equal to what you would have paid for single or family coverage under the company's plan – to enable these employees to purchase coverage through an exchange. If you provide a voucher and the employee purchases coverage through an exchange, you will not be subject to the "free rider" penalty as a result of that employee's purchase.

9. Do I have to "offer" and pay for dependent coverage also? What if the dependent (spouse or children) are covered by another employer's plan?

The Act does not require you to offer or pay for health coverage that includes spouses and dependent children (but see section entitled "Dependents to Age 26" for the requirements that apply to plans that provide coverage for children).

10. We don't know our employee's household income. How will we know if an employee is eligible for a voucher or premium subsidies?

It will be up to the exchange in your state to determine if an individual is eligible for a voucher or premium subsidy. You will then be notified by the exchange if/when an employee has qualified.

New: 12/15/2010

11. Will we have to report anything to the government regarding our plan's coverage or contributions?

Yes. Large employers that employed an average of at least 50 full time employees or any employer that requires any employee to pay more than 8% of wages for coverage must file an annual return with the IRS starting in 2014. You must report whether you offer full time employees the opportunity to enroll in coverage and provide certain other information including:

- The employer's name, the date, and the employer's EIN;
- A certification that you offer full time employees the opportunity to enroll in "minimum essential coverage";
- The number of full time employees you had for each month of the calendar year;
- The name, address, and taxpayer ID of each full time employee employed during the year and the months during which the employee and dependents were covered under your group health plan;
- The months coverage was available under the plan;
- The monthly premium for the lowest cost option in each enrollment category;
- Your share of total allowed costs of benefits provided under the plan;
- The length of your plan's waiting period;

- The plan option for which you pay the largest portion of the cost and the portion of the cost you paid for each enrollment category under that option.

If your plan is insured, you are permitted to enter into an agreement with your insurer to provide the above information in the return they are required to file.

A written statement will also have to be provided to each full time employee named in the return that includes the name, address and contact information of the entity that filed the return and the information in the return pertaining to that individual.

Exchanges

12. I've been hearing about "exchanges". Can you describe what they are?

Exchanges are arrangements through which private and non-profit insurers offer small employers (up to 100 employees) and individuals the ability to purchase health insurance. The Act requires each state to set up an exchange for the purchase of health insurance coverage. Coverage can be purchased through the exchanges starting in 2014. States have the option to allow large employers (more than 100 employees) to begin purchasing coverage through the exchanges starting in 2017.

Regional or national exchanges could also be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the exchange.

It is expected that each exchange will offer four categories of plans plus a catastrophic plan including:

- **Bronze plan** – Essential health benefits covering 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);
- **Silver plan** – Essential health benefits covering 70% of the plan benefit costs, with HSA out-of-pocket limits;
- **Gold plan** – Essential health benefits covering 80% of the plan benefit costs, with HSA out-of-pocket limits;
- **Platinum plan** – Essential health benefits covering 90% of the plan benefit costs, with HSA out-of-pocket limits;
- **Catastrophic plan** – Available to individuals up to age 30, or to those who are exempt from the mandate to purchase coverage. Provides catastrophic coverage only, with the coverage level set at the current High Deductible Health Plan levels except that preventive benefits and coverage for three primary care visits would be exempt from the deductible.

13. Will I have to buy health insurance for my employees through one of the new exchanges? Starting when?

No. Employers will not be required to purchase coverage through an exchange though it will initially be an option for small employers starting in 2014.

14. Am I considered a small employer for purposes of buying insurance through the exchanges?

A small employer for purposes of buying coverage through an exchange is defined as an employer with 100 or less full time equivalent employees. Prior to 2016, states can limit purchases through an exchange to businesses with 50 or fewer workers. Starting in 2017, states can allow businesses with more than 100 employees to purchase coverage through an exchange.

15. How do I determine how many full time employees I have?

Full time employees are defined as those employees who work on average 30 hours per week.

16. Are there any exclusions for seasonal and part time workers?

The health reform package does not require employers to provide coverage for employees working on average less than 30 hours per week ("part-time"). The hours worked by part time employees are counted to determine full-time equivalents for purposes of determining if the employer is subject to the employer mandate . This is done by taking the total number of monthly hours worked by part time employees and dividing by 120 to get the number of "full time equivalent" employees. Hours worked by part time employees are also counted to determine if the employer is eligible for the small business premium tax credit.

The healthcare reform package does not require employers to provide coverage for seasonal employees. Seasonal employees are workers who perform labor or services on a seasonal basis (no more than 120 days during the taxable year and retail workers employed exclusively during holiday seasons). They can be excluded from the threshold count to determine whether an employer has over 50 employees to be subject to the employer mandate. They are also excluded when determining if the employer has less than 25 full time equivalent employees for purposes of the small business premium tax credit and from the calculation of the employer's annual wage level for purposes of the credit.

Grandfathered Plans

17. I've heard that existing plans may be "grandfathered". What does that mean?

Existing plans, including plans maintained pursuant to a collective bargaining agreement, in operation as of March 23, 2010 are grandfathered if no significant changes have been made to the plan. However, certain benefit mandates included in the Act will apply.

18. It sounds like our plan is grandfathered. What benefit changes will we have to make? And by when?

The legislation includes the following mandates which all grandfathered group health plans, including collectively bargained plans, will have to comply with effective with the first plan year starting on or after September 23, 2010:

- Provide coverage to dependent children until they turn age 26 unless they are eligible for any other employer provided coverage that is not a group health plan of a parent
- Eliminate lifetime aggregate dollar limits on "essential benefits"
- Eliminate annual dollar limits on "essential benefits"(unless permitted by the Secretary)
- Eliminate preexisting condition exclusion for enrollees up to age 19
- Prohibit the rescinding of coverage except in the case of fraud, intentional misrepresentation, or nonpayment of premiums

Starting in 2014, grandfathered plans must:

- Eliminate annual aggregate benefit limits
- Provide coverage of dependents to age 26 regardless of eligibility for other coverage
- Eliminate preexisting condition limitations for adults
- Eliminate waiting periods of greater than 90 days

19. Our plan is collectively bargained and we heard that we don't have to make any changes until the last collective bargaining agreement expires. Has that changed?

Initially, it appeared that there was a delayed effective date for collectively bargained plans but that's not the case. Insured and self funded plans maintained pursuant to a collective bargaining agreement ratified before March 23, 2010 are deemed to be grandfathered plans. Because they are grandfathered plans, they are subject to the same reforms and effective dates as any other grandfathered plan.

For insured collectively bargained plans only, the plan will remain grandfathered until the last agreement expires, even if plan changes, including changing insurers, are made during the collective bargaining agreement that would normally result in a loss of grandfathered status.

After the last collective bargaining agreement expires, the determination of whether the plan is still grandfathered is made by comparing the coverage on the expiration date with the coverage that was in effect on March 23, 2010.

20. We also provide dental and vision coverage to our employees. Are we required to make these changes for those plans as well?

Maybe. The mandated changes for grandfathered plans only apply to your group health plans that are not "excepted benefits" as defined under HIPAA. If your dental and/or vision are excepted benefits, then you are not required to make any of the required changes for those coverages.

HIPAA excepted benefits include most health FSAs and limited scope dental and vision plans. Limited scope dental and vision benefits are those benefits that are either provided under a separate policy or contract of insurance or are not an integral part of the group health plan (i.e. employees can waive the dental or vision; and employees who elect the dental or vision pay an additional amount).

21. We provide retiree health coverage for our retired employees. Will these benefit mandates apply to our retiree plan?

It depends. There is an exception for retiree-only plans subject to ERISA that cover fewer than two active employees. For health insurers and nonfederal governmental plans subject to the Public Health Service Act, HHS has indicated they will apply a "non-enforcement" policy for insured retiree-only plans and retiree plans sponsored by non-federal governmental entities. In addition, HHS is encouraging states, which have enforcement authority over insurers, not to enforce the new health care reform provisions on these plans.

If your retiree plan covers both retirees and active employees under the same plan, then the exception will not apply and the health care reform provisions that apply to the plan will apply to both active and retired employees covered under the plan.

If your retiree plan also covers individuals on long-term disability, the answer is not clear. Until guidance is issued, HHS will treat these plans as satisfying the exception and will not apply either HIPAA or the health care reform mandates to this type of plan. However, HHS will be reviewing these types of plans and will be releasing a request for information on this area soon. After reviewing the comments submitted, they intend to publish guidance in 2011, and if more restrictive, it will be prospective, applying to plan years that begin sometime after issuance. Pending such further guidance, if you choose to adopt any or all of the HIPAA or health care reform mandates, it will not prejudice your exemption.

22. What if I like some of these changes and want to incorporate them into my plan now? Can I do that and still meet the "grandfathered plan" rules?

If you would like to immediately adopt any of the mandated changes, it will not affect your plan's status as a grandfathered plan.

23. We made some plan design changes that are effective 7/1/10. Will they result in a loss of grandfathered status?

It depends. Certain plan changes made after March 23, 2010 will result in a loss of your plan's grandfathered status unless the changes were adopted or incorporated into a legally binding contract that was executed before June 14, 2010 (See the Q&A on "transition rules' later in this section). The changes that can cause a loss of grandfathered status are more specifically described below and include any decrease in the plan's coinsurance amount, reductions in annual limits or employer contributions, reductions in benefits for the treatment or diagnosis of a particular condition, and in some cases, a change of insurers. Also, increases in coinsurance, copays, deductibles and out-of-pocket maximums can cause your plan to lose grandfathered status. If your plan changes are any of the increases described above, it will require an analysis of the amount of the increase compared to increases in medical inflation.

Update: 12/15/2010
Clarification

24. Specifically, what are the changes that cause a plan to lose grandfathered status?

Any of the following six plan design changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a plan to lose grandfather status:

1. Elimination of all or substantially all benefits for a particular medical condition.

2. Any increase in the employee's coinsurance percentage.

3. A deductible or out-of-pocket maximum increase that exceeds medical inflation plus 15%.

4. A copayment increase that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation).

5. A decrease in the employer contribution towards the cost of coverage by more than 5%.

6. Imposition of annual limits on the dollar value of all benefits below specified amounts.

These six changes are the **only** plan design changes that will cause a cessation of grandfather status.

25. How do we know what medical inflation is?

Medical inflation is 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. To calculate medical inflation, 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) 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 CPI – U values can be found on the Bureau of Labor Statistics website at:

http://www.bls.gov/cpi/tables.htm

26. If all we are doing is changing insurers, that will cause a loss of grandfather status?

It depends. If the change in insurers was effective after March 23, 2010 but prior to November 15, 2010, your plan has lost grandfathered status.

If you changed insurers and your new insurance policy was effective on or after November 15, 2010, your plan does not lose grandfathered status unless your new policy includes plan design changes that, when compared to the previous insurance policy, would exceed the allowable changes that generally cause a plan to lose grandfather status (e.g. increase in cost sharing, significant increases in copays, deductibles, etc.).

27. Is there anything we have to provide to the new insurer regarding the benefits and contributions we had under the prior insurer?

Yes. You must provide to your new health insurer documentation of the benefits, cost sharing, employer contributions, and annual limits under the prior insurer

sufficient to determine whether any plan changes that would cause a loss of grandfathered status have been made.

28. Our plan is self funded and we are changing our third party administrator (TPA). Will that cause our self funded plan to lose its grandfathers status?

No. changing third party administrators will not result in the loss of grandfathered status for your self funded plan.

29. Our plan is currently insured but we are considering a change to self funding and changing our PPO network. Would these changes cause our plan to lose grandfathered status?

The guidance we have does not address the effect of changing your plan's funding mechanism from insured to self funding or changing networks. Further guidance is necessary on this question and it may also depend on the date you make the changes. What we do know is that changing from self funding to insured coverage will cause a loss of grandfathered status because it will require a new insurance contract.

The agencies responsible for enforcing the rules have invited comments from the public regarding the effect of these types of changes (or any other changes) so we anticipate that further guidance will be forthcoming. However, it appears that any new standards subsequently published in the final regulations that are more restrictive than what was included in the interim final regulations would only apply prospectively to changes to plans made after the publication of final rules.

30. We are thinking of amending our plan to delete coverage for depression. If we make this change, will it cause our plan to lose its grandfathered status?

Yes. The elimination of all benefits or substantially all benefits to diagnose or treat a particular condition will cause a loss of grandfathered status.

31. Our plan currently pays 90% of covered services and the employee pays 10%. We want to reduce our share to 80%. Would that cause the loss of grandfathered status?

Yes. Any increase in the participant's coinsurance amount will cause the plan to lose grandfathered status.

32. Our plan currently pays 90% of covered services but we want to reduce that to 50% for durable medical equipment only. Would that cause a loss of grandfathered status?

Yes. Because it is an increase in the participant's coinsurance amount, it would cause the plan to lose grandfathered status.

33. Our plan is facing a significant premium increase this year so we want to raise the deductible. What effect will this have on our grandfathered plan status?

It depends. Employers are permitted to raise plan deductibles (or other fixed cost sharing amounts such as out-of-pocket limits) but your plan would cease to be a

grandfathered plan if the increase since 3/23/10 is greater than a percentage equal to medical inflation plus 15%.

Example: On March 23, 2010, a grandfathered health plan has a $300 deductible. The plan is subsequently amended to increase the deductible to $400. As of March 23, 2010, the medical care component of the CPI-U is 387.142. Within the 12-month period before the $400 deductible takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475.

Conclusion: The increase in the deductible from $300 to $400 is an increase of 33.33%. Medical inflation from March 2010 to the date of the change is 0.2269 (475 – 387.142 = 87.858; 87.858/387.142 = 0.2269). Therefore, the maximum percentage increase in the deductible permitted is 37.69% (0.2269 = 22.69%; 22.69% + 15% = 37.69%). Because a 33.33% increase does not exceed 37.69%, the change in the deductible would not cause the plan to lose its grandfathered status.

34. Our plan has a $10 office visit copay. We want to raise it to $20. Will this cause our plan to lose grandfathered status?

Maybe. The increase to your copay will result in a loss of grandfathered status if the increase is more than the greater of:

$5 (adjusted for medical inflation); or

A percentage equal to medical inflation plus 15%.

Example: On March 23, 2010, a grandfathered health plan has a $30 office visit copay. The plan is subsequently amended to increase the copay to $40. Within the 12-month period before the $40 copay takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 455.

Conclusion: The increase in the copayment from $30 to $40 is 33.33%. Medical inflation from March 2010 is 0.1753 (455 – 387.142 = 67.858; 67.858/387.142 = 0.1753). The maximum percentage increase permitted is 32.53% (17.53% + 15% = 32.53%). Because 33.33% exceeds 32.53%, the change in the copayment requirement at that time will cause the plan to lose its grandfathered status.

35. We want to raise the copayment for office visits, but leave all other copayments the same. Will that one change cause our plan to lose grandfather status?

Yes. Any copayment increase that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation) from March 23, 2010, will cause a plan to lose grandfather status, even if all other copayment amounts remain the same.

36. We have just received our renewal for 8/1/10 and we need to lower our contribution and increase the employee's contribution percentage for family coverage. Currently, we pay 100% of the employee's coverage and 80% of the family coverage and we want to reduce the 80% to 50%. Will this change cause us to lose grandfathered status?

Yes. To retain grandfathered plan status, you cannot decrease the percentage of premiums you pay by more than 5 percentage points below your contribution rate

on March 23, 2010. This rule applies to any tier of coverage (e.g. self-only, 2 person, family, etc.) for any class of employee. Because the decrease in your contribution for family coverage would be 30%, your plan would lose grandfathered status.

37. Our plan has an annual limit of $500,000. If we reduce that amount to $250,000, will the plan lose grandfathered status?

Yes. Grandfathered status is lost when the annual limit is reduced by any amount. Similarly, if a plan did not have an annual limit on March 23, 2010, grandfathered status is lost if one is added at a later date.

38. We are going to significantly reduce benefits and increase employee contributions for our PPO option at next renewal but we are not changing our HMO option. Does our plan lose grandfathered status for both plan options or just the PPO option?

If the changes to the PPO result in a loss of grandfathered status, only the PPO option will be affected. The HMO option will remain grandfathered for as long as no changes are made to the HMO option that would result in a loss of grandfathered status.

39. We are going to change the tiers of coverage under our plan from self-only and family to a multi-tiered structure of employee-only, employee+one, employee+two and employee+three or more. Will our plan lose grandfathered status?

The determination of whether the change in employer contribution will cause a loss of grandfathered status is made on a tier-by-tier basis. So, if you change the tier structure from what was in place on March 23, 2010, your contribution for any new tier is tested by comparing it to the contribution rate for the corresponding tier on March 23, 2010. For example, if your contribution rate for family coverage was 50% on March 23, 2010, then your contribution rate for any new tier, other than employee-only, must be within 5% of 50% (or at least 45%). If it is lower than 45%, you would lose grandfathered status.

If, however, your new tier structure only adds a new coverage tier, without eliminating or modifying any other coverage tier, and those individuals eligible under the new tier were not previously covered under the plan, then the new tier would not be compared to those in place on March 23, 2010, and would not cause the plan to lose grandfathered status.

40. Before we knew what changes would affect grandfathered status, we made several plan changes for our May 1, 2010 renewal that will result in a loss of grandfathered status. Are there any exceptions that would allow us to keep these changes without losing our grandfathered status?

Yes. There are two “transition rules” that if applicable, may allow you to keep your plan changes without losing grandfathered status.

The first transition rule says that if the changes were adopted prior to March 23, 2010, they would be considered part of the plan as of March 23rd, even though they were effective at a later date. A change is deemed to be adopted if the changes

were incorporated into a legally binding contract that was executed on or before March 23, 2010 or if a written plan amendment was adopted on or before March 23, 2010.

The second transition rule says that if plan changes were made prior to June 14, 2010 (the date regulations were released), the plan will not lose its grandfathered status if:

1. the plan changes that cause the loss of grandfathered status are revoked or modified effective by the first day of the first plan year beginning on or after September 23, 2010; and

2. the terms of the plan, as modified, would not otherwise cause the plan to lose grandfathered status.

41. We have to make changes due to Mental Health Parity for our next plan year starting on August 1, 2010. Will these changes cause our plan to lose grandfathered status?

No. Plan changes made to comply with Federal or State legal requirements will not cause a loss of grandfathered status unless the mandated changes exceed the allowable changes established in the grandfathered plan regulations.

42. If we lose our grandfathered status, what are the other health care reform requirements that will apply?

In addition to the changes required for grandfathered plans, any new plan or any plan that loses its grandfathered status will have to comply with the additional requirements listed below effective for plan years starting on or after September 23, 2010:

- Provide coverage to children to age 26 regardless of whether they are eligible for other employer-sponsored coverage;
- Coverage for recommended preventive services, without cost sharing
- For emergency room care:
  - No pre-authorization permitted – in or out of network
  - Identical coverage in and out of network
- For Primary Care Physician Designations:
  - Participants may designate any available participating primary care provider
  - Parents may select pediatrician for child(ren)
  - May not require authorization or referral for OBGYN care from participating obstetrician or gynecologist
- New claims appeal rules including both internal and external review
- Nondiscrimination rules for fully insured health plans under Code §105(h)

For plan years starting on or after January 1, 2014, new plans or plans that have lost grandfathered status will have to comply with additional requirements including:

- No discrimination against individuals participating in clinical trials (insured plans only);

- No discrimination based on health status
- Provide essential benefits and prohibit cost sharing in excess of the limits for qualified high deductible health plans (insured plans only)

43. We intend to keep our plan grandfathered as long as possible. Is there anything we have to do to verify we have not made any changes that would result in the loss of grandfathered status?

Yes. You will be required to maintain records of your plan's grandfathered status for as long as the plan takes the position that it is grandfathered. This means you must maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify your plan's status as a grandfathered health plan. This should include intervening and current plan documents, health insurance policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates.

In addition, you must make these records available for inspection to participants or State or Federal agencies upon request.

44. Will we have to tell our employees about our plan's grandfathered status?

Yes. To maintain status as a grandfathered plan, you must disclose, in any plan materials provided to participants, that your plan believes it is a grandfathered plan under PPACA. This includes SPDs, open enrollment materials, or materials provided upon opportunities to enroll in, renew or change coverage. The disclosure must also provide contact information for questions and complaints. The following model language can be used to satisfy the grandfathered plan disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.]

Dependents to Age 26

45. Our plan currently covers children to age 23, so we'll have to extend that to age 26. When do we have to do that? Can we do it now?

For grandfathered plans, the change must be made by the first day of the first plan year that starts on or after September 23, 2010. For example, a calendar year plan would have to comply by January 1, 2011. However, the change can be made sooner. You should make sure the insurer or stop loss carrier approves the change if you intend to implement it prior to the required effective date.

For insured plans, many insurers are implementing this change ahead of the actual effective date. You can contact your insurer for more information on how this change will affect your plan.

46. Do we have to offer coverage to adult children even if the "child" already has coverage through their own employer's plan?

Not for plan years starting prior to 2014, if your plan is grandfathered. Until then, you must provide coverage to dependent children until they turn age 26, unless they are eligible to enroll for any other employer provided coverage that is not a group health plan of a parent. This could include coverage through their own employer's plan or through a spouse's employer's plan.

While it is not entirely clear from the guidance we have, it appears that the child is not treated as eligible for other coverage until the first date the individual can actually enroll and be covered under the plan. For example, if the child is eligible for other coverage but cannot be enrolled due to plan restrictions, they probably remain eligible under the parent's plan until such time they can actually enroll in the other plan. Also, coverage cannot be denied under the parent's plan if the child is only eligible to enroll for COBRA coverage under their former employer or spouse's former employer's plan.

For nongrandfathered plans and all plans starting in 2014 and later, coverage must be available regardless of whether the child has any other coverage (but COB rules may still apply).

47. Our plan covers step children and in some cases grandchildren if they meet specific criteria. Will we now have to cover them to age 26 as well?

The DOL issued "safe harbor" guidance that says plans that cover the following categories of children to age 26 will be in compliance with this requirement:

- Biological children (sons, daughters);
- Stepchildren;
- Adopted children (including children placed for adoption); and
- Foster children who are placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Coverage can be discontinued for children in any of the above categories prior to age 26 if the applicable relationship no longer exists.

For an individual who is not in one of the four categories, such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

48. Can I just continue the children already on my plan, or do I have to go back and offer the coverage to those who have already aged out?

If the child's coverage under your plan was ended (or if the child was not eligible for coverage) because, under the terms of the plan, coverage was not available to age 26, you are required to give children under age 26 a special enrollment opportunity of at least 30 days. This special enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010.

49. Am I required to tell employees about this opportunity? How do I do that and by when?

Yes. You must provide a written notice to employees describing the special enrollment opportunity. You can give or send the notice to the employee or it can be included with other enrollment materials, provided the statement describing the special enrollment opportunity is highlighted. This notice must be provided no later than the first day of the first plan year starting on or after September 23, 2010. For example, a calendar year plan would have to provide the notice and the 30-day special enrollment opportunity no later than January 1, 2011.

The DOL has issued a model notice for this purpose which can be downloaded in Word format from their website at:

http://www.dol.gov/ebsa/healthreform/

50. Do I have to offer the coverage to an adult child who has aged out, but is currently on COBRA?

Yes. If the child who aged out has elected COBRA, the plan must allow the child to be enrolled as a dependent of an active employee. In addition, if the child subsequently loses eligibility due to a qualifying event, the child would have another opportunity to elect COBRA.

51. Can I charge more for these adult children?

In most cases, no. The employee cannot be required to pay more for a child's coverage based on their age (e.g. adding a surcharge for children over age 18 or over age 23). However, an additional surcharge for adult children could be applied if that surcharge is applied for every new child added to the plan regardless of age.

52. Can I offer a more limited benefit to these adult children?

No. The benefits or coverage cannot vary based on the child's age. It must be identical to the coverage that is provided to similarly situated children who are not adult children.

53. If the adult child is married are they still allowed to have the coverage?

Yes. Eligibility for coverage of children up to age 26 cannot be based on factors such as financial dependence, student status, residence, or marital status.

54. Do I have to cover the spouse or child (the grandchild of the employee) of the adult child too?

No. Plans that provide dependent coverage are only required to provide coverage to the employee's children (e.g. biological or adopted children) until the age of 26. The plan is not required to provide coverage to the employee's son-in-law or daughter-in-law or grandchildren.

55. We have an employee whose child is 25 but is not a full time student, does this mean we will have to calculate imputed income for that employee?

Not for federal tax purposes. The definition of a tax dependent in the Internal Revenue Code for group health plan purposes was amended as part of the health care reform package to include children until the end of the year they turn age 26. This change will also apply to children to age 26 who are covered under a plan that currently extends coverage to children to age 26 (or older).

The IRS has now issued Notice 2010-38 that offers guidance on the tax exclusion for these adult children. It clarifies several items including:

- Child is defined as son/daughter, step son/daughter, adopted child or eligible foster child, without regard to whether the child is financially supported by the employee or resides with the employee or is a full time student
- Coverage for these adult children can be paid for on a pretax basis under a §125 cafeteria plan
- The change in status regulations will be amended so that employees can add coverage under a §125 plan for a newly-eligible adult child where the plan has been amended mid-year to add the adult child coverage.

56. Does the same change apply for state tax purposes?

Not necessarily. In some cases, states have adopted the federal definition of gross income so that whatever is included (or not included) in income for federal purposes also applies at the state level. However, there are some states (e.g. California) where this is not the case. For those states, the state tax code will address whether and to what age dependent child coverage should not be included in income for state tax purposes. Your payroll vendor or tax counsel should be able to provide you with information on each of the states where you have employees.

Preexisting Condition Exclusions

57. Our plan has a preexisting condition limitation. Will we have to change it or eliminate it?

Yes. Starting with your first plan year beginning on or after 9/23/10, a preexisting condition limitation cannot be applied to any enrollee who is under age 19. This includes employees and spouses under age 19 and dependents under age 19.

Starting with your first plan year beginning on or after 1/1/14, preexisting condition limitations will be prohibited for all plans and all covered individuals so you will have to eliminate it altogether by that date.

58. We have a plan provision that excludes coverage for services that are the result of an injury that occurred before the effective date of the employee's coverage. Is this still permissible?

Because this provision operates to exclude benefits for a condition that was present before the effective date of coverage, it is considered a preexisting condition exclusion. Therefore, it will be subject to the same rules described above. Starting with your next plan year beginning on or after 9/23/10, it cannot be applied to enrollees under age 19, and then starting in 2014, it will have to be eliminated.

Lifetime and Annual Maximums

59. We have two plan options. One has a $1 million lifetime maximum and the other has a $2 million lifetime maximum. How will these maximums be affected?

Effective with your first plan year starting on or after 9/23/10, lifetime maximums that apply to essential benefits will have to be eliminated regardless of whether or not your plan is grandfathered.

60. How do we know what benefits are "essential benefits"?

The Act defines "essential benefits" to include the following categories of coverage:

- 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
- Pediatric services, including oral and vision care

At this time there is no guidance on the specifics of these benefit categories but it is expected that regulations defining "essential benefits" will be published in the future. Until these regulations are issued, the agencies enforcing PPACA have said they will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits".

61. Can we still keep our lifetime limit for benefits that are not considered "essential benefits"?

Yes. Lifetime limits on benefits that are deemed not to be essential benefits are permitted.

62. We have an employee who dropped coverage at our last open enrollment because her daughter's claims exceeded the lifetime maximum and no further claims were going to be paid. Do we have to let her back on the plan?

Yes. If she is eligible for coverage, you must inform the employee in writing that the plan's lifetime maximum no longer applies and she and her daughter are allowed to enroll in the plan and the daughter is eligible for benefits again.

63. Do we have to notify employees who exceeded the lifetime limit that they can return to the plan? How long can they have to reenroll?

Yes, you must provide them with at least 30 days to enroll and the enrollment opportunity must be provided no later than the first day of the first plan year starting on or after 9/23/10. If they enroll, the coverage must start no later than the first day of that plan year.

The DOL has issued a model notice for this purpose which can be downloaded in Word format from their website at:

http://www.dol.gov/ebsa/healthreform/

64. Can we require her to enroll in the plan option she was enrolled in when her daughter's claims exceeded the lifetime maximum?

No. She must be offered all the benefit options available to similarly situated employees.

65. Our plan has no lifetime maximum but it has an annual maximum of $500,000. Will we have to change or eliminate the annual maximum?

Yes. Starting in 2014, plans cannot have annual maximums on essential benefits. For plan years beginning before 1/1/14, you can have an annual maximum on essential benefits provided the limit is no less than:

- $750,000 for a plan year beginning on or after September 23, 2010, but before September 23, 2011,
- $1,125,000 for a plan year beginning on or after September 23, 2011, but before September 23, 2012, and

- $2,000,000 for plan years beginning on or after September 23, 2012, but before January 1, 2014.

66. Our plan has an annual maximum of $10,000 for chiropractic care. Do we have to remove the limit?

Until HHS has provided more guidance on the specifics of what is an essential benefit and whether chiropractic care would fall under one of the categories of essential benefits, it's not possible to answer this question. Until these regulations are issued, the agencies enforcing PPACA have said they will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits".

An alternative to having annual dollar maximums might be to replace them with day or visit limits, which are not limited or restricted for chiropractic care at this time.

67. We offer our employees a high deductible health plan combined with a Health Reimbursement Arrangement (HRA). We contribute $1,000 annually to each employee's HRA. Does the elimination of annual limits mean we have to change our HRA?

No. When HRAs are integrated with other coverage under a group health plan (e.g. with a high deductible plan), and the other coverage is in compliance with all the applicable health insurance reform provisions, the fact that the benefits are limited under the HRA does not cause it to violate PPACA.

Update: 12/15/2010
Clarification

68. We have a lot of minimum wage employees who can't afford our health plan so we offer them a "mini-med" plan that has a $75,000 annual maximum. Will we have to raise that maximum?

Maybe not. HHS has introduced a program for health plans and/or insurers to request a waiver from the restricted annual limit requirements of PPACA for so-called "limited benefit" or "mini-med" plans. Under the program, the plan or insurer can request a waiver from the annual limit requirements if complying with the annual limit requirement would result in a significant decrease in the access to such benefits or if it would result in a significant increase to the cost of the coverage.

The application for waiver must be filed at least 30 days before the beginning of the plan or policy year. In the case of a plan or policy year that begins before November 2, 2010, the application must be submitted at least 10 days before the beginning of the plan or policy year. For calendar year plan years, the application must be filed by December 1, 2010.

It is important to note however, that this waiver only applies to the annual limit restriction. All the other health insurance reform provisions of PPACA apply to limited benefit or mini-med plans on the same basis as any other group health plan or policy.

Group health plans or insurers that are approved for the waiver must provide a notice informing current and eligible participants that the plan or policy does not meet the minimum annual limits for essential benefits and has received a waiver of

the requirement. The notice is also required to include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies. In addition, the notice is required to state that the waiver was granted for only one year. For plans or issuers that have already been approved for a waiver for plan or policy years that begin before February 1, 2011, or that will receive approvals for plan or policy years that begin before February 1, 2011, the notice must be provided to current and eligible participants and subscribers within 60 days from the date of issuance of this guidance. For applicants for waivers covering plan or policy years that begin on or after February 1, 2011, the notice must be provided to eligible participants and subscribers as part of any informational or educational materials, and also in any plan or policy documents evidencing coverage that are sent to enrollees (e.g., summary plan descriptions). The guidance and model language for this notice can be found on the HHS website at:

http://www.healthcare.gov/center/regulations/guidance_limited_benefit_2nd_supp_bulletin_120910.pdf

Rescissions

69. PPACA prohibits "rescissions". What does this mean and how will it affect our plan?

Rescissions are defined as a cancellation of coverage that has a retroactive effect. Rescissions are prohibited unless the termination is due to fraud, or an intentional misrepresentation of a material fact, and are permitted by the written terms of the plan. Therefore, effective for plan years starting on or after September 23, 2010, your group health plan will not be permitted to terminate coverage retroactively under any circumstances unless the employee performs an act of fraud, or the employee intentionally misrepresents a material fact and the plan has been drafted or amended to provide that such misrepresentations will result in a termination of coverage.

Retroactive cancellation of coverage due to a failure to pay timely premiums is not considered a rescission.

70. We have several locations and sometimes we are not immediately notified by supervisors or managers when an employee loses eligibility for plan coverage when they are reassigned to a part time position. We can still terminate coverage retroactively in those cases, right?

Yes, as long as you did not continue withholding contributions from the employee's paycheck and paying claims. If you continued to withhold contributions and provide coverage, then the coverage can only be terminated prospectively.

Example. Joe has coverage under the plan as a full-time employee. The employer reassigns Joe to a part-time position and Joe is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from Joe's paycheck and paying claims submitted by Joe. After a routine audit, the plan discovers that Joe is no longer eligible. The plan rescinds Joe's coverage effective as of the date he changed from a full-time employee to a part-time employee.

Conclusion. The plan cannot rescind Joe's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may only cancel coverage for Joe prospectively.

71. We only reconcile our bill or data feed for eligible employees and dependents once a month. Can we still retroactively terminate employees and dependents off our coverage on that reconciliation back to the end of the previous month?

If you cover only active employees and families (and COBRA participants) and the individual who is no longer eligible for coverage pays no premiums for coverage after the termination (subject to COBRA), then it will not be considered a rescission, but rather a retroactive elimination of coverage back to the date of termination, due to delay in administrative recordkeeping.

72. What if we have an employee who notifies us of his final divorce from his spouse. Are we allowed to terminate the coverage of the spouse retroactively to the date of the divorce?

If your plan does not cover ex-spouses (other than under COBRA) and the COBRA premium is not paid by the employee or ex-spouse, then you are allowed to retroactively terminate coverage back to the date of divorce without it being an improper rescission. Of course, COBRA may require coverage to be offered for up to 36 months, if the COBRA premium is paid.

Patient Protections

73. What are the special rules that will apply to our HMO option regarding the choice of primary care physicians (PCP)?

The new rules on PCPs are effective for plan years starting on or after September 23, 2010 but only apply to nongrandfathered plans. If your HMO option is not grandfathered, you must allow participants or beneficiaries to elect a PCP including:

- Designating any participating primary care physician who is available to accept the individual; and
- Designating any participating physician who specializes in pediatrics who is available as a child's PCP.

74. We read that HMOs cannot require females to get authorization for OB/GYN services. How does that work?

This new rule applies only to nongrandfathered plans. If your HMO option is not grandfathered, it cannot require an authorization or a referral from the HMO or a PCP for a female seeking OB/GYN services from a participating health care professional (i.e. physician, physician assistant, midwife, etc.) who specializes in OB/GYN care.

75. Do we have to notify the employees enrolled in or enrolling in the HMO of these new rules?

Yes. If your nongrandfathered HMO plan requires the designation of a PCP, you must provide a notice informing each employee of the following:

- The plan requirements for electing a PCP;
- That any participating primary care physician who is available to accept the participant can be designated as a PCP;
- That any participating physician who specializes in pediatrics can be designated as a PCP for a child;
- The plan may not require authorization or referral for OB/GYN services provided by a participating professional who specializes in OB/GYN care.

This notice must be included in the plan's SPD or any other similar description of the benefits under the plan. The DOL has issued a model notice for this purpose which can be downloaded in Word format from their website at:

http://www.dol.gov/ebsa/healthreform/

76. There are new rules for emergency room services. How will they affect our plan?

These rules apply only to nongrandfathered plans. If your plan is not grandfathered, it must provide coverage for emergency room services in the following manner:

- Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;
- Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; and
- If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers.

Also, if the emergency services are provided out of network, the copays or coinsurance amounts imposed cannot exceed the amounts imposed for in network emergency room services.

Preventive Care

77. Our plan currently provides coverage for preventive services but we apply copays and deductibles to those services. I've heard we will have to eliminate these cost-sharing provisions. Is that true?

The Act does require new plans to provide first dollar coverage to certain specified preventive services and immunizations for plan years beginning on or after September 23, 2010, but this requirement does not apply to grandfathered plans.

78. We may have one plan option that is not grandfathered. What are the preventive services that the plan will have to cover without cost-sharing?

- Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A list of the required services can be found on the HHS website at:

http://www.healthcare.gov/law/about/provisions/services/lists.html

79. Does our nongrandfathered option have to provide 100% coverage for both in-network and out-of network services on the list?

No. You are only required to eliminate cost sharing provisions on in-network providers. You are permitted to impose cost-sharing on covered preventive services that are delivered by out-of-network providers.

80. Our nongrandfathered option has a limit on well baby visits per year. Can we keep that or other limits on the applicable preventive services?

Yes. Nothing in the regulations prevents you from using reasonable methods to determine the frequency, method, treatment, or setting for an item or service on the list as long as it doesn't conflict with specific recommendations in the guidelines. Reasonable medical management techniques may generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review or similar practices.

81. What if an employee goes to their doctor for an office visit but also gets one of the recommended preventive services at the same time. Can we still apply a copay to the office visit charge?

It will depend on the situation:

- If a preventive service is billed separately from the office visit and the primary purpose of the visit is not for preventive purposes, then you may impose cost-sharing requirements with respect to the office visit.
- If a preventive service is not billed separately from the office visit and the primary purpose of the office visit is for preventive services, then you may not impose cost-sharing requirements with respect to the office visit.
- If a preventive service is not billed separate from the office visit and the primary purpose of the office visit is not for preventive purposes, then you may impose cost-sharing requirements with respect to the office visit.

Internal Claim and Appeal Process and External Review

82. What happens when there are changes to the recommendations or guidelines for covered preventive services?

If something new is added to the recommendations or guidelines, your plan will not have to cover it until the plan year that begins on or after one year after the date the recommendation or guideline is issued.

If a recommendation or guideline is dropped, your plan will not be required to provide coverage after the recommendation or guideline is dropped.

83. What are the new claims and appeals processes and how will they apply?

Starting with the first plan year beginning on or after September 23, 2010, both insured and self-funded plans that are not grandfathered must implement new claims and appeal procedures and an external review process. Nongrandfathered plans (and insurers) will have to incorporate the current ERISA claims and appeals requirements and update them based on additional changes in PPACA. In addition, adverse benefit determinations will be subject to an external review process.

84. Our plan is a governmental plan that is not subject to ERISA and does not follow the current ERISA guidelines. Will we have to update our internal claim and appeal process?

Yes, if your plan loses its grandfathered status. Because PPACA applies to all group health plans, you would have to incorporate the current ERISA claims and appeals processes as updated by PPACA for your plan.

This same rule will apply for church plans that are not currently subject to the ERISA claims and appeals process.

85. What changes did PPACA make to ERISA's current claims and appeals rules?

There were really six changes made:

1. An adverse benefit determination now includes any rescission of coverage;

2. Urgent care benefit determinations must be made as soon as possible, but not later than 24 hours (reduced from 72 hours) after the receipt of the claim by the plan;

3. The plan must provide, free of charge, any new or additional evidence or rationale used by the plan in connection with the claim determination. This evidence must be provided in advance to give the participant a reasonable opportunity to respond prior to the review date;

4. The plan must ensure that all claims and appeals are reviewed in a manner designed to ensure the independence and impartiality of the persons involved in making the decision;

5. The plan must provide notices of adverse benefit determinations to enrollees in a culturally and linguistically appropriate manner. Moreover, additional content requirements apply for these notices to identify the claim involved, including, for example, the diagnosis, treatment, and denial codes and contact information for any office of health insurance consumer assistance;

6. The regulations emphasize completely following a full and fair process of review. Accordingly, failure to strictly adhere to the review requirements will allow the participant to initiate an external review and pursue any available remedies under applicable law, such as judicial review.

On September 20th, 2010 the DOL announced a delay in enforcement of #2, #5, and #6 above until July 1, 2011, for group health plans that are working in good faith to implement the new standards.

86. If my plan is insured, will I have to do anything?

No. The claims and appeals regulations also apply to insurers and it will be up to the insurer to provide claims and appeals processes that comply with the requirements.

87. How will the external review process apply to my plan?

Your plan will have to comply with either a State external review process or a new Federal external review process.

If your plan is insured, a State external review process will apply, if the State has a process that complies with minimum standards established under PPACA. If no process exists or the State process does not meet the minimum standards, then the Federal external review process will apply.

For self funded plans, the Federal process will apply in most cases. However, the State process will apply to self funded plans in states where the state's own external review process is binding on plans such as MEWAs or plans that are not subject to ERISA such as church and governmental plans.

88. How will the Federal external review process work?

The federal agencies responsible for establishing the program have not yet issued regulations on the actual process though they have indicated they will be released in the near future. It is expected it will be similar to the process set forth by the National Association of Insurance Commissioners (NAIC) for State external review programs. A copy of those guidelines can be found at the NAIC website at:

http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf

89. Our self funded plan year begins on January 1, 2011, and we will be making plan changes that will result in a loss of grandfathered status. If there is no Federal external review process available by that date, how will we comply with the requirement?

Because the Federal process will not be ready by January 1, there are interim "safe harbor" guidelines you will have to follow. These include:

1. Allow at least 4 months for a claimant to file a request for external review.

2. Within 5 business days, complete a preliminary review of a request for external review to determine if the individual is or was covered under the plan at the time the service was incurred, whether the claimant has exhausted the plan's internal appeal process, and whether the claimant has provided all the information and forms required to process the external review.

3. Within one day after completing the preliminary review, the plan must notify the claimant in writing of the outcome of the preliminary review. If you determine the claimant is not eligible for the external review process, the notice must include the reason for ineligibility. If the request for review is not complete, the notice must include the information needed to complete the request.

4. Assign an independent review organization (IRO) to conduct the external review.

90. We have to hire an independent review organization (IRO) to handle our external review process until the federal process is available?

Yes, in most cases. Under the safe harbor, you would have to contract with at least three IROs accredited by URAC for assignments under the plan and rotate claims assignments among the three IROs. In addition, you will have to have specific provisions in your contract with each IRO to ensure their compliance with all the steps of the external review process. A list of the required contract provisions can be found in DOL Technical Release 2010-01 at the DOL website here:

http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf

91. Is there any alternative to hiring three IROs for our self-funded plan?

Maybe. Because the safe harbor is just a guideline, plans that do not strictly comply with all the standards set forth in the technical release will be subject to a facts and circumstances analysis. Thus, a plan that does not satisfy all of the standards of the technical release's safe harbor may in some circumstances nonetheless be considered to be in compliance with the guidance.

For example, one of the standards set forth in the technical release requires self-insured plans to contract with at least three independent review organizations (IROs) and to rotate claims assignments among them (or to incorporate other independent, unbiased methods for selection of IROs, such as random selection). However, a self-insured group health plan's failure to contract with at least three IROs does not mean that the plan has automatically violated the safe harbor.

Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.

Another alternative is that you may choose to voluntarily comply with the provisions of that State external review process if the State chooses to expand access to their State external review process to self funded plans.

92. Will the new requirements for internal and external claims and appeals processes apply to my life or disability coverage?

No. The new changes under PPACA only apply to health insurers and group health plans.

Nondiscrimination Rules for Insured Plans

93. We only offer health insurance to our executives. Will we be able to continue this plan?

Yes, if the plan is a fully insured "grandfathered" plan. The nondiscrimination rules prohibit discrimination in favor of highly compensated individuals in self-funded plans under Code Section 105(h) currently. For plan years beginning on or after September 23, 2010, insured health plans (nongrandfathered) will be subject to nondiscrimination rules similar to those contained in IRS Code Section 105(h).

94. What are the nondiscrimination rules under Code §105(h) that will apply to our plan if we lose grandfathered status?

Under the current Code §105(h) rules, self funded plans must not discriminate in favor of highly compensated employees (HCEs). Until we have regulations on this new provision, it is not clear how the nondiscrimination rules will apply to insured plans. At this time we only know that the rules will be "similar" to the current rules under Code §105(h). Under 105(h), a plan is considered nondiscriminatory only if it satisfies both the eligibility and benefit tests summarized below:

Eligibility Test

Satisfy at least one of the following nondiscriminatory participation requirements:

- At least 70% of all nonexcludable (see below) employees must actually participate in the plan; or
- If at least 70% of all nonexcludable employees are eligible to participate, then 80% or more of the eligible employees actually participate in the plan; or
- The plan must benefit a classification of employees that the IRS has determined does not discriminate in favor of HCEs using standards that are applied under Code §410(b)

There are certain employees who can be excluded from consideration when determining if the plan passes the eligibility tests described above, if they are not eligible for coverage and:

- Have not completed at least 3 years of service at the beginning of the plan year.
- Have not attained age 25 at the beginning of the plan year.
- Are part-time or seasonal employees.
- Are covered under a collective bargaining agreement if the benefits are subject to good faith bargaining.
- Are nonresident aliens who receive no income from sources within the US.

Benefits Test

Under the subjective nondiscriminatory benefits test, the types and amounts of benefits provided to highly compensated individuals must be provided to all participants. The rule also implies that contributions must be the same for each participating employee. In addition:

- Maximum benefit levels cannot vary based on age, years of service, or compensation.
- Waiting periods cannot be shorter for HCEs.
- Benefits cannot discriminate in actual operation (e.g. making exceptions for just HCEs or their family members).

95. How do we know which of our employees are considered highly compensated employees?

A "highly compensated employee" is defined as any employee who is any of the following:

- One of the five highest paid officers; or
- A shareholder who owns more than 10% in value of the employer's stock; or
- Among the highest paid 25% of all employees (other than excludable employees (described above) who are not participants, and not including retired participants).

96. What are the penalties if we violate the nondiscrimination rule for insured, nongrandfathered plans?

An insured group health plan failing to comply with the nondiscrimination requirements is subject to an excise tax of $100 per day per individual discriminated against for each day the plan does not comply with the requirement.

Account-Based Plans

97. Will there be any changes to my healthcare flexible spending accounts (health FSAs)?

Yes. Healthcare FSAs will no longer be permitted to reimburse employees for expenses incurred on or after January 1, 2011, for over-the-counter medications (except insulin) unless the individual obtains a prescription for the drug or medicine.

Effective immediately, reimbursements will be permitted for the health care expenses of the employee's children until the end of the year in which the child turns age 26 on a tax-favored basis regardless of whether the child qualifies as the employee's tax dependent. The child no longer has to meet certain requirements including student status, financial support, or other dependency requirements.

Starting in 2013, the maximum contribution to a healthcare FSA will be capped at $2,500 per year (indexed annually).

98. Our FSA plan year does not start on January 1, 2011. Will my employees be able to change their election amounts mid-plan year in anticipation of the limitations for OTC reimbursements coming on January 1, 2011?

No. Mid-plan year election changes will not be allowed due to the change in the reimbursements for over-the-counter medications. Employees will still be entitled to reimbursement with a prescription. Otherwise, employees can use those election amounts for reimbursement on other qualified expenses.

99. Will there be any changes to my Health Reimbursement Arrangement ("HRA") or Health Savings Account ("HSA")?

Employer and employee contributions to Health Reimbursement Arrangements (HRAs) and health savings account (HSAs) coverage will be included in the calculation of health plan costs for purposes of the "Cadillac Plan Tax" when it goes into effect for fiscal years beginning January 1, 2018. Also, the tax on distributions from a health savings account that are not used for qualified medical expenses would be increased to 20% (from 10%) of the disbursed amount. This would be effective for taxable years beginning January 1, 2011.

HRAs and HSAs will no longer be permitted to reimburse employees for expenses incurred on or after January 1, 2011 for over-the-counter medications (except insulin) unless the individual obtains a prescription for the drug or medicine.

Effective immediately, reimbursements from an HRA will be permitted for the health care expenses of the employee's children until the end of the year in which the child turns age 26 on a tax-favored basis regardless of whether the child qualifies as the employee's tax dependent. The child no longer has to meet certain requirements including student status, financial support, or other dependency requirements.

However, the rules for distributions from an HSA remain subject to the current rules. To treat a distribution as nontaxable, the child must be a tax dependent of the employee.

100. What would qualify as a prescription for over-the-counter medications?

A written or electronic order that meets the legal requirements of the state in which the medication is purchased is sufficient if its written by any individual who is legally authorized in that state to issue a prescription.

101. Can an FSA (or HRA or HSA) still be used to reimburse employees for over-the-counter items that are not drugs or medicines?

Yes. Items that are not drugs or medicines such as crutches, bandages, blood sugar tests, or contact solutions are still reimbursable if they qualify as medical care.

102. Our FSA plan uses an electronic debit card. Can that still be used to purchase over the counter drugs or medications that have a prescription?

Generally, the answer is no. Because the debit card systems are incapable of recognizing and substantiating that the drugs or medicines were prescribed, they may not be used to purchase over-the-counter drugs or medications. The IRS has indicated that in order to facilitate this change, the IRS will not challenge the use of debit cards for purchasing over-the-counter drugs or medications purchased through January 15, 2011. For purchases made after January 15, 2011, the individual will have to substantiate the purchase prior to reimbursement based on the current rules for written substantiation. You should contact your TPA or debit card vendor for specific guidance on how these purchases will be handled.

Other

103. We have a wellness program that provides a reward of 20% of the cost of coverage for employees that meet certain wellness standards. Will we be able to keep that program?

Yes, you are still allowed to provide wellness incentives (rewards) such as premium discounts and additional benefits to individuals who participate in your wellness program. Effective 2014, the Act increases the maximum reward to 30% (or in some cases up to 50% if approved by the Secretary) of the cost of coverage for employees who participate in a wellness program.

However, increases to the wellness plan penalties that were in place on March 23, 2010 such as a premium surcharge or cost-sharing surcharge may cause a plan to lose its grandfather status.

104. Is it true we can get a grant to help us pay for a wellness program?

It depends. The Act includes grants for up to five years for small employers (less than 100 employees who work 25 or more hours per week) that establish new wellness programs. Small employers with existing wellness programs as of March 23, 2010 are not eligible for grants under this provision.

105. We have several employees who waive our group health plan coverage. Will waivers be permitted under the new law?

Yes. However, employers with more than 200 full-time employees that offer health coverage to employees must automatically enroll new full-time employees in one of the plans offered and to continue the enrollment of current employees in the health benefits plan offered through the employer.

Any automatic enrollment program must include adequate notice to employees of the enrollment and the opportunity for the employee to waive the coverage in which they were automatically enrolled.

What's not clear is the effective date of this provision. The Act indicates it's effective as of the date of enactment (3/23/10) but will not apply until regulations are issued by the Secretary.

Update: 12/15/2010
Clarification

106. Will we have to provide any other new notices or disclosures as a result of these bills?

Yes. In addition to those already described (grandfathered notice, age 26 dependent special enrollment notice, lifetime limits special enrollment notice, annual limit waiver notice and patient protection notice), HHS will develop standards within 12 months for a four page "summary of benefits and coverage" that group health plans and insurers will have to use to describe the benefits and coverage under plans. In developing such standards, HHS will work with the National Association of Insurance Commissioners. This will require plans to review and rewrite plan documents and summary plan descriptions, giving them stricter formatting and disclosure requirements and imposing higher noncompliance penalties. This four page summary must be provided in addition to the current SPD that is already required under ERISA.

Further, if a group health plan or health insurer makes any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided summary of benefits and coverage described above, the plan or insurer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. As of this writing, the effective date of this provision is not clear but government representatives have indicated that it will not be enforced until the new summary of benefits and coverage notice is released.

Starting on March 1, 2013, you must provide a written notice to each employee and to each new hire thereafter, informing the employee of the following:

- The existence of the State's exchange including a description of the services provided by the Exchange, and the manner in which the employee may contact the Exchange to request assistance.
- If your plan pays less that 60% of the total allowed costs of benefits provided under the plan, a statement that the employee may be eligible for a premium tax credit and a cost sharing reduction if the employee purchases a qualified health plan through the Exchange.
- If the employee purchases a qualified health plan through the Exchange, a statement that the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

107. Is it true we will have to make changes to what we report on our employee's W-2?

Yes. You will be required to report the aggregate cost of employer sponsored health coverage on your employees' W-2.

The draft 2011 Form W-2 includes code DD that should be used to report the aggregate cost of employer sponsored health coverage on your employees' Form W-2. However, including the cost of health benefits on the Form W-2 is optional for benefits provided in tax year 2011. The reporting is required for benefits provided in taxable years starting on January 1, 2012 or later. So, the first required reporting year will apply to W-2s issued in 2013 covering the 2012 taxable year. However, the amount reported is NOT included in the employee's gross income.

The cost is determined using rules similar to the rules for determining your plan's COBRA premium until further detailed guidance is released.

To see the draft 2011 Form W-2, go to:

http://www.irs.gov/pub/irs-utl/draft_w-2.pdf

INDIVIDUAL RESPONSIBILITY

108. Won't my employees be required to obtain their own health insurance coverage?

All individuals will be required to have health insurance, with very few exceptions. So, if you don't offer the required level of coverage to your employees and their dependents or you don't contribute at the minimum required level, your employees will be required to buy the coverage themselves. Individuals who are required to have health insurance and do not have health insurance will be required to pay a penalty, which will vary based on income levels and will be phased in over three years from 2014 through 2016. In 2016, the minimum penalty will be $695, and the maximum penalty will be $2,085.

However, if you offer the required level of coverage to your employees, they won't be eligible to purchase insurance through the exchanges, unless the cost of the coverage you offer is determined to be unaffordable. If that's the case, they will be able to purchase insurance through the exchanges. Based on their income they may be eligible for subsidized premiums as well. In addition, your organization may be required to provide these employees a voucher from you for the amount you would have contributed to their coverage. There are exceptions for low-income individuals.

Update: 12/15/2010
Clarification

109. How will the IRS verify that my employees have coverage so they can avoid the individual penalty?

Starting in 2014, you will be required to file a return annually with the IRS that includes the following information:

- The name, address, and EIN of the employer sponsoring the plan;
- The portion of the premium (if any) required to be paid by the employer;
- The name, address, and taxpayer ID of the primary insured, and the name and Tax ID of each other individual obtaining coverage under the plan;
- The dates during which the individual was covered during the calendar year;

If your plan is insured, this report will be filed by your insurer.

A written statement will also have to be provided to each individual named in the return that includes the name, address and contact information of the entity that filed the return and the information in the return pertaining to that individual.

110. We have several Medicare eligible employees. How will these bills affect their Medicare coverage?

The Act makes several improvements to Medicare including:

- Provides a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010);
- Phases down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020;
- For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013);
- For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011);
- Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage.

On the other hand, changes to the provider reimbursement levels and Medicare Advantage programs could reduce access to providers or coverage options for Medicare beneficiaries.

TAXES AND SUBSIDIES

Cadillac Plans

111. Okay, I've been hearing all about these "Cadillac plans". What are they?

A "Cadillac Plan" is determined based on the cost of the coverage provided. The cost of a plan with single coverage that exceeds $10,200 annually, or family coverage that exceeds $27,500 annually, will be considered a "Cadillac Plan" beginning in 2018. At that time, coverage with a cost that exceeds those amounts will be subject to a 40% excise tax on the value of coverage that exceeds the above amounts. The tax is imposed on insurers for insured plans. Generally, for self-funded plans, the tax will be paid by the sponsoring employer. Coverage for dental and vision plans are not included in the calculation of the plan's cost.

The maximum cost will be indexed to the consumer price index for urban consumers (CPI-U). The index could increase starting in 2020 depending on the accuracy of the Congressional Budget Office (CBO) forecasts of the premium inflation rate between now and then.

The threshold amounts will be increased by $1,650 for individual coverage and $3,450 for family coverage for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions. Employers may reduce the cost of coverage when applying the tax if the employer's age and gender demographics are not representative of the age and gender demographics of a national risk pool. Much more guidance is expected on these provisions.

112. Do I pay the excise tax or does the insurance carrier/TPA pay it? How do they know the amount?

The tax would apply to your fully insured and self funded group health plans, but not to any plans sold in the individual market, except for coverage eligible for the deduction for self-employed individuals. Although the issuer of the fully-insured plan is required to pay the tax, it is the employer's responsibility to calculate the amount of benefits that are subject to the tax and calculate the tax. For multi-employer plans, the plan sponsor is required to calculate the tax. If your plan is self-funded, you (as either the plan administrator or employer) would be responsible to both calculate and pay the tax.

113. When do I have to start paying the excise tax on these so-called "Cadillac plans"?

This new tax will be effective for taxable years beginning January 1, 2018.

Small Business Premium Tax Credit

114. As a small employer with only 21 employees, will we be eligible for any assistance to help us provide coverage to our employees?

It depends. Premium subsidies are available for small employers with fewer than 25 full-time equivalent employees and average annual wages of $50,000 or less that purchase coverage for employees and pay at least 50% of the cost. Additional premium subsidies are available for employers with 10 or less full time equivalent employees and average annual wage of $25,000 or less.

The IRS has more information about the credit, including tax tips, guides and answers to frequently asked questions available on their website at:

www.irs.gov/newsroom/article/0,,id=220809,00.html

115. How much is the tax credit?

For 2010 through 2013, the tax credit is 35% of the employer's contribution towards health premiums. After 2013, similar premium tax credits for up to two years will be available for small employers that buy coverage through an exchange.

The tax credits are reduced if the number of your full time employees exceeds 10 or if average annual wages exceed $25,000.

116. Does it include dental or vision?

Yes. The credit can also apply to dental or vision; long-term care, nursing home care, home health care, or community-based care; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental health insurance.

117. Can premiums we paid in 2010, but before the new health reform legislation was enacted, be counted in calculating the credit?

Yes. In computing the credit for a tax year beginning in 2010, you may count all premiums paid in 2010.

Update: 12/15/2010
Clarification

118. We are a tax-exempt organization. Can we qualify for the tax credit?

Yes. The tax credit is available to you if you're an organization described in Code section 501(c) that is exempt from tax under Code section 501(a). The tax credit is 25% of your contribution towards health premiums. However, the amount of the credit cannot exceed the total amount of income and Medicare (i.e., hospital insurance) tax you are required to withhold from your employees' wages for the year and your share of Medicare tax on your employees' wages.

Update: 12/15/2010
Clarification

119. Can we claim the credit if we had no taxable income for the year?

Yes. For a tax-exempt employer, the credit is a refundable credit so even if you have no taxable income, you may receive a refund.

Update: 12/15/2010
Clarification

120. How do we claim the tax credit?

The credit is claimed on your company's annual income tax return. The IRS has released a draft version of Form 8941 to calculate the small business health care tax credit. It can be found on the IRS' Small Business Tax Credit website. The final version of Form 8941 and its instructions are now available at the IRS website at:

http://www.irs.gov/app/picklist/list/formsInstructions.html

Tax-exempt organizations will claim the small business health care tax credit on a revised Form 990-T. Form 990-T will be revised for the 2011 filing season to enable eligible tax-exempt organizations — even those that owe no tax on unrelated business income — also to claim the small business health care tax credit.

121. How do we determine how many full time equivalent employees (FTE) we have for purposes of the tax credit?

The number of FTEs is determined by dividing the total hours for which you paid wages to your employees during the year (but not more than 2,080 hours for any employee) by 2,080. The result, if not a whole number, is then rounded to the next lowest whole number.

Example: For the 2010 tax year, an employer pays 5 employees wages for 2,080 hours each, 3 employees wages for 1,040 hours each, and 1 employee wages for 2,300 hours.

The employer's FTEs would be calculated as follows:

Total hours not exceeding 2,080 per employee is the sum of:

a. 10,400 hours for the 5 employees paid for 2,080 hours each (5 x 2,080)
b. 3,120 hours for the 3 employees paid for 1,040 hours each (3 x 1,040)
c. 2,080 hours for the 1 employee paid for 2,300 hours (lesser of 2,300 and 2,080)

This adds up to 15,600 hours.

15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number = 7.

122. How do we determine the amount of our average annual wages?

The amount of your average annual wages is determined by first dividing (1) the total wages paid by the employer to employees during your tax year; by (2) the number of the your full time equivalent employees for the year. The result is then rounded down to the nearest $1,000 (if not otherwise a multiple of $1,000). For this purpose, wages means wages as defined for FICA purposes (without regard to the wage base limitation).

Example: For the 2010 tax year, an employer pays $224,000 in wages and has 10 FTEs. The employer's average annual wages would be: $22,000 ($224,000 divided by 10 = $22,400, rounded down to the nearest $1,000).

Early Retiree Reinsurance Program

123. I heard that the federal government will subsidize my company's retiree medical coverage costs? Is that true? Starting when?

Yes. Until the exchanges take effect in 2014, the federal government has created a temporary Early Retiree Reinsurance Program for employers providing health coverage to retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) between the ages of 55 and 64 who are not eligible for Medicare. The reimbursement is equal to 80% of costs incurred between $15,000 and $90,000 in the plan year. To qualify for the program, you must have a program in place to generate cost savings for participants with chronic and high-cost conditions. Any payments received must be used to reduce plan or participant costs such as deductibles, co-insurance, or other out-of-pocket costs. The payments cannot be used as general revenue for the employer receiving the payments.

On May 5th, HHS released interim final regulations to implement the Early Retiree Reinsurance Program. Issues addressed in the regulations include:

- HHS will begin the Early Retiree Program on June 1, 2010, in advance of the June 21 start date required by PPACA, allowing more claims to qualify for reinsurance payments for plans this year.
- You can apply for the program through the Department of Health and Human Services. Applications will be available by the end of June.

- To receive assistance, you must have your applications approved by HHS, document claims, attest that policies and procedures are in place to protect against fraud, waste, and abuse, and implement programs and procedures that have or have the potential to generate cost savings for participants with chronic and high-cost conditions.
- Applications will be processed in first-come, first-serve order.
- Claims incurred between the start of the plan year and June 1st are credited towards the $15,000 threshold, but only medical expenses incurred after June 1, 2010 are eligible for reimbursement.
- Your spending on retiree coverage is expected to remain level – payments should be used to offset premium increases or reduce participant costs.
- The program for "chronic and high cost conditions" applies to participants with conditions where $15,000 or more is likely to be incurred during plan year.
- Your plan will be subject to audits to assure fiscal integrity.

On June 29, 2010, HHS started accepting applications for the Early Retiree Reinsurance Program.

NOTE: This program is limited in duration and funding so submitting a completed application as soon as possible is strongly recommended.

124. How and when will we know if our application for the Early Retiree Reinsurance Program has been certified?

On August 31, 2010, HHS started notifying Account Managers and Authorized Representatives of a plan sponsor via email that their application has been approved. The Account Manager and Authorized Representative will also receive a registration email from HHS' ERRP Center (errpnotice@errp.gov) inviting them to register for the ERRP Secure Website at: http://errp.gov/

In addition, HHS has posted an interactive map and alphabetical list of the employers that have been accepted to date. The website for the map and list is:

http://www.healthcare.gov/news/factsheets/early_retiree_reinsurance_program.html

125. We received notification that our application has been approved and we already have claims that are eligible for reimbursement. How do we submit the claims?

You will use the ERRP Secure Website at http://errp.gov/ to register your plan's Account Manager and Authorized Representative, view and change application information; submit summary cost data, claims line-item data, and other information; and request ERRP reimbursements. You will also be allowed to assign the individuals and/or vendors responsible for submitting information on behalf of your plan and add or remove individuals, or designees, associated with an application.

Not all of these functions will be immediately available on the ERRP Secure Website so check back often for updates.

126. Will we have to tell our employees if we are participating in the early retiree reinsurance program?

Yes. You must provide a notice to plan participants notifying them that, because you are participating in the ERRP with respect to the plan, you may be using the reimbursements to reduce plan participants' premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs, and therefore they may experience changes to the benefits under the plan.

A model notice and instructions on the manner and timing of delivering the notice can be downloaded from the ERRP Secure Website at:

http://www.errp.gov/download/Notice_to_Plan_Participants.pdf

Medicare Part D Drug Subsidy

127. Will I still be allowed to deduct the Medicare Part D retiree drug subsidies I receive from the federal government? Will the subsidies still even be available?

The Act does not change the subsidy program, so the Medicare Part D retiree drug subsidies will still be available to you. However, the Act will eliminate the tax deduction starting in 2013 if you receive Part D drug subsidy payments. This will only affect employers subject to corporate taxes. Public entities, not-for-profit and religious entities are not affected by this change.

Even though the deduction is not eliminated until 2013, it will likely require immediate changes to your financial statements.

Other

128. Our plan is self funded. Are there any direct costs we have to worry about?

Yes. Starting with plan years ending after September 30, 2012, sponsors of self funded plans (including governmental plans) must pay a temporary annual tax of $2 ($1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan for the year. This tax applies through 2019.

129. Will my employees see any other tax increases?

Yes. They will see an increase of 0.9% in their FICA withholding if their income is in excess of $200,000 and couples filing jointly with incomes in excess of $250,000. This change will be effective in 2013.

The Medicare tax (a total of 3.8%) is also applied to net investment income for individuals or couples meeting these thresholds.

Also effective January 1, 2013, the threshold floor for deductibility of medical expenses on individual income tax returns is increased from 7.5% of Adjusted Gross Income (AGI) to 10%. The AGI floor for those 65 and older (and their spouses) remains at 7.5% through 2016.

While not taxes directly imposed on employers or their employees, the Act imposes many new taxes and fees on various sectors of the healthcare industry, including insurers. Time will tell what effect these taxes and fees will have on consumer prices for healthcare services.

MISCELLANEOUS

130. Will reform reduce my health insurance costs?

This is the $64,000 question. Some economists believe there may be small reduction to health insurance costs due to competition from the exchanges. Insurance company analysts and lobbyists believe costs will go up because the individual mandate will not drive enough new insureds into the system to offset the added costs related to guaranteed issuance of policies and elimination of preexisting condition exclusions.

131. Are there any other requirements that I should know about that aren't getting as much media attention?

New Voluntary Long Term Care Program: The Community Living Assistance Services and Supports (CLASS) program creates a new, national, voluntary long-term care benefit that will provide a cash benefit to participants if they become unable to perform at least two activities of daily life. Individuals will pay into the program for at least five years before qualifying for benefits. The benefit would be at least $50 per day and could be used to purchase any non-medical services and supports necessary to maintain community residence. There is no lifetime limit on the benefit. It is intended to be a self-supporting program. Premiums will be determined by HHS. There will be no underwriting requirement to enroll in the Program. You may choose to enroll all employees automatically into the program and withdraw from their wages the monthly premium, with the employee having the ability to opt-out. Employer participation in the program is optional. This is effective January 1, 2011. More guidance is expected prior to implementation of the program.

New Nutritional Labeling Guidelines: The Act requires chain restaurants with 20 or more locations and food sold from vending machines to display the nutritional content of each standard item on the menu or menu board, (including drive-through menu boards), or in close proximity to the vending machine selection buttons. The information should include the number of calories and percentage of daily diet requirements. Daily specials and temporary menu items (less than 60 days per year) are excluded from this requirement.

Tax on Indoor Tanning Services: The Act imposes a tax on indoor tanning services of 10% effective for services performed July 1, 2010 and thereafter.

Reasonable Break Time For Nursing Mothers: The Act amends the Fair Labor Standards Act to require you to provide a reasonable break time for an employee to express breast milk for a nursing child for 1 year after the child's birth, as well as a place, other than a bathroom, that is shielded from view and free from intrusion by coworkers and the public for such purpose. If you have less than 50 employees, the requirements will not apply if you can show they would impose an undue hardship.

The DOL's Wage and Hour division has issued a fact sheet providing general information on the break time requirement for nursing mothers under PPACA. The Fact Sheet can be viewed or downloaded here:

http://www.dol.gov/whd/regs/compliance/whdfs73.htm

Adoption Assistance: The Act increases the adoption tax credit and adoption assistance exclusion by $1,000, makes the credit refundable, and extends the credit through 2011. The enhancements are effective for tax years beginning after December 31, 2009.

132. Is COBRA coverage extended now beyond 18 months for my terminating employees?

No, COBRA coverage is not expanded beyond the already existing 18-, 29- and 36-month COBRA qualifying events. One of the proposed pieces of legislation did include an extension of COBRA until the date at which the exchanges opened in 2014, but that was not included in the final bill that was passed.

133. I've heard that several state attorneys general have filed a lawsuit against the federal government claiming that it is unconstitutional to force individuals to buy health insurance. Is it?

The individual mandate to purchase insurance is considered necessary to the Act to make sure that young, healthy people and their premium payments are included in the plans to balance out those older individuals accessing care on a more frequent basis potentially beyond the cost of their premium. Opponents to the lawsuit say the federal government has the right to regulate interstate commerce, which includes any business that operates across state lines, including health insurance. Supporters of the lawsuit say that the insurance mandate does not involve interstate commerce. Opponents also point out that the federal government has the Constitutional right to tax, and that the Act does not require that an individual purchase insurance, he or she can choose to pay the tax instead. What is also not clear at this point is whether the courts will be willing to hear the challenges now, since the requirement to purchase insurance isn't effective until 2014. The court may require that the state Attorneys General show injury to someone prior to moving forward with the lawsuit. We have to admit the answer to this question is not entirely clear and we will leave it to the judicial branch to determine.