

Health Care Reform

Frequently Asked Questions & Answers

May 21, 2010

Disclaimer: This document addresses certain provisions of the Health Care Reform Law (the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act) (together, “HCR”) that affect employers, and is intended only for informational purposes based on Aon’s current understanding of HCR. It should not be relied upon as to any legal rights, obligations, or liability any particular employer may have under HCR. In addition, this summary was not prepared with the intent of being used, and cannot be used, by any employer for the purpose of (i) avoiding any tax penalties, or (ii) promoting, marketing, or recommending to another party any matter it addresses. For up-to-date information regarding HCR, please check our website at www.aon.com/healthcarereform.

Health Accounts

1. Does the new Flexible Spending Account (FSA) cap of up to \$2,500 include Dependent Care FSAs or just health FSAs? Does the cap also apply to health savings accounts (HSAs)?

Annual salary reduction contributions to health FSAs under a cafeteria plan are limited to \$2,500 per employee beginning January 1, 2013 (for taxable years beginning after 2012). The annual limit will be adjusted for inflation (CPI) beginning in 2014.

The limits apply only to health FSAs; they do not apply to dependent care FSAs, health reimbursement arrangements (HRAs), or HSAs. (Current law continues to limit contributions to dependent care FSAs and to HSAs.)

2. When is the exclusion of over-the-counter (OTC) drugs applied to FSAs?

Effective for taxable years beginning on or after January 1, 2011, OTC medications (except insulin) that are not prescribed by a physician will no longer be considered qualified medical expenses that can be reimbursed through health accounts, including health FSAs, HSAs, and HRAs.

3. What reimbursements for OTC medicines are prohibited?

It appears that expenses for excluded OTC medicines that are incurred on or after January 1, 2011, would no longer be reimbursable through health accounts (but expenses incurred before that date could be reimbursed after that date).

Plan Design Provisions

4. Do we have any direction at this time on what (if any) annual benefit maximums are permitted? For instance, are day or visit limits for therapies still permitted? Is a \$1,000 annual maximum for spinal manipulations acceptable? Or should these limits just be removed?

HCR prohibits any annual limits on the dollar value of “essential health benefits” for any health plan participant for plan years beginning on or after September 23, 2010, although HHS may permit “restricted” annual limits on essential health benefits for plan years beginning before January 1, 2014. We have no guidance from HHS on what constitutes “restrictive” annual limits on essential benefits.

Annual limits per beneficiary generally may be imposed on specific covered benefits that are not “essential health benefits” if otherwise permitted under federal or state law. In addition, it appears that day or visit limits for nonessential or essential health benefits would continue to be permitted.

Therefore, to the extent that HHS rules that any specific service is not considered an “essential health benefit,” it appears that an annual dollar maximum for that service would be acceptable.

5. What is the definition of “essential health benefits” in HCR?

HCR provides that HHS will define what constitutes essential health benefits, except that such benefits will include at least the following general categories and the items and services covered within the 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.

6. Is there a limit on cost-sharing for emergency room coverage?

HCR provides that emergency room copayments or coinsurance must be the same for in-network and out-of-network providers. In addition, the law prohibits plans from requiring prior authorization for emergency room services.

It is unclear when this provision is effective, but it appears to apply to grandfathered and nongrandfathered plans effective for plan years beginning on or after September 23, 2010.

Dependent Coverage

7. Please explain the requirement to cover dependent children up to age of 26. Is there a requirement that the child be a full-time student?

Group health plans, including grandfathered plans, that offer dependent coverage of children must make coverage available to adult children (even if the child is not a dependent of the parent for federal income tax purposes):

- until their 26th birthday (we believe that this means up through the calendar day immediately preceding the 26th anniversary of the dependent's date of birth); and
- regardless of the child's student or marital status.

This provision generally is effective for the first plan year beginning on or after September 23, 2010 (i.e., January 1, 2011, for calendar year plans), although collectively bargained plans may have a later effective date. Until the first plan year beginning on or after January 1, 2014, grandfathered group health plans are not required to extend coverage to adult children up to age 26 who have access to another eligible employer-sponsored health plan (a group health plan or group health insurance coverage which is a governmental plan, or any other plan or coverage offered in the small or large group market within a State).

8. Does the provision requiring employers to extend coverage to adult children (to age 26) also require us to subsidize that coverage as we do other dependents, or can we charge them a higher amount under a different enrollment tier?

Employers cannot charge more for coverage of adult dependent children than for other similarly situated dependents who did not lose coverage because of loss of dependent status. In addition, adult child dependents must also be offered the same benefit packages available to other dependent children.

9. What employer-provided adult dependent child coverage is eligible for tax-free treatment?

Coverage is tax-free if it provides reimbursement of expenses for medical care of the adult child. For example, the following types of plans can be provided tax-free to adult dependent children:

- Major Medical
- Dental
- Vision
- HRA
- Health FSA
- Specified Disease
- Supplemental Medical
- Onsite Medical

10. What group health plans are exempt from the requirement to adult child dependent coverage?

The new group health plan coverage requirement for adult children (up to age 26) does not apply to HIPAA-excepted benefits that are limited-scope dental or vision benefits which are provided under a separate insurance policy or are otherwise not an integral part of the plan (i.e., participants must have the right to elect not to receive coverage for the benefits, and a participant who elects coverage must pay an additional premium for that coverage). Limited-scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth), while limited-scope vision benefits are benefits substantially all of which are for treatment of the eye.

11. Will an employee be taxed on any coverage provided to an adult child up to age 26, or did the law change the definition of "dependent" for these purposes so that the coverage will not be taxable?

The coverage of an employee's adult children, and reimbursements of their medical expenses, under an employer-provided health plan is not taxable for any year in which the child has not yet turned 27. To be eligible for coverage, the child otherwise does not have to be considered a dependent for exemption purposes on their parents' federal tax return.

12. How will coverage of adult children be taxed in 2010?

Effective March 30, 2010, coverage under an employer-provided health plan and amounts paid or reimbursed under such a plan for medical care of an employee, his spouse, his dependents (within the meaning of the Internal Revenue Code), or his child (within the meaning of the Internal Revenue Code) who has not attained age 27 as of the end of the employee's taxable year are excluded from the employee's gross income.

13. Can employees make mid-year changes to their health plan elections for 2010 regarding coverage of adult children?

On or after March 30, 2010, an employer may permit employees to make a mid-year change in their cafeteria plan elections that affect coverage of children under age 27, including becoming newly

eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage. If this is implemented by an employer in 2010, the cafeteria plan must be amended by December 31, 2010, retroactive to the first date in 2010 when employees are permitted to cover children under age 27 (but not before March 30, 2010).

14. Can an employer voluntarily comply with the extension of dependent coverage to age 26 requirement earlier than the required effective date (first plan year beginning on or after September 23, 2010)?

Employers can voluntarily extend coverage of dependent children to age 26 in advance of the required effective date specified in the law (the first plan year beginning on or after September 23, 2010). Voluntary compliance before the mandatory effective date will not cause a plan to lose grandfathered health plan status for any purpose under the Affordable Care Act, as amended.

15. Are there special procedures for enrolling newly eligible dependent children under age 26?

Yes. Any adult child enrolling in group health plan coverage pursuant to this new enrollment right under HCR must be treated as a special enrollee under HIPAA. Group health plans must offer a 30-day special enrollment opportunity, and a written notice must be provided to eligible dependents regarding their enrollment rights no later than the first day of the first plan year beginning on or after September 23, 2010. The written notice must include a statement that the children whose coverage ended, who were denied coverage, or were not eligible for coverage because the availability of coverage ended before attainment of age 26 are eligible to enroll in the plan. The notice may be provided to an employee on behalf of the employee's child. Plans may include the notice in their enrollment materials, provided that the statement of special enrollment rights is prominently displayed.

16. How are dependent children under age 26 who are currently receiving coverage through COBRA affected by this requirement?

Dependent children under age 26 who qualify for the special enrollment opportunity and are covered under COBRA must be provided the opportunity to enroll in the plan other than as a COBRA qualified beneficiary.

17. Are children under age 26 who were previously never enrolled in the plan now eligible for coverage?

Yes. Group health plans must now provide children who were previously never enrolled in the plan because of ineligibility due to age a special enrollment opportunity to enroll in the plan as of the first day of the first plan year beginning on or after September 23, 2010.

18. Are plans required to cover the children (under age 26) of employees who are not enrolled in the plan?

Group health plans must offer both the benefit-eligible parent and the child a special enrollment opportunity to enroll in the plan as of the first day of the first plan year beginning on or after September 23, 2010.

19. Are plans required to allow parents the option to switch benefit packages if their children qualify for the special enrollment opportunity?

If a child qualifies for the special enrollment opportunity, and the parent is enrolled in one of multiple benefit package options that are available, group health plans must provide both the parent and the child the opportunity to enroll in any benefit package option for which the child might otherwise be eligible, in effect allowing the parent to switch benefit package options.

Grandfathered Plans

20. Please explain grandfathering and which requirements are waived for grandfathered plans.

HCR draws a distinction in some cases between new market reforms and consumer protections that are applicable to all group health plans and those that are not applicable to “grandfathered health plans.” The term “grandfathered health plan” is not clearly defined, although the prevailing interpretation is any group health plan in existence on the date of the law’s enactment (March 23, 2010) is considered a grandfathered plan.

The grandfathered plan rule is not limited to individuals enrolled on the date of enactment, but rather:

- New employees (and their families) may be covered under an employer’s grandfathered plan
- Family members of current employees who are covered by the grandfathered plan may also be added, if their enrollment was permitted under plan terms on March 23, 2010

Provisions applicable to all group health plans as of the law’s relevant effective date, regardless of “grandfathered” status, include:

- Coverage of adult children up to age 26 (grandfathered group health plans do not have to comply with this requirement until the first plan year beginning on or after January 1, 2014, if the adult child is eligible for coverage under another eligible employer-sponsored health plan)
- Lifetime/annual limit restrictions
- Rescission restrictions
- Preexisting condition exclusions
- 90-day waiting period limit
- Uniform summary of benefits

Grandfathered health plans are exempt from various provisions of HCR, including:

- Coverage of preventive services without cost-sharing
- Cost sharing limits
- Insured group health plan nondiscrimination rules
- Claims appeals and review process
- Selection of doctors and referral requirements
- Coverage of clinical trials
- No discrimination against providers.

It is unclear the extent to which a plan will be considered “grandfathered” if it is amended significantly, including potentially new plan designs or features, or offered to new categories of employees who previously were ineligible for the plan. Until further official guidance is issued, employers should proceed cautiously before modifying their existing health plans.

Employer Coverage Requirements

Coverage

21. How does HCR impact part-time worker coverage?

There generally is no requirement under HCR for employers to offer health coverage to any employees (whether full-time or part-time). However, employers that employed an average of at least

50 full-time employees (defined as those employees for any month who work on average at least 30 hours per week) during the prior calendar year (an “applicable large employer”) may be subject to certain financial penalties if a full-time employee enrolls in a qualified health plan through an Exchange and receives a premium tax credit or cost-sharing reduction during any month in the current calendar year (i.e., the so-called “free rider” or “shared responsibility” penalty). Part-time employees are relevant for this purpose only to determine whether the employer is an applicable large employer: when determining whether an employer employed at least 50 full-time employees in the prior year, the number of part-time employees is “converted” into the equivalent number of full-time employees (on an aggregated basis of hours worked for the month divided by 120 hours) and then added to the number of full-time employees. Seasonal employees employed for no more than 120 days are disregarded when determining whether the employer employed at least 50 full-time employees in the prior year.

22. When do plans governed by collective bargaining agreements have to comply with the market reform/plan design requirements?

HCR provides that health insurance coverage maintained pursuant to one or more collective bargaining agreements (CBAs) ratified before March 23, 2010 is not subject to many of the employer mandates in the law until the date on which the last of the CBAs relating to the coverage terminates. It is unclear whether this provision applies to self-insured plans.

Employer “Free Rider” Penalty

23. How does the “free rider” penalty work?

Effective for the first plan year beginning on or after January 1, 2014, applicable large employers (discussed above) will be subject to the so-called “free rider” penalty if any of their full-time employees purchase subsidized insurance through an Exchange. For purposes of the penalty, a “full-time employee” is defined as an employee who works on average at least 30 hours per week with respect to any month.

Employers who **DO NOT** offer health coverage to full-time employees must pay a penalty of 1/12 times \$2,000 per month per full-time employee, without including the first 30 employees in the calculation. Penalties are calculated on a monthly basis.

Employers who **DO** offer coverage must pay a penalty for each employee who purchases subsidized coverage in the exchange AND either of the following criteria is satisfied:

- the employer’s coverage is deemed “unaffordable” for the employee because it exceeds 9.5% of household income; or
- the plan’s share of the total allowed costs of benefits has an actuarial value of less than 60%.

The monthly penalty is equal to 1/12 times \$3,000 for each non-covered employee who meets the criteria specified above, subject to a ceiling of 1/12 times \$2,000 times the number of full-time employees. For purposes of the ceiling, the first 30 full-time employees are not taken into account.

The free rider penalty is paid by employers and is not tax deductible.

24. Will employees need to work a minimum number of hours in order to be covered under an employer's health plan?

Employers can still establish the eligibility criteria for group health plan coverage. However, applicable large employers will be subject to the “free rider” penalty if they do not offer full-time employees the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.

25. Does the free rider penalty apply to part-time employees?

Employers will not be subject to a penalty for not offering coverage to employees who work less than 30 hours per week. However, part-time employees are included in the calculation to determine whether employers potentially are subject to the penalty for any year because they employed at least 50 full-time employees in the prior year.

26. Does the free rider penalty apply to seasonal employees?

If an employer is considered an applicable large employer (i.e., employed at least 50 full-time employees in the prior year), then it must provide health coverage for all full-time employees (working 30 or more hours per week), or be subject to the free rider penalty. This requirement appears to apply monthly with respect to any full-time employee, including seasonal employees who work at least an average of 30 or more hours per week for the month. *Note: Seasonal employees who are employed for no more than 120 days are disregarded only when determining whether the employer is an applicable large employer.*

27. Is the free rider penalty tax-deductible to employers?

No, employers cannot deduct any free rider penalty amounts.

“Free Choice” Vouchers

28. Please explain how vouchers work?

HCR provides that employers that offer, and subsidize any portion of, minimum essential coverage must provide free-choice vouchers to qualified employees to be used to purchase Exchange-provided coverage. This provision is effective for taxable years beginning on or after January 1, 2014.

29. With regards to vouchers, what is the definition of a qualified employee?

A qualified employee is any employee during a plan year:

- who does not participate in the employer’s health plan;
- whose contribution towards minimum essential coverage under the employer plan is more than 8.0%, but not more than 9.5% (HCR states that this is 9.8%, although that appears to be an error), indexed for inflation, of the employee’s annual household income during the taxable year; and
- whose household income does not exceed 400% of federal poverty limit for a family of the size involved.

30. How will employers know which employees are eligible for vouchers?

The Exchange will notify the employer when an employee has opted to enroll in an Exchange-provided plan and is eligible for the voucher payment. It is unclear how the notice will be provided and how payments will be processed; these details will be established by regulations.

31. How do employers determine the amount of the voucher to provide to eligible employees?

The voucher amount is equal to the employer's monthly subsidy towards the cost of the plan which would have been paid by the employer if the employee were covered, based on the employee's coverage level (e.g., individual or family coverage), and to which the employer pays the largest portion of the cost.

32. If employers provide vouchers for eligible employees, are they also subject to the free rider penalty for those employees?

No, the free rider penalty is not imposed for employees who receive vouchers.

33. Do employees who receive vouchers have to pay taxes on the voucher amount?

No, the voucher value is excludable from the employee's federal taxable income to the extent it is used to pay for Exchange-provided coverage. If the cost of Exchange coverage is less than the voucher amount, the difference is paid to the employee and includable in income. The employer can deduct the amount of the voucher for federal income tax purposes.

34. Are employees who receive vouchers also eligible for premium tax credits and cost-sharing reductions through an Exchange?

No, voucher recipients are ineligible for tax credits or cost-sharing reductions through an Exchange.

Retiree Health Provisions

35. What is the pre-65 retiree reinsurance program and will it significantly reduce costs?

The federal government will allocate \$5 billion toward the creation of a temporary reinsurance program for employer-sponsored early retiree coverage that will reimburse 80% of claims between \$15,000 and \$90,000. The purpose of the program is to encourage employers that currently offer retiree medical coverage to continue to do so until the Exchanges are up and running. Eligible employers have the potential to save up to \$75,000 per claim.

Eligible claims are those for individuals at least age 55 (and their dependents) who are not eligible for Medicare and are not active workers.

- Includes documented retiree cost-sharing (deductibles, copays, coinsurance, etc.)
- Includes medical and prescription drug claims (dental claims are not explicitly included)

Eligible plans must apply for the program and meet minimum requirements for management of participants with chronic and high-cost conditions. Reinsurance payments received by employers must be used to reduce retiree and/or sponsor costs. A sponsor must be able to explain how reimbursements will be applied to maintain its level of effort in contributing to support the plan.

Reimbursements are not treated as taxable income to the employer.

36. What is the effective date of the pre-65 retiree reinsurance program?

The program is effective June 1, 2010, and ends January 1, 2014 (or sooner, if funds are depleted). Sponsors may apply for plan years that begin before June 1, 2010, but end after that date. In that case, the amount of claims incurred before June 1, 2010 (up to \$15,000) count toward the \$15,000

cost threshold and the \$90,000 cost limit. The amount of claims incurred before June 1, 2010, in excess of \$15,000 is not eligible for reimbursement and does not count toward the cost limit. The reinsurance amount to be paid is based solely on claims incurred on and after June 1, 2010, and that fall between the cost threshold and cost limit for the plan year.

Tax Provisions

37. How is the 40% excise tax on high-cost plans calculated?

A 40% non-deductible excise tax will be imposed on insurers (or the administrator, in the case of a self-insured group health plan, a health FSA, or an HRA), effective for tax years beginning on or after January 1, 2018, on the aggregate value of employer-sponsored health coverage to the extent the coverage exceeds thresholds of \$10,200 for individuals and \$27,500 per year for families (indexed for inflation). Coverage under multiemployer plans is deemed to be family coverage for this purpose.

These thresholds are increased to \$11,850 for individual coverage and \$30,950 for family coverage, for retirees over age 55 who are not Medicare-eligible and for workers in certain “high-risk” professions. Plans that have higher healthcare costs than the national average, due to the age and/or gender of their employees, may also qualify for higher thresholds.

The dollar thresholds will be increased in 2018 if premiums for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan increases by more than 55% for the period 2010 to 2018.

The amount subject to the excise tax for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the year, and the amount of employer contributions to an HSA or Archer MSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer-sponsored health insurance coverage, including coverage for any supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount. For self-funded plans, values are calculated using the methodology for COBRA continuation coverage purposes. Amounts potentially subject to the tax include:

- Health plans and other supplemental coverage
- Amounts reimbursable under health FSAs and HRAs
- Employer contributions towards HSAs or Archer MSAs

Certain benefits are excluded from the calculation, including:

- Separate insurance policies for treatment of the mouth or eye
- Disability insurance
- Liability insurance
- Workers’ compensation or similar insurance

38. Who will figure the 2018 value of our health plans relative to the high-cost excise tax (so-called “Cadillac” standard)?

Aon Consulting actuaries will use our actuarial modeling tools to determine the value of an employer’s plan coverages and the amount, if any, that exceeds the threshold amounts.

Reporting

39. What health benefit amounts will be reported on Forms W-2?

Employers must include on annual Forms W-2 the aggregate cost of group health plan benefits (excluding FSA, HSA, or Archer MSA contributions, or the cost of long term care, and certain other excepted benefits) provided to employees for taxable years beginning on or after January 1, 2011 (i.e., Forms W-2 issued in 2012 for 2011 wages, and issued thereafter for subsequent years).

Employers can calculate the reportable value based on a methodology similar to that used under COBRA (minus the 2% COBRA administrative fee, if charged). If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate individual and family premiums for this purpose.

Material Modifications

40. Does HCR require advance notice to participants of material modifications to health plans?

Plans must provide 60-days advance notice of any material modifications in plan terms that are not reflected in the new uniform summary of benefits required to be issued by employers annually (the first one is to be issued no later than March 23, 2012). There is no official guidance yet on what would be considered a “material modification.”

41. Are employers subject to penalties for not providing advance notification of material modifications to plans?

Employers are subject to a \$1,000 fine per participant for each willful failure.

Wellness Grants

42. Which employers are eligible for wellness grants from the federal government?

HCR establishes a grant program for small employers that employ fewer than 100 employees who work 25 or more hours per week and that did not provide a workplace wellness program as of March 23, 2010. HHS is charged with developing program criteria based on evidence-based research and best practices.

43. How is the wellness grant program funded?

The program is funded with \$200 million for the period of federal fiscal years 2011 through 2015.

44. What types of wellness programs do employers have to provide in order to qualify for the wellness grant program?

To qualify for the program, eligible employers are required to provide a comprehensive workplace wellness program that includes:

- Health awareness initiatives (including health education, preventive screenings, and health risk assessments);
- Efforts to maximize employee engagement and participation;
- Initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials); and
- Supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health).

45. How do employers apply for the wellness grant program?

Eligible employers who want to participate in the program must submit an application to HHS (application details are yet to be determined by HHS) that includes a proposal for a qualified comprehensive workplace wellness program.