Questions and Answers on Health Care Reform

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	Question	Answer
Annual Limits		
1	What are "restricted annual limits"?	Under Health Care Reform, annual limits are being phased out. By 2014, no annual limits will be permitted for essential health services. Until 2014, health plans may have reasonable restrictions on annual limits, as permitted by guidance that will be issued by the Department of Health & Human Services ("HHS"). In setting guidelines for these "restricted annual limits," HHS is charged with ensuring that those covered by plans will have access to needed services with minimal impact on premiums.
Cost Sharing		
2	Does the prohibition against cost-sharing for preventive health mean that a health plan that covers 100% of the expenses of immunizations and preventive health services may not charge a $25 office visit copay?	More guidance is needed. However, under the language in the statute, it seems that charging a $25 copay for an office visit in which the only services provided are immunizations and preventive health services would no longer be allowed. It is not clear what would happen if preventive health services are bundled with non-preventive health services in the same office visit.
Participating Physician		
3	Is a health plan required to consider as a participating physician *any* primary care provider that a participant or beneficiary chooses?	No. Under the new law, a health plan that requires or provides for the designation of a participating primary care provider is required to allow individuals covered under the health plan to designate any *participating* primary care provider who is available to accept such individual. This does not mean that a health plan must allow participants or beneficiaries to designate non-participating primary care providers. It also means that an individual can only designate a participating physician who is willing to accept the individual as a patient.
Grandfathered Plans		
4	Is there additional guidance regarding the definition of	Not yet, but we are hoping for guidance soon.

	grandfathered plans?	
Mental Health Parity		
5	Will health plan coverage changes made in 2010 to comply with the new mental health and substance use disorder parity regulations cause the loss of grandfathered status?	We are still waiting for guidance as to how a health plan might lose its grandfathered status. However, we are hopeful that changes made to comply with laws or regulations that were passed or issued prior to Health Care Reform will not cause the loss of grandfathered status.
Excepted Benefits		

6	Do the health plan mandates in part A of title XXVII of the Public Health Service Act , including those added by Health Care Reform, apply to dental plans, vision plans, or retirement medical plans?	Although it's not entirely clear yet, we think that certain "excepted benefits" that do not have to comply with HIPAA portability requirements will also not have to meet the new health plan mandates under Health Care Reform.
		
		In general, "excepted benefits" include:
		
		• Coverage only for accident, or disability income insurance, or any combination thereof;
		• Coverage issued as a supplement to liability insurance;
		• Liability insurance, including general liability insurance and automobile liability insurance;
		• Workers' compensation or similar insurance;
		• Automobile medical payment insurance;
		• Credit-only insurance;
		• Coverage for on-site medical clinics;
		• Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
		• The following benefits, if offered separately from medical benefits:
		  ○ Limited scope dental or vision benefits;
		  ○ Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
		  ○ Such other similar, limited benefits as are specified in regulations;
		• The following benefits, if offered as independent noncoordinated benefits:
		  ○ Coverage only for a specified disease or illness; and
		  ○ Hospital indemnity or other fixed indemnity insurance; and

		• Medicare supplemental health insurance if offered under a separate policy, certificate, or contract of insurance. We are still waiting for clarification on whether the new health plan mandates will apply to retiree-only health plans.
Adult Child Coverage		
7	When do employers have to comply with the adult child coverage requirements?	Health plans that offer dependent child coverage have to comply with the adult child coverage mandate starting with the first plan year beginning on or after September 23, 2010. This will be the plan year beginning January 1, 2011, for calendar year plans.
8	Are health plans required to cover families of employees?	No. Health Care Reform does not require an employer health plan to cover dependents. However, if a health plan covers dependent children, then it must provide coverage to adult children until age 26. A plan has the option of covering a child on a tax-free basis until the end of the year in which the child turns age 26.
9	If an adult child is married and required to be covered, do the spouse and any children of the adult child also need to be covered?	No. Health plans do not need to provide coverage to the spouse or children of covered adult children.
10	Are health plans able to add coverage for adult children now?	Health plans are able to add coverage for adult children before the required implementation date. However, to do so this year will require an amendment to the health plan document by December 31, 2010. Additionally, insured health plans should confirm that the insurer will provide coverage for adult children, and self-insured health plans should confirm that the re-insurer will provide stop-loss coverage for adult children. A list of insurers that have agreed to provide coverage to adult children who graduate or age off their parents' insurance before the required implementation date is available from the Employee Benefits Security Administration at http://www.dol.gov/ebsa/newsroom/fsdependentcoverage.html. The exclusion from gross income for adult children is already effective and applies to both reimbursements for medical care expenses and to the value of the employer-provided health insurance. So, employees who have adult children who are added to their health plan will not have to include the value of such coverage in their gross income.
11	What benefits must a	A health plan must offer all the benefits packages to adult children that are

	health plan provide to adult children?	available to similarly situated individuals who did not lose coverage because of loss of dependent status.
12	What amount may a health plan charge for coverage of adult children?	A health plan may only charge the same amount for coverage of adult children as for similarly situated children who did not lose coverage because of loss of dependent status. This means that if dependent coverage is provided under family coverage, then the health plan may not impose an additional premium surcharge for children over age 18. However, if the health plan offers tiers of coverage based on the number of dependents and the cost of coverage increases based on the number of covered individuals regardless of age, then the health plan may charge an additional premium surcharge for the adult child provided the surcharge is not based on the adult child's age.
13	What if an adult child is currently on a health plan through COBRA? Does the adult child now have the ability to receive coverage under the health plan at the normal cost-sharing rates?	Health Care Reform requires that health plans provide coverage for adult children until age 26 for plan years beginning on or after September 23, 2010. So if an adult child is currently on COBRA, the health plan will have to allow the employee to add the adult child to the employee's coverage under the health plan with coverage starting on the first day of the next plan year. Health plans will have to provide adult children a 30-day special enrollment period that must begin no later than the first day of the next plan year beginning on or after September 23, 2010 and regardless of whether open enrollment is otherwise available. This special enrollment period can coincide with the normal open enrollment period to satisfy this requirement. The health plan will have to provide coverage to adult children at the cost-sharing rates that are available to similarly situated children who did not lose coverage because of loss of dependent status.
14	Can Health FSA funds be used for the reimbursement for medical care expenses of adult children until age 26?	Yes
Non-Discrimination		
15	If a health plan offers dependent coverage to only the managerial level employees is it necessary to offer dependent coverage to all employees?	A health plan that covers dependents only for managerial level employees raises nondiscrimination issues. If this is a self-insured health plan, it would be necessary to evaluate the situation carefully in light of all the facts and run nondiscrimination tests to see if it could be maintained as a nondiscriminatory plan. For plan years beginning on or after September 23, 2010, the nondiscrimination rules will also apply to non-grandfathered fully insured health plans. Fully-insured grandfathered plans will not need to meet these requirements as long as they retain their grandfathered status.

Consumer Driven Plans		
16	Will "enrollment in an Exchange" be a new permitted election change under the § 125 regulations?	More guidance is needed. Such guidance may come in the final § 125 regulations.
17	May participants of a Health FSA that includes a grace period continue to receive reimbursements for over-the-counter medical expenses incurred after December 31, 2010?	No. For medical expenses incurred after December 31, 2010, including during any grace period for the 2010 plan year (i.e., January 1, 2011, to March 15, 2011), reimbursements are allowed only if the medicine or drug is prescribed, except that insulin may continue to be covered without a prescription. This rule applies to both calendar year and non-calendar year plans and there is no "grandfathering" of existing plans.
18	When is the Health FSA annual limitation of $2,500 effective?	The Health FSA annual limitation of $2,500 is effective for a participant's tax year (generally the calendar year) beginning after December 31, 2012.
Affordable Coverage		
19	How does the employer determine an employee's "household income" for purposes of ascertaining if the employer's health plan provides affordable coverage?	Whether the employer's health plan offers affordable coverage will be determined based on the employee's application for premium tax credits and reduced cost-sharing made to an Exchange. Employees will have to provide certain tax-related information, including information for determining household income, on their application. The Exchange will then transfer this information to HHS and HHS will request verification of the tax related information from the IRS. Once verified, HHS will notify the Exchange of the results. Exchanges will then report to an employer whether it has any employees for whom the employer's coverage is deemed unaffordable.
20	Regarding affordable coverage, is there a difference between self-only coverage and family coverage?	When an employee purchases self-only coverage it is clear that affordable coverage will be determined based on the cost of self-only coverage. However, when the employee purchases family coverage Health Care Reform is unclear whether affordable coverage is determined based on the cost of self-only coverage or family coverage. More guidance is needed regarding this determination.
21	How is the "cost" of health plan coverage determined for purposes of affordable coverage?	The cost is determined based on the portion of the annual premium which would be paid by the individual (regardless of the method of payment).
Essential Health Benefits		
22	Is there a more detailed definition of what	Essential health benefits include:

	qualifies as an "essential health benefit"? For example, where would transplant fall? Chiropractic care?	• Ambulatory patient services, • Emergency services, • Hospitalization, • Maternity and newborn care, • Mental health and substance use disorder benefits (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. More guidance is needed as to the specific procedures and services that are considered to be "essential health benefits."
Full-Time Employee		
23	What is a considered a full-time employee?	In many instances, the term full-time employee is used but not defined in Health Care Reform. However, sometimes a definition is provided. The following are some of the more important requirements that refer to full-time employees or employees for determining the applicability of the requirement. a. For the employer play or pay mandate, a full-time employee during any month is an employee who is employed on average for at least 30 hours of service per week. This likely includes contract employees working for specific limited time periods greater than a month. More guidance is needed regarding the meaning of "hours of service," including with regard to employees who are not compensated on an hourly basis. To determine if an employer has 50 or more full-time employees, the employer must count full-time employees and "full-time equivalents," which are determined by dividing total hours of service provided by non-full-time employees for the month by 120. b. For the requirement that employers automatically enroll new full-time employees if they have more than 200 full-time employees and offer employees enrollment in one or more health plans, more guidance is needed regarding the definition of the term full-time employee.

		c. For determining whether an employer has on average 100 or fewer employees on business days during either of the two preceding years in order to be eligible for the simple cafeteria plan rules, the term employee is not defined. d. For the small employer health insurance tax credit, the number of full-time equivalent employees equals the total number of hours for which wages were paid to employees during the tax year, divided by 2,080. However, if an employee works for more than 2,080 hours of service, then only 2,080 hours of service are considered in the calculation. Leased employees are considered employees. However, self-employed individuals, 2% shareholders of an S corporation, 5% owners of the employer, and those who are related to these individuals or who are members of the same household as these individuals are not employees. In addition, a seasonal worker is not considered an employee unless he or she works for the employer for more than 120 days during the taxable year. e. For purposes of determining whether a qualified health plan offered through an Exchange may be offered through a cafeteria plan, the term full-time employee as used in the definition of qualified employer is not defined. In general, a qualified employer will be an employer who employed an average of at least one, but not more than 100, employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.
24	Would it be beneficial for a large company to separate into several smaller companies to avoid having to pay the applicable penalties for failing to provide affordable coverage?	This is unlikely to be beneficial. Individual employers within the same controlled group of companies are treated as one employer under the employer aggregation rules, so any transaction to break up a large company and avoid Health Care Reform would have to transfer ownership of the smaller surviving companies to unrelated individuals or entities. Also, such a transaction would have significant costs and tax effects that could outweigh the cost of the penalty for failing to provide affordable coverage.
Free Choice Voucher		
25	Will HHS supply model "free choice vouchers" to employers?	Although Health Care Reform does not directly address this issue, presumably HHS or the Exchanges will provide additional guidance on vouchers, including their content and appearance requirements.
Cost of Coverage		
26	How is the "cost" of group health plan coverage determined for	For insured health plans, this would be the full cost of the premium (as paid by both employee and employer). For self-insured health plans, this would be the cost determined under rules similar to the rules for determining the

	purposes of W-2 reporting?	cost that may be charged for COBRA coverage (without the 2% administrative charge that may be added to the cost of COBRA coverage).

27	Does short-term disability coverage or long-term disability coverage have to be included in the aggregate cost of applicable employer-sponsored coverage on an employee's W-2?	No. For tax years beginning after 2010, employers need to include the aggregate cost of applicable employer-sponsored coverage on an employee's W-2. Applicable employer-sponsored coverage is health plan coverage offered by an employer to an employee that is excludable from the employee's gross income under Tax Code § 106, such as medical, dental and vision coverage and coverage for on-site medical clinics. The following items do not have to be included:
		• Coverage only for accident, or disability income insurance (short-term and long-term), or any combination thereof;
		• Coverage issued as a supplement to liability insurance;
		• Liability insurance, including general liability insurance and automobile liability insurance;
		• Workers' compensation or similar insurance;
		• Automobile medical payment insurance;
		• Credit-only insurance;
		• Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
		• Coverage for long-term care; and
		• The following benefits, if offered as independent noncoordinated benefits, payment is not excludable from income, and no deduction is allowed:
		  ○ Coverage only for a specified disease or illness; and
		  ○ Hospital indemnity or other fixed indemnity insurance.

28	How will the aggregate cost of applicable employer-sponsored coverage reported on an employee's W-2 affect employees in regard to their personal income taxes?	The W-2 reporting requirement is informational only. It does not result in any additional income to the employee. Under Tax Code § 106, the cost of employer-provided health coverage continues to be excluded from the gross income of an employee.
Automatic Enrollment		
29	For the automatic enrollment requirement, what if an employer at the time of open	It is unclear whether the employer only needs to determine the number of full-time employees at the beginning of a plan year or throughout the plan year. The legislation requires an employer who has more than 200 full-time employees and offers employees enrollment in one or more health plans to

	enrollment has 200 or less full-time employees but then hires employees throughout the year and later has more than 200 full-time employees?	automatically enroll new full-time employees in the plan with the lowest employee premium unless an employee opts out or elects to participate in another plan. Additional guidance is expected to address how to count employees for this purpose.
Domestic Partners		
30	Does Health Care Reform address domestic partner benefits?	No. While Congress considered some bills which would have exempted domestic partner benefits from income tax, those domestic partner benefit provisions were not included in the Health Care Reform passed by Congress.
SPDs		
31	Does Health Care Reform require that health insurers provide SPDs?	Health Care Reform does not require that health insurers provide SPDs. However, beginning March 23, 2012, group health plans and health insurers will be required to provide, as developed by HHS, uniform summaries of health benefits and coverage that are limited to not more than 4 pages (using at least 12 point font) and use language understandable by the average participant. Also, notice must be provided 60 days prior to the effective date of any material modification to the plan that is not covered by the most recent summary of health benefits and coverage.