

The Patient Protection and Affordable Care Act (PPACA)

Frequently Asked Questions (FAQs)

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Glossary of Common Terms	3
1099 Requirement	4
60-day Prior Notice Requirement for Material Plan or Coverage Changes	4
Annual Limits	4
Annual Limit Waiver Program	5
Automatic Enrollment	5
Cadillac Plan Tax	5
Church Group Health Plans	6
CLASS Act (Community Living Assisted Services and Support)	6
Classification of Employees	6
COBRA and PPACA	7
Collective Bargaining Agreements	7
Comprehensive Health Coverage Requirement	7
Dental and Vision	8
Dependent Coverage	8
Early Retiree Reinsurance Program (ERRP)	9
Employer Mandate	9
Essential Benefits	10
Exemption for GHPs with Fewer Than Two Current Employee Participants	10
Exemption for a Plan Covering Retirees and Individuals on Long-term Disability	10
Four-page Summary of Benefits and Coverage	11
Full-time Worker	12
Grandfathered Health Plans	12
HSA/FSA/HRA	14
Individual Mandate	15
Internal Appeals and External Review	15
Lifetime Limits	16
Local Government Plans	17
Medical Loss Ratio Interim Final Rules	17
Medicare	18
Model Notices	18
Nondiscrimination Rules for Fully Insured Plans	18
Nursing Mothers	19
Over-the-counter Drugs	20
Pre-existing Condition Insurance Plan (PCIP)	20
Preventive Services	21

Reporting Obligations for Employers Due to Health Care Reform	21
Rescissions	22
Seasonal Employees	22
Self-funded Plans	23
Simple Cafeteria Plan for Small Employers	23
Small Group Tax Credit	24
State Exchange	25
Free Choice Voucher	25
W-2 Reporting	25
Waiting Period	26
Wellness Programs	26

Glossary of Common Terms

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) form the health care reform legislation. Specifically, PPACA was signed by President Obama on March 23, 2010, but a week later, HCERA was signed by the president, amending PPACA. Therefore, references to PPACA are to both acts combined.

CBA: Collective Bargaining Agreement

CMS: Centers for Medicare & Medicaid Services

COBRA: Consolidated Omnibus Budget Reconciliation Act

The Departments: The U.S. Department of Labor, the U.S. Department of Health and Human Services and the U.S. Department of the Treasury (including the Internal Revenue Service)

DOL: U.S. Department of Labor

EBSA: Employee Benefits Security Administration

ERISA: Employee Retirement Income Security Act

FLSA: Fair Labor Standards Act

FSA: Flexible Spending Arrangement

HCERA: Health Care and Education Reconciliation Act of 2010

HHS: U.S. Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act

HRA: Health Reimbursement Account

HSA: Health Savings Account

IRC: Internal Revenue Code

IRS: Internal Revenue Service

PHSA: Public Health Service Act

PPACA: Patient Protection and Affordable Care Act

1099 REQUIREMENT

What was the 1099 requirement under PPACA?

Under current law, businesses send Form 1099 for payments in excess of \$600 for rent, interest, dividends and non-employee services when these payments are made to entities other than corporations. Payments made to a corporation and payments for merchandise are generally not required to be reported.

If the law had not been repealed, according to §9006 of PPACA, corporations would no longer be exempt from 1099 reporting (with the exception of nonprofit corporations). The law would have significantly broadened the scope of who gets a 1099 and for what.

Was it repealed?

Yes. It was repealed on April 14, 2011, when President Obama signed HR 4 into law, creating Public Law No. 112-009.

60-DAY PRIOR NOTICE REQUIREMENT FOR MATERIAL PLAN OR COVERAGE CHANGES

When are group health plans and health insurance issuers required to comply with the notice requirement, which generally requires a 60-day prior notice for material modifications to the plan or coverage?

Any material modification of plan terms or coverage that is not reflected in the most recently provided four-page Summary of Benefits and Coverage (SBC) must be issued in a summary of material modification at least 60 days before the modification becomes effective. Proposed guidance issued on Aug. 22, 2011, clarified that only mid-plan-year changes must be provided 60 days in advance of the effective date. A modification that occurs in connection with a renewal or open enrollment would be provided within 30 days of the plan year beginning.

The statute leaves unclear the effective date of this requirement, but the proposed regulations clarified that the first distribution date is intended to be March 23, 2012, although comments are requested as to whether this date should be delayed. PHSAs, § 2715(d)(4); Q/A-4, DOL's FAQs About Affordable Care Act Implementation, Part V, found at www.dol.gov/ebsa/faqs/faq-aca5.html.

ANNUAL LIMITS

May a health plan still have annual dollar limits on benefits?

Annual dollar limits are first restricted, and later prohibited — but only on the value of “essential health benefits.” For plan years beginning before Jan. 1, 2014, however, restricted annual limits on essential health benefits are permissible, as determined by HHS. The interim final regulations adopt a three-year phased approach for restricted annual limits, under which the annual limits may be no less than the following:

- \$750,000 for plan years beginning on or after Sept. 23, 2010, but before Sept. 23, 2011;
- \$1.25 million for plan years beginning on or after Sept. 23, 2011, but before Sept. 23, 2012; and
- \$2 million for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.

Annual dollar limits are prohibited on essential health benefits beginning on Jan. 1, 2014. Plans may place an annual dollar limit and a lifetime dollar limit on spending for health care services that are not “essential health benefits.”

Some plans may be eligible for a waiver from the rules concerning annual dollar limits, if, among other requirements, complying with the limit would mean a significant decrease in access to benefits for those currently covered or a significant increase in premiums. PHSAs §2711, as added by PPACA §§1001(5) and 10101(a).

ANNUAL LIMIT WAIVER PROGRAM

How does the waiver program work for the class of plans and coverage that includes “limited benefit” or “mini-med” plans, which often offer lower-cost coverage to part-time workers, seasonal workers and volunteers who otherwise might not be able to afford coverage at all?

The waiver process is only available if compliance with PPACA’s annual limit restrictions would result in a “significant decrease in access to benefits” or a “significant increase in premiums.” The guidance released by HHS described several factors that would be taken into account on a case-by-case basis in order to determine if the waiver was granted.

More information about those factors and how to submit the waiver can be found at the HHS website (www.hhs.gov/ociio/regulations/annual_limit_waivers.html). A group interested in filing for a waiver must submit the application not less than 30 days before the beginning of the plan or policy year.

Guidance issued on Aug. 19, 2011, clarified that sponsors of stand-alone HRAs are not required to seek waivers from the PPACA annual dollar limits on the coverage of essential benefits if the HRA was in effect prior to Sept. 23, 2011. However, if an employer maintains an HRA that was not in effect prior to Sept. 23, 2011, a waiver application must have been received by Sept. 22, 2011, or else the plan would be subject to the restricted annual limit requirements.

What is the deadline for submitting a waiver?

On June 17, 2011, the CMS announced that the annual limit waiver program would end, effective Sept. 22, 2011. Applications that have been approved will need to apply for a waiver extension, as well as submit an annual renewal application and provide consumer notices to participants in the plan. Applications that have not yet been approved should have been submitted by Sept. 22, 2011, or else comply with the annual dollar limits on the value of essential health benefits under the plan.

AUTOMATIC ENROLLMENT

When do employers have to comply with the new automatic enrollment requirements required by PPACA?

PPACA amends the FLSA to require certain large employers to:

- Automatically enroll new full-time employees in one of the employer’s health benefit plans (subject to any waiting period authorized by law); and
- Continue the enrollment of current employees.

Employers subject to the rule are those who (1) are subject to the FLSA, (2) have more than 200 full-time employees and (3) have one or more health benefit plans. Adequate notice must be provided, and employees who are automatically enrolled must be given an opportunity to opt out of coverage.

PPACA does not specify an effective date for the automatic enrollment requirement. In sub-regulatory guidance, the DOL has indicated that employers are not required to comply with this requirement until regulations are issued. A Request for Information was issued in May 2011 by the EBSA and the rule is currently in the prerule stage. The DOL and the Treasury Department will coordinate to develop the rules that apply in determining full-time employee status for purposes of implementing the requirement. FLSA §18A, as added by PPACA §1511; “FAQs About Affordable Care Act Implementation Part V,” Q/A-3: found at www.dol.gov/ebsa/faqs/faq-aca5.html.

CADILLAC PLAN TAX

How is the Cadillac Plan Tax calculated?

Starting in 2018, the 40 percent excise tax will be imposed on fully insured and self-funded plans based on the value of coverage that exceeds annual thresholds of \$10,200 for individuals and \$27,500 for families. The thresholds will be

indexed for inflation (CPI-U) plus 1 percent in 2019, and by CPI alone in 2020 and thereafter. The thresholds for retirees and workers in “high-risk” industries are higher, \$11,850 for individuals and \$30,950 for family coverage. Coverage under multiemployer plans is deemed, for purposes of the threshold, to be family coverage. Plans that have higher costs than the national average due to the age and/or gender of their employees may also qualify for higher thresholds.

The threshold amount will be increased starting in the first year (2018) if premiums for the Federal Employees Health Benefits Plan’s (FEHBP) Blue Cross Blue Shield standard option increases by more than 55 percent for the period 2010 to 2018.

The tax will be applied to the aggregate cost of health plans, FSAs and HRAs, and employer contributions toward HSAs (employee contributions are not counted). Self-funded plans will use their COBRA calculations to determine the cost of the plans. Stand-alone dental and vision policies, as well as disability insurance, are excluded from the tax. IRC §4980I.

CHURCH GROUP HEALTH PLANS

Are church group health plans subject to the mandates found under PPACA?

With limited exceptions, group health plans maintained by a church employer are subject to the PHSA mandates incorporated into the IRC, because the IRC definition of group health plan contains no exception for church plans (Code §9832(a)). Church plans are exempt, however, from the PHSA mandates incorporated into ERISA, because church plans that have not made an election under IRC §410(d) to be subject to ERISA are exempt in general from ERISA’s requirements. ERISA §§4(b)(2) and 3(33). A church plan is a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches that is exempt from tax under IRC §501 and IRC §414(e).

CLASS ACT (COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS)

What is the CLASS Act and how will it affect employers?

On Oct. 14, 2011, HHS announced it will halt implementation of the CLASS Act. Under this program, the Secretary of HHS was supposed to create procedures and protocols establishing a national voluntary long-term care insurance program for purchasing community living assistance services. In order to implement the program, HHS was required to develop, by Oct. 1, 2012, at least three “actuarially sound” benefit plans that would remain solvent for 75 years. HHS cited actuarial and solvency challenges as the reasons it had “not identified a way to make CLASS work at this time.” There is no action needed by employers at this time.

CLASSIFICATION OF EMPLOYEES

Can a group health plan vary employer contributions based on bona fide employment classifications?

The plan would still need to pass nondiscrimination testing, but yes, in general, a group health plan may vary employer contributions based on bona fide employment classifications, although a self-funded plan is not permitted to vary contributions based on age, years of service or compensation.

26 CFR 54.9802-1(d)(1) states:

“A plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer’s usual business practice ... examples of classifications that ... may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations.”

COBRA AND PPACA

Did PPACA extend the COBRA maximum coverage period?

No. PPACA did not extend the maximum time periods of continuation coverage provided by COBRA. COBRA establishes required periods of coverage for continuation of health benefits. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Individuals who become disabled may extend the 18-month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours.

DOL's FAQs entitled "Health Care Reform and COBRA" can be found at www.dol.gov/ebsa/faqs/faq-PPACA.html.

COLLECTIVE BARGAINING AGREEMENTS

How does PPACA affect plans that are negotiated by unions — collective bargaining agreements (CBAs)?

The regulations provide that, in the case of health insurance coverage maintained pursuant to one or more CBAs ratified before March 23, 2010, the coverage will be treated as grandfathered until the last CBA terminates, regardless of whether there is a change that would otherwise destroy grandfathered status. The regulations and preamble make it clear that the special rule for collective bargaining plans is limited to insured arrangements. Thus, self-funded collective bargaining plans will be treated the same as non-bargained plans and will need to comply with the grandfathering rules, including the new mandates and the limitations on plan changes, even before the relevant CBA expires. Treas. Reg. §54.9815-1251T(f)(1); DOL Reg. §2590.715-1251(f)(1); HHS Reg. §147.140(f)(1); Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537.

COMPREHENSIVE HEALTH COVERAGE REQUIREMENT

What is the comprehensive health coverage requirement and how is it connected to the essential health benefits package (also known as minimum essential coverage)?

Effective for plan years beginning on or after Jan. 1, 2014, health insurance issuers offering coverage in the individual or small group market must ensure that such coverage includes the "essential health benefits package." PHSA §2707(a). Note that the requirement does not apply to certain stand-alone dental plans. PHSA §2707(d).

To provide the essential health benefits package, a plan must:

- Provide essential health benefits, as described in PPACA §1302(b); "Essential health benefits" is to be defined by regulations, but they include minimum benefits in general categories and the items and services covered within those categories.
- Limit cost-sharing, as described in PPACA §1302(c).
- Provide bronze, silver, gold or platinum level coverage (PPACA §1302(d)). The four prescribed coverage levels vary based on the percentage of full actuarial value of benefits the plan is designed to provide, as follows:
 - Bronze: designed to provide benefits actuarially equivalent to 60 percent of full value;
 - Silver: designed to provide benefits actuarially equivalent to 70 percent of full value;
 - Gold: designed to provide benefits actuarially equivalent to 80 percent of full value; and
 - Platinum: designed to provide benefits actuarially equivalent to 90 percent of full value.

- Or a catastrophic plan (also known as “young invincibles” coverage), as described in PPACA §1302(e), available to individual insurers in 2014. This is a plan that provides coverage for essential health benefits and provides no benefit for any plan year until the individual has incurred cost-sharing expenses equal to the overall cost-sharing limit for the plan year. The deductible cannot apply to at least three primary care visits.
 - A catastrophic plan is permitted only in the individual market and only for (1) young adults (those under age 30 before the plan year begins) and (2) those persons exempt from the individual mandate because affordable coverage is not available or they have a hardship exemption. PPACA §1302(e).

Is the essential health benefits package in the previous question different from the essential health benefits referred to by the health care reform law to describe the benefits that qualified health plans (QHPs) are required to cover?

Yes, they are different. “Essential health benefits” is the term used by the health care reform law to describe the benefits that qualified health plans (QHPs) are required to cover. PPACA §1301. Minimum essential coverage is a totally separate concept. It is the term used to describe the coverage required to fulfill the individual mandate — and that employers may be required to offer to avoid the pay-or-play tax. IRC §5000A(f).

Are insurance coverage and health plans that qualify as grandfathered health plans required to comply with PPACA’s comprehensive health coverage requirement?

No. PPACA §1251(a)(2).

DENTAL AND VISION

Are dental and vision plans subject to PPACA?

Benefits that are considered “excepted benefits” under HIPAA’s portability provisions are not subject to PPACA provisions. This would include stand-alone dental, vision, Medicare supplemental plans and TRICARE supplemental plans.

Under HIPAA, dental and vision benefits generally constitute excepted benefits if they:

- Are offered under a separate policy, certificate or contract of insurance; or
- Are not an integral part of the plan. For dental or vision benefits to be considered not an integral part of the plan (whether insured or self-insured), participants must have a right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium.

Therefore, stand-alone dental and vision policies are not required to comply with the provisions of health care reform, regardless of whether the plan is self-funded or fully insured. However, a dental or vision plan that is part of the major medical policy (not stand-alone) would need to comply with PPACA. DOL’s “FAQs About the Affordable Care Act Implementation Part II,” Q/A-6; found at www.dol.gov/ebsa/faqs/faq-aca2.html.

DEPENDENT COVERAGE

When do plans have to change the dependent age to 26?

The dependent coverage requirement became effective for plan years beginning on or after Sept. 23, 2010. Enrollment of adult child dependents will occur at the start of the applicable plan year. PPACA §1004(a).

Will the adult child dependent (up to age 26) be able to enroll under the parents' family plan or will the group be required to enroll the adult child as a 'single'? Will the benefits or cost be different?

Eligible adult children wishing to take advantage of the new coverage will be included in the parents' family policy. Any qualified individual must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status. The qualified adult child dependent cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status. PPACA §1004(a); DOL's "Young Adults Fact Sheet"; found at www.dol.gov/ebsa/newsroom/fsdependentcoverage.html.

What is the definition of "dependent" for purposes of the dependent child mandate?

In the DOL's "FAQs About the Affordable Care Act Implementation Part I" found at www.dol.gov/ebsa/faqs/faq-aca.html, the DOL, HHS and the IRS clarify that, for purposes of the mandate, a plan must provide coverage up to age 26 for adult dependents who meet the definition of "child" found in IRC §152(f)(1). This definition includes biological sons and daughters, stepchildren and adopted children (including children placed for adoption and eligible foster children). A plan may, however, be more generous in plan design by extending dependent coverage to those outside of the definition found in IRC §152(f)(1), such as a grandchild, niece or nephew. In addition, state laws may require more expansive coverage.

EARLY RETIREE REINSURANCE PROGRAM (ERRP)

Is the Early Retiree Reinsurance Program still taking new applications?

No. Effective May 6, 2011, the ERRP stopped accepting new ERRP applications. This is consistent with PPACA §1102(f), which allows this limitation based on the availability of funding. A Federal Register Notice regarding this decision has been released and can be found in the following link: <http://edocket.access.gpo.gov/2011/pdf/2011-7934.pdf>.

EMPLOYER MANDATE

Does PPACA require an employer to provide insurance coverage for its employees and contribute a certain amount toward such coverage?

The act does not require an employer to provide insurance coverage for its employees, but starting in 2014, some employers will be assessed a penalty if no coverage or insufficient coverage is provided. Employers with 50 or more employees may be subject to the penalty if they don't offer "qualified" and "affordable" insurance coverage and at least one employee receives a premium tax credit when purchasing individual or family coverage through the state exchange. The number of employees is determined by adding full-time employees (working 30+ hours per week) with full-time equivalents (total part-time hours for the month divided by 120).

There are two types of penalties: one for employers that provide no insurance coverage and one for employers that provide insufficient insurance coverage. If an employer does not offer insurance and at least one full-time employee receives a premium tax credit, the employer must pay a penalty of \$2,000 per full-time employee (not full-time equivalent), excluding the first 30 employees. If the employer offers coverage, but the coverage is not "qualified" (pays at least 60 percent of allowed charges and meets minimum benefit standards) or "affordable" (employee contributions exceed 9.5 percent of his/her household income), then the employer must pay \$3,000 for each employee that receives a premium tax credit when purchasing individual or family coverage through the state exchange (penalty capped at \$2,000 per full-time employee, with the first 30 being excluded).

An employer will not be considered to employ more than 50 full-time employees if (a) the employer's workforce only exceeds 50 full-time employees for 120 days or fewer during the calendar year, and (b) the employees in excess of 50 who were employed during that 120-day (or fewer) period were seasonal workers. "Seasonal worker" means a worker who performs labor or services on a seasonal basis as defined by the DOL, including agricultural workers covered by 29 CFR § 500.20(s)(1) and retail workers employed exclusively during holiday seasons. IRC § 4980H(c)(2)(B)(i).

Are small employers with 1-49 employees exempt from the employer mandate penalty if they do not provide insurance coverage?

Yes. IRC §4980H(c)(2)(D)(i).

ESSENTIAL BENEFITS

What benefits are considered “essential benefits”?

PPACA states that lifetime dollar limits are prohibited and annual dollar limits are first restricted (then prohibited in 2014), but only on the value of “essential health benefits.”

“Essential health benefits” include minimum benefits in general categories and the items and services within those categories (to be determined by HHS), such as:

- Ambulatory patient services
- Emergency services
- 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, PPACA §1302(b)

Until HHS issues regulations, there is no way to precisely determine which benefits will be considered “essential” within the categories listed above. For purposes of enforcement, until such regulations are issued, the agencies will take into account “good faith” efforts to comply with a reasonable interpretation of “essential health benefits,” but a plan must apply this definition consistently. 75 Fed. Reg. 37188, 37191.

EXEMPTION FOR GROUP HEALTH PLANS WITH FEWER THAN TWO CURRENT EMPLOYEE PARTICIPANTS

Do the HIPAA statutory exemptions for group health plans with “less than two participants who are current employees” apply to PPACA’s group market reforms?

Yes. The preamble to the interim final regulations on grandfathered plans noted that statutory provisions in effect since 1997 exempting group health plans with “less than two participants who are current employees” from HIPAA also exempt such plans from the group market reform requirements of PPACA. Accordingly, under the terms of these statutory provisions, group health plans that do not cover at least two current employees (such as plans in which only retirees participate) are exempt from PPACA’s market reform requirements. 75 FR 34539-34540; Q/A-1, DOL’s FAQs About the Affordable Care Act Implementation, Part III found at www.dol.gov/ebsa/faqs/faq-aca3.html.

EXEMPTION FOR A PLAN COVERING RETIREES AND INDIVIDUALS ON LONG-TERM DISABILITY

Before PPACA, a plan covering retirees and those on long-term disability was exempt under HIPAA. Can we continue to treat that plan as exempt?

The Departments have not issued guidance on this specific issue. In order to fully analyze the issue, and balance the goal of ensuring that PPACA’s market reforms and patient protections are provided to eligible enrollees of group health plans with the goal of preventing disruption of existing coverage, the Departments will be issuing a request

for information (RFI) very soon. The RFI will solicit comments from employers and other stakeholders to inform future guidance. After reviewing the comments submitted, the Departments intend to publish guidance on this issue later in 2011.

Until guidance is issued, the Departments will treat plans described above as satisfying the exemption from HIPAA and PPACA's group market reforms for plans with less than two participants who are current employees. To the extent future guidance on this issue is more restrictive with respect to the availability of the exemption than this interim relief, the guidance will be prospective, applying to plan years that begin sometime after its issuance.

Pending such further guidance, a plan may adopt any or all of the HIPAA and PPACA market reform requirements without prejudice to its exemption. The Departments encourage such voluntary compliance. Q/A-2, DOL's FAQs About the Affordable Care Act Implementation, Part III found at www.dol.gov/ebsa/faqs/faq-aca3.html.

FOUR-PAGE SUMMARY OF BENEFITS AND COVERAGE

What is the new required summary of benefits and when must it be distributed?

PPACA expands ERISA's disclosure requirements by requiring that a four-page "Summary of Benefits and Coverage" (SBC) be provided to applicants and enrollees before enrollment or re-enrollment. The summary must accurately describe the "benefits and coverage under the applicable plan or coverage." The four-page summary requirement applies in addition to ERISA's SPD and SMM requirements. Although effective for plan years beginning on or after Sept. 23, 2010, the four-page summary requirement contains a special distribution deadline of 24 months after the enactment of PPACA (March 23, 2010), March 23, 2012.

PPACA required the Secretary of HHS to issue guidance addressing the four-page summary requirement by March 23, 2011 (i.e., 12 months after the enactment date). On Aug. 22, 2011, the DOL, HHS and U.S. Department of the Treasury released proposed rules for the SBC requirement. Starting in 2012, health insurers and group health plans will have to provide a new plan document, the SBC, along with a uniform glossary of terms, to employees before enrollment. The SBC will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. Individuals will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year and within seven days of requesting a copy from their health insurance issuer or group health plan. The SBC will include a health plan comparison tool for consumers, known as "Coverage Examples," which will illustrate what proportion of care expenses a health insurance policy or plan would cover for three common benefits scenarios: having a baby, treating breast cancer and managing diabetes. Health plans and issuers will be required to provide 60 days' prior notice before any material modification is made in the plan or coverage that is not set forth in the most recent SBC provided to the enrollees.

The proposed rules were open to public comments until Oct. 21, 2011. As these are merely proposed rules, employers do not have to take any action immediately. Nonetheless, employers and plan sponsors should be aware of the upcoming requirements when developing a long-term compliance strategy.

Who does the summary requirement apply to and who must provide the summary?

The four-page summary requirement applies to group health plans and insurers but not to certain "excepted benefits." Importantly, grandfathered group health plans must comply with this mandate.

The four-page summaries must be provided by plan administrators (for self-insured health plans) and insurers (for insured health plans). Self-insured plans must prepare and provide the four-page summaries themselves or make arrangements with a third party to provide the notice on the plan's behalf. However, if the third party fails to provide the four-page summaries as required under health care reform, then the plan will be out of compliance, despite its arrangement with the third party, and subject to penalties. PHSA § 2715(a), as added by PPACA §1251(a)(3) and §10103(d)(1).

Who must receive the summary?

Generally, the four-page summaries must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy) and enrollees (at initial enrollment and annual enrollment). PHSA §2715(d)(1), as added by PPACA.

Is there a penalty for failing to provide the four-page summary?

A penalty of up to \$1,000 per failure can be assessed on insurers (for insured health plans) and plan administrators (for self-insured health plans) that do not provide the four-page summaries in a timely manner. The fine cannot be paid from plan or trust assets. 42 USC §300gg-15(f).

FULL-TIME WORKER

Can an employer still have an employment policy stating that a full-time employee is one who works 40 hours per week or will the minimum number of hours change with PPACA?

“Full-time” is defined as 30 hours per week for provision of health insurance purposes, but this is not intended to impact other employer benefits that may hinge on 40 hours. At this time it is unclear how the hourly requirement will be calculated for employees whose hours vary by the week. For example, if a person works 20 hours one week and 40 hours the next week followed by 20 hours the next, what will the time period be for determining whether the 30-hour requirement is met? Being discussed are time periods such as a month or a quarter. There may also be state implications to consider in the case of fully insured plans.

GRANDFATHERED HEALTH PLANS

What is meant by “grandfathered plan”?

A grandfathered health plan is a plan in which an individual was enrolled on March 23, 2010. Renewal of the plan after such date of enactment does not alter the grandfathered status of the plan.

With respect to a grandfathered plan that is renewed, family members can enroll in the plan if enrollment is permitted under the plan terms in effect as of March 23, 2010. A grandfathered plan may also permit new employees (and their families) to enroll in such a plan.

Grandfathered plans are exempted from which health care reform mandates?

- Coverage of preventive services
- Application of in-network rates to all providers of emergency services
- Requirement that any in-network MD may be selected as primary care physician
- Requirement that individuals may see an OB/GYN without a referral
- New coverage appeal process
- Discrimination rules concerning highly compensated individuals

What health care reforms do group health plans have to meet even if they are grandfathered?

Grandfathered group health plans are not exempt from requirements related to:

- Annual and lifetime limits;
- Dependent coverage for children under age 26;
- Rescission prohibition;
- Pre-existing condition exclusions;
- Excessive waiting periods;
- Four-page Summary of Benefits and Coverage;
- Employer mandates; and
- Changes to consumer driven accounts, including FSAs, HRAs and HSAs.

Our group health plan has been in effect since March 23, 2010. What are the six specific changes that could cause the plan to relinquish grandfathered status?

Any of six changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status. Briefly stated, these six changes are:

- Elimination of all or substantially all benefits to diagnose or treat a particular condition
- Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20 to 25 percent)
- Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points
- Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, \$5 plus medical inflation)
- Decrease in an employer's contribution rate toward the cost of coverage by more than 5 percentage points
- Imposition of annual limits on the dollar value of all benefits below specified amounts

For a plan that is continuing the same policy, these six changes are the only changes that would cause a cessation of grandfathered status under the interim final regulations. Q/A-1, DOL's FAQs About the Affordable Care Act Implementation, Part II found at www.dol.gov/ebsa/faqs/faq-aca2.html.

Will a group health plan lose its grandfathered status if the employer changed insurance issuers, (i.e., switching from one insurance company to another)?

No. The original regulation only allowed self-funded plans to change third-party administrators without necessarily losing their grandfathered plan status. However, an amendment released on Nov. 15, 2010, allows all group health plans to switch insurance companies and shop for the same coverage at a lower cost while maintaining their grandfathered status. 26 CFR §54.9815-1251T(a)(1)(i). To retain grandfathered status, though, they must ensure that the structure of the coverage does not violate one of the other rules for maintaining grandfathered plan status, such as significant cost increases or a reduction in benefits.

If a group health plan changes issuers, what documentation must be provided?

The amendment issued on Nov. 15, 2010, provided that, to maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate or contract of insurance must provide to the new health insurance issuer documentation of plan terms (including benefits, cost sharing, employer contributions and annual limits) under the prior health coverage. These plan terms must be sufficient to determine whether any change is being made, other than a change in carriers, which would cause the plan to lose grandfathered status. This documentation may include a copy of the policy or summary plan description. 26 CFR §54.9815-1251T(a)(3)(ii). The amendment applies only to changes that are effective on or after Nov. 15, 2010. It does not apply retroactively to changes effective before this date. 26 CFR §54.9815-1251T(a)(1)(ii)

Our fully insured group plan was effective Oct. 1, 2010, and we switched carriers, losing the plan's grandfathered status. Since the DOL now says it is permissible to switch insurance carriers, can we get our grandfathered status back?

No. The amendment does not apply retroactively to changes to group health insurance coverage that were effective before Nov. 15, 2010.

My plan offers three benefit package options: a PPO, a POS arrangement, and an HMO. If the HMO relinquishes grandfathered status, does that mean that the PPO and POS arrangement must also relinquish grandfathered status?

No. The grandfather analysis applies on a benefit-package-by-benefit-package basis. In this situation, it is permissible to treat the PPO, POS arrangement and HMO as separate benefit packages. Accordingly, if any benefit package ceases

grandfathered status, it does not affect the grandfathered status of the other benefit packages. Q/A-2, DOL's FAQs About the Affordable Care Act Implementation, Part II: www.dol.gov/ebsa/faqs/faq-aca2.html.

How do the grandfathered rules regarding changes in employer contributions apply where an employer restructures its tiers of coverage?

The interim final grandfather regulations provide that the rules for changes to employer contributions apply on a tier-by-tier basis. As a result, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. In this example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50 percent (i.e., at least 45 percent).

If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under these rules. Therefore, for example, if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfathered status. Q/A-3, DOL's FAQs About the Affordable Care Act Implementation, Part II found at www.dol.gov/ebsa/faqs/faq-aca2.html.

If an employer plan sponsor raises the copayment level for a category of services (such as outpatient or primary care) by an amount that exceeds the standards set forth in the interim final regulations, but retains the copayment level for other categories of services (such as inpatient or specialty care), will that cause the plan to relinquish grandfathered status?

Yes. Each change in cost sharing is separately tested against the standards of the Departments' interim final grandfather regulations. Q/A-4, DOL's FAQs About the Affordable Care Act Implementation, Part II: www.dol.gov/ebsa/faqs/faq-aca2.html.

HSA/FSA/HRA

Is the maximum FSA contribution limit of \$2,500 applicable to individuals or families?

The limit applies on a per-participant basis, which means that employees with family members are not permitted to make higher health FSA salary reductions. However, a husband and wife who are each eligible for their own employment-based health FSAs will have separate limits. In other words, each spouse could separately elect up to \$2,500. Similarly, an employee who works for two or more unrelated employers may be permitted to salary reduce up to \$2,500 under each employer's health FSA. IRC§125(i), as amended by PPACA.

Will there be any changes to my HRA or HSA?

Employer and employee contributions to HRAs and HSA 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 on Jan. 1, 2018. Employee salary reductions to a health FSA will also be included in calculations, as well as any reimbursements made in excess of the salary reductions.

Also, there is an increased excise tax on distributions from HSAs that are not used for qualified medical expenses. Reimbursements that do not qualify as eligible qualified medical expenses are increased to 20 percent (from 10 percent) of the disbursed amount. This is effective for distributions made after Dec. 31, 2010. I.R.C. §§223(f)(4)(A) and 220(f)(4)(A).

Over-the-counter medications without prescriptions will no longer be reimbursable through an HSA, HRA or health FSA for medical expenses. This is effective Jan. 1, 2011. IRC §§220(d)(2) and 223(d)(2).

INDIVIDUAL MANDATE

What is the individual mandate? When is it effective?

Individuals will be required to maintain minimum essential coverage for themselves and their dependents starting in 2014.

Is there a penalty if an individual doesn't comply?

Those who do not comply with the individual mandate will be required to pay a penalty for each month of noncompliance. The penalty will equal the greater of either: (1) a percentage of the amount by which household income exceeds the personal exemption for the applicable tax year (applicable income) or (2) a flat dollar amount assessed on each taxpayer and any dependents with the total penalty for a family capped at three times the flat dollar amount for one taxpayer. PPACA §5000A(c).

Are all American citizens and legal residents required to purchase qualified health insurance coverage?

All American citizens and legal residents are required to purchase qualified health insurance coverage unless the individual falls into one of the following exceptions:

- Religious objectors;
- Illegal immigrants;
- Incarcerated individuals;
- Taxpayers with income under 100 percent of poverty, and those who have a hardship waiver;
- Members of Indian tribes;
- Those who were not covered for a period of less than three months during the year; or
- Individuals with income below the income tax threshold. PPACA, §5000A(e).

The penalty for those who are required, but fail, to purchase qualified health insurance coverage is equal to the higher of:

- For 2014: 1 percent of income or \$95
- For 2015: 2 percent of income or \$325
- For 2016: 2.5 percent of income or \$695
- Thereafter: Cost of living adjusted. PPACA §5000A(c)(3).

What happens if a taxpayer fails to pay a penalty?

A taxpayer who is required to pay a penalty but fails to do so will receive a notice from the IRS that they owe the penalty. If the taxpayer still does not pay the penalty, the IRS can attempt to collect the funds by reducing the amount of the taxpayer's tax refund in the future. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or penalty for such failure. The IRS may not file notice of lien or levy on any property for a taxpayer who does not pay the penalty.

INTERNAL APPEALS AND EXTERNAL REVIEW

My plan already provided an external review process before PPACA was enacted. Can my already-existing external review process be deemed to comply with PHS §2719(b)?

If your plan existed prior to enactment of PPACA, you should first check to see if your plan is a grandfathered health plan. If it is, the new external review provisions of PHS §2719(b) do not apply to your plan. PPACA §1251(e).

If your plan is not a grandfathered health plan and it is fully insured, the insurer will likely be utilizing existing state external review processes to comply with the new federal requirements. States have until Jan. 1, 2012, to ensure that their external review processes include the necessary standards, and HHS will determine whether each state external

review process meets the required standards by July 31, 2011. If a state's external review process does not meet these minimum standards, group health plans and health insurance issuers in the group and individual market in that state are required to establish their own external review process that meets the minimum standards established by the HHS.DOL Reg. §2590.715-2719(c)(3) and Technical Release 2011-02.

If your plan is not a grandfathered health plan and it is self-insured, relief is also provided. On Aug. 23, 2010, the DOL issued Technical Release 2010-01, which sets forth an enforcement safe harbor. If the plan complies with one of the methods set forth in the release, then neither the DOL nor the IRS will take any enforcement action with respect to PHSA§2719(b) during the transition period. DOL Technical Release 2011-01 at www.dol.gov/ebsa/newsroom/tr11-01.html for additional information, including effective dates related to this provision.

What if a self-insured plan's external review process does not satisfy the safe harbor in the DOL technical release?

For plans that do not satisfy the safe harbor in the technical release, compliance will be determined on a case-by-case basis under 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 PHSA §2719(b). Q/A-8, DOL's Questions Regarding Affordable Care Act Implementation found at www.dol.gov/ebsa/faqs/faq-aca.html.

However, two separate Technical Release documents (2010-01 and 2011-01) issued in August 2010 and March 2011 set forth an interim enforcement safe harbor for self-insured plans not subject to a state external review process or to the HHS-supervised process. This safe harbor permits a private contract process under which plans contract with accredited IROs to perform reviews. The guidance provides that self-insured plans must contract with at least two IROs by Jan. 1, 2012, and with at least three IROs by July 1, 2012, and to rotate assignments among them in order to be eligible for a safe harbor from enforcement from the DOL or IRS.

What if a self-insured plan does not contract directly with any IRO, but contracts with a third-party administrator (TPA) that, in turn, contracts with an IRO?

Technical Release 2010-01 does not require a plan to contract directly with any IRO. Where a self-insured plan contracts with a TPA that, in turn, contracts with an IRO, the standards of the technical release can be satisfied in the same manner as if the plan had contracted directly. Of course, such a contract does not automatically relieve the plan from responsibility if there is a failure to provide an individual with external review. Moreover, fiduciaries of plans that are subject to ERISA have a duty to monitor the service providers to the plan. DOL Reg. §2560.503-1(h)(2)(iii); Q/A-9 DOL's FAQs Regarding Affordable Care Act Implementation found at www.dol.gov/ebsa/faqs/faq-aca.html.

What if there is no IRO in my plan's state?

The IRO is not required to be in the same state as the plan. Plans may contract with an IRO even if it is located in another state. Q/A-10, DOL's FAQs Regarding Affordable Care Act Implementation found at www.dol.gov/ebsa/faqs/faq-aca.html.

LIFETIME LIMITS

Can a plan still have a lifetime limit on benefits paid?

Under PPACA, lifetime limits on the value of "essential health benefits" are prohibited in any health plan or insurance policy issued or renewed on or after Sept. 23, 2010. PHSA §2711, as amended by PPACA §§1001(5) and 10101(a). However, be aware that plans can put a lifetime dollar limit on spending for health care services that are not "essential health benefits" so long as the limits are otherwise permissible under other federal and state laws. Treas. Reg. §54.9815-2711T(b)(1).

The ban on lifetime dollar limits for most covered benefits applies to every health plan that is not considered an "excepted benefit" plan — whether coverage is received through an individual plan or through an employer. Clarify that the rules apply to grandfathered health plans (PHSA, §2711, as added by PPACA §§1001(5) and 10101(a)) and to group health plans and insurers (as defined by applicable provisions of PHSA, ERISA and the IRC). PPACA§1251(a)(4)(A)(ii), as amended by HCERA §2301(a).

LOCAL GOVERNMENT PLANS

Does health reform apply to governmental entities?

Yes. According to PHS §2722(a)(1)(A) and (B), there are no exceptions for state and local government plans under PPACA. However, HHS will not enforce these mandates against excepted benefits provided by state or local governments. PHS §2722(b) and (c). Also, the PHS mandates incorporated into ERISA and the Code generally do not apply to state or local governmental plans. ERISA §§3(32) and 4(b)(1); IRC §§414(d) and 9831. Thus, the provisions concerning fully insured, self-insured and grandfathered plans generally apply equally to state and local government plans as they do to the private insurance market and private employers.

MEDICAL LOSS RATIO INTERIM FINAL RULES

What is a medical loss ratio?

The medical loss ratio (MLR) is the cost of claims plus amounts expended on health care quality improvement expressed as a percentage of total premiums (excluding taxes and fees and allocable adjustments for risk adjustments, risk corridors and reinsurance PHS §2718(b)(1)(A)).

What are the MLR insurer reporting requirements?

Beginning in 2011, insurance companies that issue policies to individuals, small employers and large employers will have to report the following information in each state it does business:

- Total earned premiums;
- Total reimbursement for clinical services;
- Total spending on activities to improve quality; and
- Total spending on all other non-claims costs excluding federal and state taxes and fees, PHS §§2718(a) and (b)(1)(A), as added by PPACA §§1001(5) and 10101(f).

What is the medical loss ratio (MLR) calculation and when does it go into effect?

On Nov. 22, 2010, HHS issued interim final rules, effective as of Jan. 1, 2011, on the MLR calculation. Generally, under PPACA, health insurers must meet an MLR of 80 percent for insurance sold in the individual and small-group markets and a minimum of 85 percent in the large-group market. The MLR interim final rules outline disclosure and reporting requirements and discuss how insurance companies will calculate their MLR and, if needed, provide required rebates to policyholders. The rule allows “mini-med” plans to follow a different calculation formula than other plans in 2011. “Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements” under PPACA, 45 CFR Part 158, 75 Fed. Reg. 74863.

How will “mini-med” plans and “expatriate” plans be treated differently under the MLR interim final rules?

Under the interim final rules, insurers generally will report aggregate premium and expenditure data for each market. However, for the 2011 calendar year only, HHS will apply a methodological adjustment to the way the MLR is calculated for policies that have a total annual limit of \$250,000 or less (“mini-med” plans) and for expatriate plans, allowing insurers to report the experience from these plans separately from other policies. 45 CFR §§158.221(b)(3) and (4) and 158.120(d) (3) and (4). Insurers with mini-med or expatriate plans may apply to HHS for the special adjustment but are then required to report MLR data on an accelerated, quarterly basis. 45 CFR §158.110(b). HHS plans to revisit the special circumstances for these plans after reviewing the quarterly filings.

How will the MLR calculation affect agent and broker commissions?

With respect to the issue of agent and broker commissions, the rule includes agent and broker commissions as part of the “non-claims costs” in the MLR calculation and does not allow any portion of the commissions to be considered a pass-through expense excluded from the MLR calculation. The rule does, however, recognize “the potential impact of the MLR standard on agents and brokers,” and seeks comments on the approach taken by HHS. 75 Fed. Reg. 74863, 74877. For more information, see the CMS bulletin found at http://cciio.cms.gov/resources/files/2011_05_13_mlr_q_and_a_guidance.pdf.

MEDICARE

How will PPACA affect those employees who are eligible for Medicare coverage?

PPACA makes several changes to Medicare Part D coverage, including the following:

- The donut hole will be gradually closed for Medicare Part D beneficiaries. In 2010, such beneficiaries will receive a \$250 rebate. Thereafter, the beneficiary coinsurance rate will gradually phase down for the donut hole from 100 percent to 25 percent by 2020.
- Pharmaceutical manufacturers must provide a 50 percent discount on prescriptions filled for brand-name drugs which fall in the Medicare Part D donut hole, beginning in 2011.
- Between 2014 and 2019 the out-of-pocket amount that qualifies a beneficiary for catastrophic coverage will be reduced. PPACA, § 3301.

MODEL NOTICES

Where can I go to find health care reform model notices?

Model notices can be found at the DOL website, www.dol.gov/ebsa/compliance_assistance.html#section2, many in both English and Spanish.

NONDISCRIMINATION RULES FOR FULLY INSURED PLANS

When do the new nondiscrimination rules for non-grandfathered, fully insured plans go into effect?

The nondiscrimination rules for non-grandfathered, fully insured plans have been delayed, with no effective date at this time.

On Dec. 22, 2010, the IRS issued Notice 2011-1. The Notice delays the timing for compliance with certain nondiscrimination requirements of PPACA. Under PPACA §2716, non-grandfathered fully insured group health plans are required to comply with the nondiscrimination requirements found in IRC §105(h). Namely, such plans must not discriminate in favor of highly compensated individuals as to plan eligibility and benefits. Notice 2011-1 delays compliance with PPACA §2716 until after regulations or other administrative guidance under §2716 has been issued. As a result, a non-grandfathered insured group health plan sponsor will not be required to file IRS Form 8928 to report and pay excise taxes for plan years occurring before this anticipated guidance is released.

Are “management only” plans a thing of the past under this bill?

If the plan is fully insured and grandfathered, they can continue the management carve-out plan until the plan loses grandfathered status.

If the plan is fully insured and non-grandfathered, the plan will be able to continue the carve-out until an effective date is established and groups must comply with and pass the nondiscrimination testing. This will happen after regulations or other administrative guidance under PPACA §2716 has been issued. Once that happens, non-grandfathered plans will need to pass the nondiscrimination testing under §105(h).

If the plan is self-insured, it is already subject to nondiscrimination testing, as are any plans that are subject to IRC §125 (i.e., those plans that allow premiums to be paid on a pre-tax basis). While the tests under IRC §§105(h) and 125 are different – as are the definitions of a “highly compensated individual” – both are designed to ensure that a benefits plan is not designed to discriminate in favor of highly compensated individuals. In most cases, management carve-out plans will not pass the nondiscrimination testing under either §105(h) or §125.

Can certain employee groups be excluded from nondiscrimination testing under 105(h)?

For purposes of the nondiscrimination testing under §105(h), there are certain classes that can be excluded for eligibility testing purposes. These employees include:

- Employees who have not completed three years of service;
- Employees who have not attained age 25;
- Part-time or seasonal employees;
- Collectively bargained employees; and
- Nonresident aliens with no U.S. source of income.

NURSING MOTHERS

What is the break time requirement for nursing mothers under PPACA?

PPACA § 4207 amended §7 of the FLSA to require all employers to provide “reasonable break time for an employee to express breast milk for her nursing child for one year after the child’s birth each time such employee has need to express the milk.” Employers are also required to provide “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.” The frequency of breaks needed to express milk, as well as the duration of each break, will likely vary.

The FLSA nursing mothers requirement does not preempt states’ laws that provide greater protections to employees (for example, providing compensated break time, providing break time for exempt employees or providing break time beyond one year after the child’s birth). Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way that other employees are compensated for break time.

Only employees who are not exempt from the FLSA’s overtime pay requirements are entitled to breaks to express milk. While employers are not required under the FLSA to provide breaks to nursing mothers who are exempt from the overtime pay requirements of §7, they may be obligated to provide such breaks under state laws.

Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship. Whether compliance would be an undue hardship is determined by looking at the difficulty or expense of compliance for a specific employer in comparison to the size, financial resources, nature and structure of the employer’s business. All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Does an employer with multiple locations need to designate a place for nursing mothers at each location?

The law ensures that nursing mothers will have a private place to express breast milk at their place of employment. Thus, an employer with multiple locations will need to comply with the requirements of the act. The only exception would be for employers with less than 50 employees who are unable to implement the provision due to an undue hardship. It should be noted that a location with less than 50 employees would not qualify for the exception if there are 50 or more total employees within the company.

This is an area where further guidance would be welcomed. Although the DOL has published a fact sheet describing the anticipated application of this new legislation, no interpretive regulations have been issued, thus leaving many questions unanswered. Until regulations are issued, employers will have to use their best judgment in resolving these issues. The DOL fact sheet can be found here: www.dol.gov/whd/regs/compliance/whdfs73.htm.

OVER-THE-COUNTER DRUGS

Can over-the-counter (OTC) drugs be reimbursed through a tax-favored account?

As background, PPACA §9003 added §106(f) to the IRC. §106(f) revises the definition of medical expenses for employer-provided accident and health plans, (including health FSAs) and HRAs) and for HSAs and Archer MSAs to exclude OTC medicines or drugs unless prescribed. Thus, after Jan. 1, 2011, distributions from HSAs and Archer MSAs and reimbursements from health FSAs and HRAs may not cover expenses incurred for OTC medicines or drugs without a prescription (with the exception of insulin). The prohibition does not apply to non-medicine items available over-the-counter (e.g., equipment, supplies and medical devices).

According to Notice 2011-5, the IRS is permitting the use of health FSA and HRA debit cards to purchase prescribed OTC drugs and medicines, as long as these five requirements are satisfied:

- Prior to purchase, the prescription (Rx) is presented in any format to the pharmacist, who then dispenses the product and assigns an Rx number.
- The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser or person for whom the Rx applies, and the date and amount of the purchase.
- The pharmacy retains all records for review by the employer or its agent upon request.
- The debit card will not accept a charge for an OTC medicine or drug without an assigned Rx number.
- All of the other usual requirements are satisfied.

As long as these requirements are satisfied, the purchase will be considered fully substantiated at the time and point of sale. The above requirements must be met for vendors such as drug stores and pharmacies, non-health-care merchants with pharmacies, and mail order and Web-based vendors that sell prescription drugs.

PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)

What is the Pre-existing Condition Insurance Plan (PCIP)?

PPACA §1101 established the Pre-existing Condition Insurance Plan (PCIP), which is a temporary high-risk pool administered by either a state or the HHS. The PCIP will provide a new health coverage option for individuals who have been uninsured for at least six months, have a pre-existing condition or have been denied health coverage because of a health condition, and are U.S. citizens or are residing here legally.

The program:

- Will cover a broad range of health benefits, including primary and specialty care, hospital care and prescription drugs. All covered benefits are available, even to treat a pre-existing condition.
- Will not charge a higher premium just because of your medical condition.
- Does not base eligibility on income.

HHS, with the help of the U.S. Office of Personnel Management and the U.S. Department of Agriculture's National Finance Center, will run the PCIP in some states. The federal government is contracting with a national insurance plan to administer benefits in those states. Other states have requested that they run the program themselves. The program may vary depending on the state residency of the individual. The implementing regulations can be found at 45 CFR Part 152.

PREVENTIVE SERVICES

Do the mandated preventive services apply to HSA and HRA plans?

PHSA §2713, as added by PPACA, includes the mandated preventive services provision. This provision applies to “a group health plan and a health insurance issuer offering group or individual health insurance coverage.” The relevant definition for what constitutes a “group health plan” is that set forth in 42 U.S.C. §300gg-91. In that section “group health plan” means an employee welfare benefit plan (as defined in § 3(1) of ERISA) to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise. An HRA plan is included in this definition of a group health plan. However, the DOL has taken the position that HSAs are not ERISA employee welfare benefit plans, so the mandated preventive services would not apply to HSAs. See Field Assistance Bulletin 2004-1 found at [/www.dol.gov/ebsa/regs/fab_2004-1.html](http://www.dol.gov/ebsa/regs/fab_2004-1.html) and Field Assistance Bulletin No. 2006-02 found at www.dol.gov/ebsa/regs/fab_2006-2.html.

The legislation requires all plans to cover preventive services and immunizations, recommended by various federal agencies, and it also specifically includes certain child preventive services and women’s preventive care. Plans are prohibited from imposing any cost-sharing requirements.

Does this mean that an employer cannot charge a copayment for these services?

The regulations implementing the preventive services mandate clarify that “cost-sharing” includes copayments, coinsurances and deductibles. Treas. Reg. § 54.9815-2713T(d); DOL Reg. § 2590.715-2713(d); HHS Reg. § 147.130(d). Keep in mind that the regulations also explain that plans and insurers with provider networks can impose cost-sharing requirements on out-of-network preventive services. Further, cost-sharing is permitted for office visits when preventive services are billed separately (or are tracked as individual encounter data separately) or are not the primary purpose of an office visit.

REPORTING OBLIGATIONS FOR EMPLOYERS DUE TO HEALTH CARE REFORM

What are some of the new reporting obligations for employers due to health care reform?

The new reporting obligations for employers under PPACA are listed below:

- **W-2 Reporting:** Employers must report the “aggregate cost” of “applicable employer-sponsored coverage” on an employee’s Form W-2 starting with the 2012 tax year on the Form W-2 issued in January 2013. “Applicable employer-sponsored coverage” generally includes any employer-provided coverage under an insured or self-insured health plan, but is subject to numerous exceptions, including exceptions for accident-only insurance, disability income insurance, long-term care coverage, coverage only for a specified disease, and hospital indemnity or other fixed indemnity insurance. The term also does not include stand-alone, insured dental, or vision coverage. Strictly speaking, HSA and Archer MSA contributions, and salary reduction contributions to a health FSA, are included in the definition of applicable employer-sponsored coverage, but they are explicitly excluded from the W-2 reporting obligation. PPACA §9002 (amending IRC § 6051(a)).
- **Summary of Benefits and Coverage:** PPACA expands ERISA’s disclosure requirements by requiring that a four-page “Summary of Benefits and Coverage” be provided to applicants and enrollees before enrollment or re-enrollment. PHSA § 2715(a). The Secretary of HHS is charged with issuing guidance on this subject by March 23, 2011. Plans are not required to comply until guidance is issued. When effective, plans in violation will pay a fine of not more than \$1,000 for each failure (each enrollee shall constitute a separate offense).
- **Material Modification of Plan Notice:** Any material modification of plan terms or coverage that is not reflected in the most recently provided Summary of Benefits and Coverage must be issued in a summary of material modification at least 60 days before the modification becomes effective. PHSA § 2715(d)(4). Plans are not required to comply with this requirement until HHS has issued guidance on the Summary of Benefits and Coverage.

- **Quality of Care Reporting:** PPACA requires group health plans and health insurance issuers to submit an annual report to the Secretary of HHS addressing plan or coverage benefits and provider “reimbursement structures” that may affect the quality of care in certain specified ways. The reporting requirements are to be developed no later than March 23, 2012, and the secretary may enforce the requirement by “appropriate penalties.” Copies of the report must be made available to enrollees during each open enrollment period. PHSA § 2717(a).
- **Exchange Notice:** Effective beginning on March 1, 2013, PPACA amends the FLSA to require that employers provide all new hires and current employees with a written notice about the state exchange and the consequences if an employee decides to purchase coverage through the exchange in lieu of employer-sponsored coverage. FLSA § 18B.
- **Minimum Essential Coverage:** Effective in 2014, any insurer or self-funded employer that provides “minimum essential coverage” to an individual must report certain health insurance coverage information to the IRS. The insurer or employer must also provide a written statement to the covered individual. An employer that fails to comply with these reporting requirements is subject to penalties equal to \$50/missed statement, with a maximum potential penalty of \$100,000. IRC § 6055.
- **Qualified and Affordable Coverage:** Effective in 2014, PPACA requires certain employers to report to the IRS whether they offer their full-time employees and their employees’ dependents the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan. Reporting employers must also provide a related written statement to their full-time employees. The penalty equates to \$50/missed statement, with a maximum potential penalty of \$100,000. IRC §6056.

RESCISSIONS

What is a rescission and how is it affected by health care reform?

A rescission is a termination of coverage that has a retroactive effect. Group health plans and insurers are prohibited from rescinding coverage for individuals who are covered under the plan or coverage — except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage and with advance notice, effective as of plan years beginning on or after Sept. 23, 2010. PHSA § 2712. The plan must provide at least 30 days’ advance written notice to each participant who would be affected before coverage may be rescinded. Treas. Reg. § 54.9815-2712(a)(1); DOL Reg. § 2590.715-2712(a)(1); HHS Reg. § 147.128(a)(1).

Keep in mind that if there is a state law with stricter standards as to when coverage may be rescinded or canceled, that stricter law will apply.

Can employers cancel coverage for employees who don’t pay their portion of the monthly premium?

Yes, this is one example when retroactive termination of coverage is allowed. Technically, a cancellation of coverage for nonpayment is excluded from the definition of rescission. Treas. Reg. § 54.9815-2712(a)(2); DOL Reg. § 2590.715-2712(a)(2); HHS Reg. § 147.128(a)(2).

SEASONAL EMPLOYEES

Are seasonal employees defined or referred to under health care reform?

There are two references to seasonal employees in PPACA for benefit plan purposes.

The first is under the Small Business Tax Credit program. For this purpose, seasonal employees are not counted when determining the employer’s size and average annual wage. “Seasonal” employee is defined as a worker who performs work on a seasonal basis and does not work for the employer for more than 120 days. IRC § 45R(d)(5).

The same definition applies for the employer mandate purpose in 2014. When calculating whether the employer has 50 or more employees (and is thus subject to the employer mandate), seasonal employees would not be included. IRC §§ 4980H(c)(2)(B)(ii) and (E).

SELF-FUNDED PLANS

Are there any provisions of PPACA applicable to fully insured plans that are not applicable to self-funded plans?

Generally, the mandates applicable to fully-insured plans apply to self-funded plans as well. We are aware of three important provisions under PPACA that do not apply to self-funded plans: modified community rating standards, minimum loss ratio requirements and the requirement to provide an essential benefits package. Each provision is discussed briefly below.

PPACA applies strict modified community rating standards to certain insurers, which eliminate health factors and other factors (e.g., gender), to determine appropriate premium amounts. Insurers' ability to rate groups will be limited to geographic area, age and tobacco use. PHS § 2701, as added by PPACA § 1201. Self-funded plans may develop premium rates without regard to these strict limitations.

PPACA requires insurers in all markets to comply with certain minimum loss ratio (MLR) standards. For large group plans, the MLR is 85 percent and small group plans the MLR is 80 percent. PHS § 2718. This means that only 15 percent or 20 percent, respectively, of an insurer's revenue may go toward administrative costs and costs related to certain quality initiatives. If an insurer fails to meet these MLR standards, the insurer must rebate the amount over the threshold to the insureds. 45 CFR Part 158.

Health insurers selling plans through a state exchange and insurers in the individual and small group market must provide an "essential benefit" package. Essential benefits are defined to include items and services covered within the following 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 services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. PPACA § 1302(b). Self-funded plans are not required to cover such items and services and therefore have more flexibility in plan design.

SIMPLE CAFETERIA PLAN FOR SMALL EMPLOYERS

What employers will be eligible to establish a simple cafeteria plan?

Any employer that during either of the two preceding years employed an average of 100 or fewer employees on business days will be allowed to adopt a new "simple" cafeteria plan. If an employer has 100 or fewer employees for any year and establishes a simple cafeteria plan for that year, then it can be treated as meeting the requirement for any subsequent year even if the employer employs more than 100 employees in the subsequent year. However, this exception does not apply if the employer employs an average of 200 or more employees during the subsequent year. IRC § 125(j)(5)(A) and (B).

What is the benefit of the simple cafeteria plan?

This provision allows small but growing employers to continue to offer simple cafeteria plan benefits to employees without the concern of having to meet the nondiscrimination requirements of a classic cafeteria plan. These plans will be treated as meeting the nondiscrimination rules for cafeteria plans and most (but not all) component benefits (for example, health FSAs and DCAPS) so long as specified contribution, eligibility and participation requirements are met. It also appears that it will satisfy the nondiscrimination rules of IRC §§ 79, 105, and 129. IRC § 125(j).

What are the contribution, eligibility and participation requirements for a simple cafeteria plan?

A simple cafeteria plan must make a contribution to provide qualified benefits on behalf of each qualified employee, in an amount equal to a uniform percentage (not less than 2 percent) of the employee's compensation for the year, or an amount not less than the lesser of a) 6 percent of the employee's compensation for the plan year, or b) twice the amount of the salary reduction contributions of each qualified employee. If the employer bases the satisfaction of the

contribution requirements on the second option, it will not be in compliance if the rate of contributions to any salary reduction contribution of a highly compensated or key employee is greater than the rate of contribution for any other employee. IRC § 125(j).

A simple cafeteria plan also must satisfy minimum eligibility and participation requirements. The rules need clarification, but it currently appears that the requirements are met if all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and if all employees have the same election rights under the plan. IRC 125(j).

Can an employer elect to exclude any employees?

An employer may elect to exclude from the plan employees who:

- Have not attained the age of 21 before the close of the plan year;
- Have less than one year of service with the employer as of any day during the plan year;
- Are covered under a CBA if there is evidence that the benefits covered under the plan were the subject of good faith bargaining between employee representatives and the employer; or
- Are nonresident aliens working outside the United States whose income did not come from a U.S. source. IRC 125(j).

SMALL GROUP TAX CREDIT

What is the tax credit available to small employers?

For tax years 2010 through 2013, small employers will receive a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases out as firm size and average wage increases, taking into account what constitutes an "eligible" small employer as explained below. IRC § 45R; IRS Notice 2010-44 found at www.irs.gov/pub/irs-drop/n-10-44.pdf; IRS Notice 2010-82 found at www.irs.gov/pub/irs-drop/n-10-82.pdf

During the second phase, for tax years 2014 and later, eligible small businesses that purchase coverage through the state exchange are eligible for a tax credit of up to 50 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases out as firm size and average wage increases.

What is defined as an eligible small employer for purposes of the tax credit?

A small employer is defined for purposes of the tax credit as an employer with fewer than 25 full-time equivalent (FTE) employees and includes leased employees. This does not include seasonal workers unless the seasonal workers work more than 120 days per year. There are other types of employees who are not included, such as 2 percent shareholders and 5 percent owners of S corporations. FTE employee is determined by dividing the total number of hours of service for which wages were paid by the employer during the taxable year by 2,080, rounded to the next lowest whole number. If an employee works in excess of 2,080 hours during any taxable year, the excess is not taken into account. IRC §45R; IRS Notice 2010-44 found at www.irs.gov/pub/irs-drop/n-10-44.pdf; IRS Notice 2010-82 found at www.irs.gov/pub/irs-drop/n-10-82.pdf.

The employer's average wage amount is also relevant for determining whether a small employer is eligible for this tax credit. The tax credit applies to employers with an average annual wage amount of less than \$50,000 for years 2011, 2012 and 2013. Subsequent years will be adjusted according to a cost of living adjustment. The average wage amount is determined by dividing the aggregate amount of wages which were paid by the employer to employees during the taxable year by the number of FTE employees.

Thus, an eligible small employer is one that has fewer than 25 FTE employees and an average annual wage amount of less than \$50,000. In addition, the employer must contribute at least 50 percent of the total premium cost to be eligible.

STATE EXCHANGE

What is a state exchange?

State exchanges are intended to act like a portal through which consumers will be provided information about insurance coverage and through which insurance can be procured. Insurers will offer individual and small employers (up to 100 employees) the ability to purchase health insurance starting in 2014. States may open up the exchanges to allow large employers (more than 100 employees) to begin purchasing coverage starting in 2017.

Insurers will be required to offer certain categories of plans in the exchange, plus a catastrophic plan available to the young and healthy. PPACA §1311.

FREE CHOICE VOUCHER

Was the employee free choice voucher provision repealed?

Yes. The provision that was found in §10108 of PPACA was repealed in the “Department of Defense and Full-Year Continuing Appropriations Act, 2011,” HR 1473, which was signed by President Obama on April 15, 2011. This represents a major change in the employer provisions of health care reform.

The provision would have taken effect in 2014. “Offering employers” would have been required to provide certain “qualified employees” a voucher to be used in state exchanges when purchasing health coverage. An offering employer is any employer that offers minimum essential coverage to its employees through an “eligible employer-sponsored plan,” including grandfathered plans, and pays any portion of the costs of the plan. A qualified employee is an employee who does not participate in a health plan offered by the offering employer, whose household income for the tax year is not greater than 400 percent of the poverty line for a family of the size involved, and whose required contribution for minimum essential coverage through an eligible employer-sponsored plan:

- Exceeds 8 percent (indexed) of the employee’s household income for the tax year ending within the plan year; and
- Does not exceed 9.8 percent (indexed) of the employee’s household income for the tax year. The amount of the voucher would have been determined by whichever health plan offered by the employer resulted in the largest employer premium contribution. If the exchange coverage cost less than the voucher amount provided by the employer, the employee would have kept the excess contribution. Any excess amounts would have been tax-deductible for employers but taxable to the employee.

Employers would not have been penalized under the employer mandate (effective in 2014 and also known as the pay-or-play penalty) for any employee who was provided with a voucher. It is important to note that the employer mandate, requiring employers to pay a penalty for not offering coverage or offering coverage deemed unaffordable, was not repealed as part of HR 1473.

W-2 REPORTING

When will the mandatory W-2 health cost coverage reporting requirement go into effect?

On March 29, 2011, the IRS issued interim employer guidance on reporting the cost of health insurance coverage on employees’ W-2s, which is required. While the IRS previously made such reporting optional for tax year 2011 for all employers, it went one step further in Notice 2011-28 and provided additional relief for smaller employers – those filing fewer than 250 Forms W-2 – by making the requirement optional for those employers for the 2012 tax year as well (2012 W-2 forms would generally be furnished to employees in January 2013).

IRS Notice 2011-28 (found at www.irs.gov/pub/irs-drop/n-11-28.pdf) includes information on how to report the information required on a W-2, what coverage must be included and how to determine the aggregate cost of such coverage. The IRS emphasized that the reporting to employees is for informational purposes only and will not cause excludable employer-provided health care coverage to become taxable. The IRS also made clear that employers will not have to issue W-2s to retirees who receive health care coverage but no longer receive wages or salary.

What is considered employer-sponsored coverage and will need to be reported on the W-2?

The “aggregate cost” of employer-sponsored coverage will need to be reported on the W-2. Aggregate cost includes both employer and employee contributions and is calculated similarly to COBRA premiums. It includes both self-funded and fully insured medical coverage. Notice 2011-28 clarified that employer contributions to a health FSA and stand-alone dental and vision coverage, must be included in the W-2 reporting. It would not include disability insurance, long-term care coverage, HRA contributions, HSA contributions (which are already reported in another part of the W-2) or employee contributions to a health FSA. PPACA §9002.

Because employers will be required to include the value of benefits on an employee’s W-2, does this mean that employer-sponsored benefits will be treated as taxable income?

No. The W-2 reporting requirement is for informational and transparency purposes only.

WAITING PERIOD

How does health care reform affect waiting periods?

A waiting period is the period that must pass before coverage begins for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan. For plan years beginning on or after Jan. 1, 2014, any waiting period that exceeds 90 days will be considered an excessive waiting period and will be prohibited. PPACA §§2708 and 10106; HCERA §100.

WELLNESS PROGRAMS

How do the Departments’ interim final grandfather regulations affect wellness programs sponsored by group health plans?

Group health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries, by rewarding high quality providers, and by incorporating evidence-based treatments into benefit plans. However, penalties (such as cost-sharing surcharges) may affect the plan design in a manner that would cause the plan to lose grandfathered status. Thus, the incentives and the resulting plan design changes should be examined carefully. In addition, plans should take steps to ensure compliance with applicable nondiscrimination rules (such as the HIPAA nondiscrimination rules for group health plans and group health insurance coverage with respect to an individual based on a health-status-related factor) and any other applicable federal or state law. Q/A-5, DOL’s FAQs About the Affordable Care Act Implementation, Part II, found at www.dol.gov/ebsa/faqs/faq-aca2.html.

Did health reform change the incentive amount that may be offered to wellness plan participants?

A wellness plan that requires participants to satisfy a certain health standard (such as being a nonsmoker or having a certain cholesterol level) may offer an incentive related to the group health plan to achieve that standard (for example, participants who achieve the health standard may pay a lower premium contribution amount). The incentive amount is currently limited to a maximum of 20 percent of the cost of employee-only coverage. For plan years beginning on or after Jan. 1, 2014, the incentive limit is increased to 30 percent of the cost of employee only coverage. The secretaries of Labor, the Treasury and HHS have the right to increase to 50 percent if they deem it appropriate. PPACA §2705.

What is the Wellness Grant Program for small employers?

The Wellness Grant Program will assist eligible employers with implementing a comprehensive workplace wellness program for employees. To be eligible for the grant, the employer must have fewer than 100 employees and must not have had a wellness program in place on March 23, 2010. The effective date of this program is unknown at this time. PPACA §10408.

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