



## HEALTH CARE REFORM UPDATE

### FREQUENTLY ASKED QUESTIONS ABOUT HEALTH CARE REFORM

For ease in review, questions have been separated into categories. Click on the category of interest to move to that section of the document.

[Dependents Up to Age 26 / Dependent Coverage](#)

[Taxes](#)

[Individual Mandate](#)

[Waiting Periods](#)

[Employer Mandate](#)

[Exchanges](#)

[Grandfathered Plans](#)

[Part-Time Employees](#)

[Flexible Spending Accounts](#)

[Other Issues](#)

[Market Reforms/Plan Design Changes](#)

[Notification of Material Plan Changes](#)

[Mandated/"Essential" Benefits](#)

[Out-of-Pocket Limits](#)

[Implementation](#)

[Auto-Enrollment](#)

[Other Market Reform/Plan Design Questions](#)

[Retiree Reinsurance Program](#)

[Wellness](#)

#### **Dependents Up to Age 26 / Dependent Coverage**

##### **How does the new legislation define “dependents”, specifically regarding the provision requiring coverage for dependents up to age 26?**

On Monday, May 10, 2010 the US Department of Health & Human Services (HHS) issued interim final regulations (IFR) to implement the adult child dependent coverage provisions of the Patient Protection and Affordable Care Act (PPACA). The IFR is available at

[http://www.hhs.gov/ociio/regulations/pr\\_a\\_omnibus\\_final.pdf](http://www.hhs.gov/ociio/regulations/pr_a_omnibus_final.pdf).

Under the IFR a plan or issuer may define “dependents” for purposes of eligibility for dependent coverage of children only in terms of age and the relationship to the employee. For purposes of this provision, the IFR requires that employers who offer dependent coverage must extend the opportunity to enroll in that coverage to adult children up to their 26<sup>th</sup> birthdays. No coverage is required for spouses or children of dependents who become eligible for coverage under this provision.

##### **How can employers know if a dependent covered under an employee’s plan is truly a dependent, according to the most recent definition?**

Employers can request that employees certify their dependents as eligible for coverage.



**I've heard that if a dependent has coverage through another employer he or she must accept it. Is this true?**

Yes, under certain circumstances. Up until 2014, "grandfathered" group plans need only provide coverage to those adult dependents that do NOT have access to their own employer-sponsored coverage. After 2014, all plans (including those that are grandfathered) must extend this coverage to all eligible dependents (the definition of which, again, can only be dependent on age (i.e., whether or not they have attained age 26) and relationship to the employee.)

**What if my 26-year-old "dependent" son is still in college and has a baby? Am I able or obligated to cover my grandchild as well, according to the new legislation?**

First, keep in mind that this extended coverage requirement applies only until the dependent's 26th *birthday*. So in this example (where the 26-year-old dependent is clearly *past* that date), the provision would not require the plan to cover him, let alone your grandchild. With that said, employers MAY offer coverage for grandchildren, but the statute doesn't require it.

**Presently, in our plan, dependents are only covered because they are in college. Does this go away?**

Yes. If you offer dependent coverage, you will be required to extend eligibility to any dependent—regardless of whether or not they're a full-time student—until their 26<sup>th</sup> birthday.

**Can you design your plans so you don't offer dependent coverage over 19? Is there a way for employers to circumvent this mandate for existing/grandfathered plans at least until 2014?**

For plan years starting after September 23, 2010, if a plan offers coverage of dependents, it must extend the opportunity to enroll in that coverage to employees' adult children up to age 26. This means that if the plan now offers dependent coverage up to age 19, it must offer the same coverage to dependents age 19-26.

**So, do the new mandates change our definition of a dependent, if the language we use is broader than what's in the new legislation? For example, we currently offer coverage for our employees' dependents and their children (i.e., the employees' grandchildren).**

The statute affects the definition of a dependent child who is eligible for coverage. If you as an employer offer coverage to a broader group of dependents than what's outlined in the statute, you can continue covering that wider universe of dependents.

**Are the employees responsible for paying the full premium for their 23 to 26 year old child OR does the company have to assume the premium, as they would for any other dependent?**

HHS regulations specify that all qualifying dependents up to age 26 must be offered all of the same benefit packages and cannot be required to pay more for coverage than similarly situated individuals who were eligible for dependent coverage under the employer's old requirements. This means that if the company presently assumes some or all of the premiums for dependents, it must do the same for those adult dependents who become eligible under this new provision of the law. A few things to consider:

- Being married does not disqualify a dependent for coverage under this provision.
- The provision does not require coverage of the eligible dependent's dependents (i.e., the employee's grandchildren).



At this point, we suggest that employers include the additional covered dependents as part of their existing dependent rate tiers with a one to three percent adjustment in the overall cost of dependent coverage. (You can present this new provision, which may come as good news for some, as the rationale behind the increase in your employee communication materials.)

**With dependent coverage being extended to age 26, how will we be affected as an employer?**

There are two specific ways that employers will be affected:

1. There will be increased costs associated with administering coverage for dependents up to the age of 26, represented in either a) the premium on a fully insured basis, or b) in administration services only (ASO) fees if the employer is self-funded.
2. Employers will need to revise their plan summaries to reflect the new mandates, which is where Trion can be of great value since managing plan summaries is part of our service offering. We can help employers make the necessary changes to these documents, as well as assist them in updating various other employee and partner communications.

###

**Taxes**

**Is it the company's responsibility to deduct the Medicare tax?**

Yes, with respect to the increased Medicare wage tax for employees that earn more than the \$200,000 threshold. It's not the company's responsibility to deal with the new Medicare tax on investment income (the employee will have to handle that directly). An employer only needs to worry about individual employees who earn more than \$200,000—and not whether a spouse's income pushes an employee over the threshold.

**How do we handle employees with variable income that could allow earnings over \$200,000?**

You need to withhold the tax upon variable exceeding \$200,000, as received.

**With regards to the excise tax on "Cadillac Plans", how is the threshold calculated for a self-insured plan?**

Note that the "Cadillac tax" does not go into effect until 2018, and rules to implement the tax, including ones governing valuation, have yet to be adopted. A logical valuation choice for self-insured plans would be to use the COBRA valuation, but this question cannot be answered definitely until regulatory guidance is issued. In the meantime, Trion is in the process of developing a calculator to help you and other employers estimate the annual excise tax. More information on that tool is forthcoming, as we roll out the model to our clients.

**Do we have guidelines for how the benefits are to be shown on the W-2?**

Not yet. The IRS will issue guidelines on how to define and report the cost of coverage. It might be the COBRA valuation for self-insured plans, but that is yet to be determined. The only specifics provided by the law in this area state that employee contributions to Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), and Flexible Spending Accounts (FSAs) are not to be included for this purpose.



**Does the fact that the insurance value must be recorded on W-2 mean that non-tax or pre-tax benefits become taxable?**

No, the legislation does not change the tax rules on what is pre- or post-tax.

**With regard to W-2 for self-insured plans, are employers required to report the cost per employee, or the actual fee employees pay?**

Employers must report the cost of each employee's "coverage," not what the employee pays. This means both the employer's and employee's contribution must be reported.

**Are we required to report the value of benefits on W-2's in 2011? (These would be the W-2s for the tax year 2010.)**

No. You will be required to report the value of benefits for the tax year 2011, so reporting would be done on the W-2s that go out in January 2012. There has been some confusion about this, probably because the law states that it applies after December 31, 2010.

**What would the tax ramifications be if our company decided to opt out of offering all plans for 2011?**

The true answer would depend on your company's unique circumstances. Generally speaking, however, a company that decides not to offer employee health coverage (assuming the employer is subject to the employer mandate) will have to pay a tax in the form of a \$2000 per full-time employee penalty. The interplay between this and any other tax ramifications of not offering coverage, such as giving up the ability to deduct what the company pays to provide coverage, is something each company must evaluate for itself. Trion can help you assess the situation in your organization and make the best possible decision.

Likewise, from an employee perspective, the ramifications would depend on each employee's individual circumstances. Generally, if an employee no longer has access to employer-based coverage, the legislation intends to give that employee access to coverage through the Exchange. If the employee must pay for some part of that coverage (because they are ineligible for subsidies), they'll probably have to use after-tax dollars (that's the way the individual market works now, at least). That raises the question of whether they'd be able to deduct some of that expense, which depends on the individual. If the employee decided not to obtain coverage, they would be obligated to pay the individual mandate penalty, which is a tax. Again, for employers, this is an issue worth analyzing for competitive value—Trion can help.

**Who is responsible for paying the Cadillac tax?**

The "coverage provider" is responsible. So, for fully insured plans, this is the entity that provides the benefit or the carrier. For self-insured plans, the statute makes the plan administrator responsible for paying the tax. For arrangements where an employer makes contributions to an HSA or MSA, the employer is responsible for paying the tax.

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## **Individual Mandate**

### **Will individuals have to purchase health insurance under the new health care reform bill if they currently choose not to have any?**

With a few exceptions, as of January 1, 2014, every individual will be expected to have health insurance, or pay an annual penalty fee for not maintaining this coverage. Enrollment in an employer group health plan satisfies this “individual mandate”. The new law also requires state-based health exchanges be established to provide competitive options for individuals looking to purchase medical benefits.

###

## **Waiting Periods**

### **In terms of the new 90-day waiting period outlined in the new legislation, how is 90 days defined? Are the eligibility and waiting periods now combined?**

According to the legislation, eligibility must be within 90 days, meaning new employees must be able to participate in the plan within 90 days. That can be on the 90<sup>th</sup> day or the first day, but as an employer, you can't have them wait *beyond* 90 days. That means that if you currently have a waiting or eligibility period of 90 days, with employees eligible the first day of the month following that period, you would be out of compliance. The regulations do not distinguish between a waiting period for "employment" and a waiting period for "benefits". So, regardless of what an employer names the period between an employee beginning work and becoming eligible to participate in benefits, the total time must not exceed 90 days.

### **The new bill states that 90 days is the recommended waiting period for employers who want to bring somebody new onto their plans—it also says employers could be fined for making individuals wait longer. Is this true?**

Yes. According to the new law, employers with waiting periods that exceed 90 days will be fined as much as \$100 for each employee who's denied access to coverage; this is \$100 for *each day* over the 90 days each individual is not able to join the plan. As it stands now, this provision—and its requisite penalties—will go into effect in 2014.

###

## **Employer Mandate**

(Applies To “Large” Employers -- >50 Employees)

### **What is the definition of a full-time employee?**

The legislation defines full-time employees as those who work an average of at least 30 hours per week. The statute mandates that calculations of hours worked are to be made on a monthly basis and retrospectively, at the end of your tax year.

### **I'm confused by the regulations on “affordable” employer-based coverage. We have employees we classify as seasonal and part time. If we don't offer coverage to them, is that considered to be “unaffordable”? What's the true definition?**

First, keep in mind that the employer mandate only requires you cover full-time employees, and not part-time employees. (For purposes of the employer mandate, the statute defines a part-time employee as someone who averages less than 30 hours of work per week.) The statute does not address the question of whether a seasonal employee must be covered—this is an issue we anticipate will be addressed in the regulations developed by HHS.



- With regards to the “affordability” test, it comes into play in determining whether one of your employees is eligible for a subsidy or a voucher to buy insurance through an Exchange. The definition of affordable coverage in that context is either coverage that does not: come with premiums costing more than eight percent of the employee’s family income; or require the employee to pay more than 40 percent of the cost of coverage, in both instances for a family whose income is below 400 percent of the federal poverty level.

The interesting thing that is not addressed in the statute (and will need to be clarified by HHS) is whether an employer who opts to cover part-timers could then be subject to penalties for providing part-time employees with unaffordable coverage.

**Do the unaffordable coverage requirements apply to small employers with fewer than 50 employees who have income greater than \$50,000?**

The unaffordability provisions say only that they apply to “employees” offered unaffordable coverage – they do not differentiate between large and small employers. If you are a small employer who has opted to provide coverage even though you are not obligated to do so, the law does not address whether you’ll have to pay a penalty. We expect the HHS will offer more clarity around this provision in their regulations.

**Is there an expectation that employers will have to provide coverage for part-time employees and their dependents?**

No. The legislation does not require employers to provide coverage for part-time employees or their dependents.

**Does the mandate mean that employers must cover employees who working more than 30 hours a week? What if our company defines part-time employees as those working 32 hours a week?**

The determining factor is the law’s definition of “full-time,” and not the employer’s. So you would be obligated to cover someone who works an average of 32 hours per week (assuming you, as the employer, are covered by the mandate)—regardless of the fact that you define that person as part-time.

**If that’s the case, should I change my definition of full- and part-time employees? Or should I just pay the penalty?**

It’s your choice. Either way, it’s the way the law is defined that governs whether you have to cover the employee or pay a penalty. If you decide to keep your own definition of part-time but still cover employees who work 30 to 32 hours per week, you won’t be penalized. Since this might be complicated administratively, Trion anticipates that more employers will consider changing their definitions. We will certainly partner with our clients to ensure they make the best decision possible—both fiscally and competitively.

**Does the law define how employees are included to determine if we’re a large employer? For example, we have more than 100 employees, but we also have several different companies. Do we break them up into individual entities or stay together?**

The legislation states that the IRS definition will apply in terms of deciding whether a group of companies will be considered as separate or a single entity. Generally, IRS rules say that if companies are under common control, they are considered a single entity. If your different companies meet the common control test according to these rules, they would be treated as a single employer for employer mandate purposes.



### **Does the definition of seasonal employees affect college students, etc?**

The legislation only addresses seasonal employees in the context of determining whether an employer has 51 or more employees and is covered by the employer mandate. It provides that an employer's seasonal employees will not be counted for this purpose if the employer's workforce a) exceeds 50 full-time employees for 120 calendar days or fewer during the calendar year; and, b) the employees in excess of 50 employed during the 120 day period are "seasonal" workers, as defined by the DOL.

The DOL may have to provide some additional guidance on the definition of seasonal worker, but the statute does state that seasonal workers will include:

- Retail workers employed during the holiday season, and,
- Employment described in current DOL regulations as "seasonal," specifically, employment that ordinarily pertains to or is exclusively performed at certain seasons or times of year—and which, from its nature, may not be continuous or carried on throughout the year.

Keep in mind that the statute does not explicitly address whether employers are obligated to provide coverage to seasonal workers, and this is an issue that should be addressed by HHS' regulations. It may be that the same rule that applies to all workers will ultimately apply to seasonal ones as well (i.e. if a seasonal worker works more than 30 hours each week, as calculated each month, that worker might be classified as a "full-time employee" for the time they work for an employer).

One way for an employer to avoid this situation, if it happens, is to use the ability to impose a 90-day waiting period. This would reduce the chances of being out of compliance, at least with respect to seasonal employees who are with the employer for less than 90 days. To avoid issues with non-discrimination, however, the employer needs to ensure that the 90-day waiting period is imposed on all employees and not simply targeted to those who are seasonal.

### **Will we be able to define an employee as seasonal even if he or she works at least 40 hours per week but fewer than six months?**

Again, as is the case for part-time workers, the employer's definition does not matter when it comes to determining which workers must be counted to determine employer-size under the employer mandate provisions—and which workers must be offered health coverage. (See the above answer for more information on determining employer size and what constitutes a "seasonal" worker, according to both the DOL and the statute.)

Consider that, in the context of this question, an employee who works 40 hours a week for 120 days or less a year only satisfies *half* of the test under the statute – that employee must also be classified as a seasonal worker under DOL regulations, in order for that person not to count against the 51 plus worker threshold.

### **When I take the mandates to my chief financial officer and compare the costs of providing benefits (i.e. \$8,000 to \$10,000 per employee, plus the Cadillac tax and any penalties) against the cost of dropping coverage and paying a \$2,000 per employee penalty, it will seem like an easy decision. Why should employers bother to consider providing health care coverage?**

If you look at it solely from a mathematical perspective, it may seem to be an easy choice. But it's not. Employers will have to factor in whether offering benefits coverage provides them with recruiting and other advantages. Trion is working with clients to make the appropriate evaluation and determine what makes the most sense from both a financial and "good employer" perspective. We believe that, despite how appealing it may seem to drop employee coverage, there is still great value in providing it.



**What's in place to prevent employers from paying penalties rather than providing coverage – since in some cases the penalties will cost less?**

Nothing. There is nothing in the legislation that requires you to offer coverage today –it's a tipping point issue. With that said, if we're all in a competitive environment, employers will need to evaluate whether it's worth it to offer health coverage to maintain a competitive advantage, notwithstanding the fact that the penalties might be more cost effective.

###

**Exchanges**

**Can you explain how employers must interact with Exchanges?**

Employers have no direct relationship with Exchanges. Small employers will have the option of getting coverage through an Exchange; but for large employers, there is no relationship beyond reporting. So the Exchange will notify large employers when and if they have employees who are eligible for subsidized coverage or vouchers to buy coverage through the Exchange.

**If we have between 50 and 100 employees, can we look at the Exchange and then privately make our own contract with the carriers?**

Sure. Although you'll need to weigh those options. Trion can help you assess the right course of action in this situation.

**Are self-insured plans (SIPs) eligible to participate in Exchanges?**

No, self-insured plans would not be offered through an Exchange, because entities set them up for their own employees—and not for sale to others.

**Will there be a federal exchange that will be the same for all states or will it be state by state and administered individually?**

The legislation directs each state to set up its own Exchange. In this regard, the law only contemplates the federal government stepping in if a state fails to set up its own Exchange, but even then, that Exchange would still be for that state. The law gives states some leeway to set up regional Exchanges that involve more than one state, but that's the states' decision to make, so we can't predict whether they'll be established.

**Does the employer issue the voucher to the employee?**

The process for how the vouchers will work has yet to be set up. We anticipate that employees will apply for vouchers through the Exchanges, the Exchanges will make eligibility determinations, and then the Exchanges will notify employers about whether they have employees who qualify for vouchers. Beyond that, we will have to await the specific rules on the voucher program for details about who issues them.

**What is the “cost of coverage” and the premium cost of employees?**

The “cost of coverage” is something that must be defined by HHS, but we anticipate the way the cost of coverage will be calculated for a self-insured plan will be based on the COBRA actuarial value. As for the “premium,” this figure will certainly include the amount the employee must pay in premiums for his or her individual coverage, and probably those paid for dependent coverage as well.



### **What if you are a multi-state employer? Where does the employee file?**

The employee must apply for benefits with the Exchange in the state in which he or she resides.

### **Is the possible CO-OP like the self-insured group plan?**

The legislation does not sufficiently address whether a CO-OP would be precluded from being self-insured, although the language of the statute does clearly contemplate these entities as health insurance issuers. The statute states that the CO-OP program is intended to foster the creation of “qualified non-profit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.”

###

### **Grandfathered Plans**

#### **What exactly are the grandfathered plans under the Senate and Reconciliation Bills and is there a quick list of the provisions that apply to grandfathered plans only?**

Like so many things, a “grandfathered” plan is not quite what it used to be. Under the bill that was first signed into law – the PPACA – a “grandfathered” plan is any plan in which an individual is enrolled – either directly or through any group plan – on the date of enactment (March 23, 2010). (PPACA § 1251).

Regulatory guidance released on June 14, 2010 provides more details about the definition of grandfathered plans. The guidance is available at [http://www.federalregister.gov/OFRUpload/OFRData/2010-14487\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2010-14487_PI.pdf). For group plans, new beneficiaries can be added to the plans without affecting the “grandfather” status. And changes necessitated by PPACA or state law can be made without affecting “grandfather” status.

However, the following types of changes will cause a plan to lose grandfathered status:

- eliminating benefits – eliminating all or substantially all benefits to diagnose or treat a particular condition;
- raising co-insurance charges – increasing a percentage cost-sharing requirement (such as coinsurance) above the level it was at on March 23, 2010;
- raising co-pays “significantly” – compared with the copayments in effect on March 23, 2010, increasing those co-pays by more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation (as of March 23, 2010) plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status;
- raising fixed-amount cost-sharing other than co-payments “significantly” – compared with the fixed-amount cost-sharing (e.g., deductibles, out-of-pocket limits) required as of March 23, 2010, increasing these amounts by a percentage equal to medical inflation plus 15 percentage points;
- lowering employer contributions “significantly” – decreasing the percent of premiums or other fixed cost of coverage the employer or employee organization pays toward the cost of any tier of coverage for any class of similarly situated employees by more than 5 percentage points below the contribution rate that was in place on March 23, 2010, relative to the amount contributed by employees;



- new or decreased annual limits – adding or tightening any annual dollar limit in place as of March 23, 2010. Plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. Keep in mind that for plan years beginning after September 23, 2010, annual limits must be eliminated until HHS issues regulations on permissible ones;
- changing insurance companies – if an employer decides to buy insurance from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when self-insured plans switch plan administrators and it does not apply to collective bargaining agreements;
- requiring employees to switch plans to avoid compliance – if an employer requires employees to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing “as a means of avoiding new consumer protections,” grandfathered status will be revoked; or,
- sales or merger to avoid compliance – merging with or engaging in a sale to another plan to avoid complying with the law will cause grandfather status to be revoked.

To maintain grandfather status, plans must disclose that they are considered grandfathered in any plan materials provided to participants or beneficiaries, and must provide contact information for any questions or complaints about their grandfathered status. The grandfathering rules provide model language to assist plans with complying with this disclosure obligation. Grandfathered plans will also have recordkeeping obligations with respect to the information necessary to verify grandfathered status (e.g., records documenting the terms of the plan that were in effect on March 23, 2010) and must make such records available for examination by participants or regulators.

As a general matter, “grandfathered” plans under PPACA were exempt from most of the market reforms included in the bill with just a few exceptions. But the Reconciliation bill subsequently added several more exceptions, meaning that “grandfathered” plans – including those that are self-insured – will be subject to the following new requirements for the first plan year after September 23, 2010 (Reconciliation bill § 2301)–

- No waiting enrollment waiting periods for new employees longer than 90 days (PPACA § 1201 (adding § 2701 to the Public Health Service Act));
- No lifetime coverage limits for essential benefits (PPACA § 1001 (adding § 2711 to the Public Health Service Act));
- No annual coverage limits on essential benefits except as may be permitted by HHS (PPACA § 1001 (adding § 2711 to the Public Health Service Act));
- Extension of dependent coverage until the dependent turns 26 (until 2014, however, group coverage need not be extended to a dependent that is directly eligible for his/her own employer-provided coverage) (PPACA § 1001 (adding § 2714 to the Public Health Service Act));
- The new uniform coverage disclosure rules (PPACA § 1001 (adding Section 2715 to the Public Health Service Act) and § 1251);



- The medical loss ratio/rebating-related requirements (does not apply to self-insured plans) (PPACA § 10101 (adding Section 2718 to the Public Health Service Act));
- A ban on policy rescissions except in cases of fraud (PPACA § 1001 (adding Section 2712 to the Public Health Service Act); and
- No pre-existing conditions exclusions for children up to the age of 19 (applies to all in 2014) (PPACA § 1001 (adding § 2704 to the Public Health Service Act) and § 10103(e)).

A plan that loses grandfathered status, and plans considered to be “new” plans, would be required to comply with the following additional market reforms:

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

###



## Part-Time Employees

### **Does the legislation require employers to offer medical coverage to part-time employees?**

No. There is no penalty for failure to cover part-time employees. Part-time employees are defined as those who work an average of fewer than 30 hours per week. Part-time employees only come into consideration when an employer must calculate its size (i.e., whether it has more or less than 50 employees) for purposes of the employer mandate or small business tax credit eligibility. As part of that determination, employers must calculate the number of “full-time-equivalent” (“FTE”) employees by taking the number of hours worked each month by part-time employees (if any) and dividing that number of hours by 120. The resulting figure is the number of FTEs, which must then be added to the number of true full-time employees (i.e., those working 30 or more hours per week) to come up with the number of employees to be counted in determining employer size.

###

## Flexible Spending Accounts

### **How does the reduction in Health Care Flexible Spending Account (FSA) limits affect employers?**

Currently, employers decide how much their employees can contribute to health care FSAs (dependent care accounts are not affected by the new bill); they can set the annual plan year maximum as high or low as they want. For example, prior to the legislation, the average employer-set maximum contribution among Trion’s FSA clients was \$4,000.

Under the newly passed health care reform legislation bill, however, as of 2013, employers will only be permitted to establish health care FSA plans with an annual plan year maximum no higher than \$2,500. They’ll need to effectively communicate this change to employees to help them understand this new limitation.

### **Will changes to health care FSAs be made during renewal or off-cycle?**

This change goes into effect January 1, 2013.

###

## Other Issues

### **When the Reconciliation Bill was signed/enacted, which date will take precedent on the various six month after enactment provisions?**

March 23, 2010 (the date the first bill, the PPACA, was signed).

### **The bill states that we have to notify employees 60 days in advance of changes to the plan, but we often don’t know what those changes will be until just before our Open Enrollment periods. How do we navigate this provision?**

This is going to drive a business change, and companies will need to decide how to accommodate the provision. The requirement is to give notice before material changes take effect, not before Open Enrollment. So if, for example, your Open Enrollment period runs from October 1<sup>st</sup> through October 14<sup>th</sup> for a January 1<sup>st</sup> plan year, the information provided in connection with the October 1 enrollment would serve to notify employees of any changes well before the 60-day requirement. That’s one scenario.



Here's another: Let's say you hold Open Enrollment from November 15<sup>th</sup> to November 30<sup>th</sup> for a January 1<sup>st</sup> plan year. In this case, you would have to provide information to your employees regarding plan changes in advance of your Open Enrollment.

As a practical matter, this may seem cumbersome, but this keep in mind:

- This is for changes that are not already in plan documents.
- The definition of "material change" is vague at this point and requires additional clarification. Trion can help you manage this issue, which affects many of our clients. In fact, we've started to meet with carriers to determine the best strategies for addressing this requirement.

As HHS provides greater clarity, we'll continue to share information on how to proceed.

**We are a VEBA Trust: Each company qualifies based on ownership to "parent". Each company has a separate EIN, operates independently and files taxes separately. Some companies have less than 50 full-time employees. Given this structure, can companies that meet the small company test be eligible for the tax credits even if they participate in a larger group plan for the purposes of economic pooling/leveraged procurement?**

**Also, are these same "small companies" subject to the mandates of the small company or exempt since they participate in a larger group plan by virtue of being in the Trust (aka the larger pool)?**

Note examples beyond 501(c)(9) VEBA Trust could potentially include private equity / partnership groups, holding companies, etc. The small business tax credit provision has an aggregation provision (Patient Protection and Affordable Care Act ("PPACA") § 1421(a) creating Internal Revenue Code [IRC] section 45R (e)(5)) that essentially says commonly controlled entities will be considered as a single employer. If the VEBA participants are NOT commonly controlled, each should be able to qualify for the credit independently; the same should be true for companies that are not commonly controlled and participate in a larger group plan for economic/leverage reasons.

The employer mandate section incorporates the same aggregation provision as the small business tax credit section (see PPACA § 1513 creating IRC section 4980H (d)(2)(C)(i)). So if the pool participants are NOT under common control, each one with 50 or fewer employees should be classified as a small employer and exempt from the mandate.

The statute incorporates specific provisions already existing in the IRC concerning partnership groups and other types of corporate groups (IRC sections 414 (b), (c), (m), and (o)). Those particular rules would need to be consulted to determine whether such groups are aggregated as a single employer for purposes of the small business tax credit and employer mandate.

**If there are state laws that are more generous, such as New Jersey requiring coverage to age 30 for insured plans, which law will take precedence – state or federal (reform bill)?**

Regulatory guidance issued on June 14, 2010 advises that the federal law is generally not preemptive. So unless PPACA specifically states to the contrary in a particular provision (and it does not in the case of dependent coverage), the more generous state law will apply. There may be an issue regarding exchange plans and state-required mandates, but that shouldn't have any effect until 2014 when the Exchanges go into effect. So for example, if a state has a mandate that's more generous than federal law, the state must defray the cost of the additional mandates for any individuals who qualify to receive federal assistance to pay for their health coverage.



**Does the reform bill apply to government entities, such as school districts and municipal entities?**

We believe the short answer is yes. The analysis necessary to reach that conclusion is incredibly convoluted, but here's a quick synopsis: The reforms generally apply to "group health plans" and issuers offering group coverage. Unless the reform statute indicates otherwise (and it does NOT in this case), the definitions of these terms in Section 2791 of the Public Health Service Act (PHSA) apply. The PHSA defines "group health plan" by reference to Employee Retirement Income Security Act (ERISA), which describes the term as "an employee welfare benefit plan"; ERISA, in turn, says an "employee welfare benefit plan" is any plan, fund, or program maintained by "an employer or by an employee organization" to provide medical among other benefits. It also defines an "employer" very broadly, as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan." We conclude that this definition of "employer" is broad enough to encompass any governmental unit.

**Does the implementation timeline apply to union plans/collective bargained plans or are the effective dates applied at the next labor contract date?**

PPACA Section 1251(d) contains a special implementation rule for coverage maintained under collectively bargained agreements (CBAs), which directs that any changes that apply to such coverage need to be implemented only when the "last of the CBAs relating to such coverage" terminates. However, this special implementation rule appears to have been rendered meaningless by the regulations issued on grandfathering. Those regulations provide that 1) the special implementation rule applies to insured, but not self-insured, CBA coverage, and 2) grandfathered CBA plans (i.e., ones under CBAs ratified prior to March 23, 2010) must implement the reforms applicable to grandfathered plans at the same time as non-CBA plans. This latter rule means that grandfathered CBA plans must implement the required reforms their first plan year after September 23, 2010 regardless of whether, or when, the CBA expires.

**Confirm that union plans have to implement at their contract date instead of following the Bill's timelines, because we have heard that the Reconciliation Bill changed the Senate provision on union plan implementation.**

PPACA Section 1251(d) contains the provision governing implementation for collectively bargained coverage. As for the Reconciliation bill, it does not amend Section 1251(d). It only amended Section 1251(a), which lists provisions that will apply to grandfathered plans as well as new plans. See the question and response immediately above for a discussion of the implementation requirements for CBA plans.

**Are there any penalties for terminating retiree coverage and having them go into the Exchanges?**

There doesn't appear to be. The penalties are assessed for employers who do not offer coverage to "full time employees" (see PPACA § 1513 (adding § 4980H (a)(a) to IRC), which include those that work an average of at least 30 hours a week (see PPACA § 1513 (adding § 4980H (d)(4) to IRC). But there is an incentive for employers not to drop retirees -- the reinsurance program for those ages 55 to 64 in section 1102 of the PPACA.

**Are the limits for reimbursement under the reinsurance program for early retirees applied to individual claims or the overall cost of benefits?**

According to the Interim Final Rules issued by HHS for the program, the reinsurance reimbursement is 80 percent of the cost of all of the claims paid by the plan and the participant for each plan participant that are between \$15,000 and \$90,000 for the plan year. For more information about the program, see the Interim Final Regulation available at <http://www.hhs.gov/ociio/regulations/gate.pdf>.



**If an employer provides only employees with a “qualified” plan but doesn’t offer spouse/dependent coverage, how do you treat it regarding employer mandate and related provisions?**

The statute says an employer can be penalized if it "fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage..." (See PPACA § 1513(a) (adding § 4980H(a)(1) to the IRC). Our legal partners at Steptoe & Johnson expect this will be interpreted to mean if an employer does not already offer coverage to dependents, it must begin to do so starting in 2014. But note that the calculation of penalties is assessed based on the number of full-time employees – and not the number of uncovered dependents. Our experts have discussed this issue quite extensively. They’ve examined the practical effect of covering employees but not dependents, when there’s no penalty assessed. One view is that employers will be penalized for not covering dependents as they would for not covering employees; therefore, the penalty will be equal to the number of full-time employees (-30) times \$2,000. We think this is the view the HHS is most likely to adopt, although we won’t know for sure until regulations are issued.

**Are dental, vision, employee assistance program, and prescription-only plans included in employer mandate, market reform and other “employer requirement” sections of the bill?**

Regarding the employer mandate and other employer requirement sections: We think the answer is probably no, but the analysis is somewhat convoluted. The statute says "minimum essential coverage" must be offered. The individual mandate section of the statute says "excepted benefits" as defined in section 2791 of the Public Health Service Act are not treated as "minimum essential coverage". "Excepted benefits" include "limited scope dental or vision benefits" and other similar limited benefits if offered under a separate policy, certificate or contract from medical. So although the definition of "minimum essential coverage" in the individual mandate section attempts to ensure that individuals are not trying to get by with very limited coverage, we don’t see an indication that the definition of "minimum essential coverage" is any different in the employer mandate section.

Regarding the market reform sections, the grandfathering rules issued on June 14, 2010 state that the market reform provisions do not apply to “excepted benefits” such as dental-only and vision-only plans.

**If we’re self funded, how does the legislation affect us?**

By and large, almost all of the provisions included in the bill apply to self-insured plans on the same terms and conditions as they do to other similarly situated group plans. The primary exceptions are that self-insured plans are exempt from the Medical Loss Ratio provisions and from the premium increase review provisions (although they do have to make information filings listing their costs under the MLR provisions)..

**Since the legislation removed the pre-existing condition limitation, does that mean late and/or special enrollees can enroll in the plan at any time during the year?**

No. Our understanding is that they’d still be subject to the Section 125 qualifying event rules and couldn’t just enroll at any time.

**How is a small group defined and what’s the difference in handling small groups?**

It depends on the provision. In some cases, a small group can have 25, 50, or 100 lives. These small employers may be more affected by health care reform in some instances due to new:

- Market reforms like guaranteed issue and renewal and rate reform, coverage limits, and medical loss ratio requirements.



- State- and small business-based health benefits exchanges that allow small companies to purchase qualified coverage.
- Subsidies, like small business tax credits, an early reinsurance program for retirees, and wellness grants.

### **Are covered preventive benefits defined by regulation?**

Not yet, although a more detailed definition of “preventive services” is something we anticipate will be provided by HHS regulations. For the moment, we have only the description set forth in the statute of the following categories of “preventive” services:

- Evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this law.

The statute further states that for its own purposes and those of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current (other than those issued in or around November 2009).

### **There are a lot of provisions in this bill. What do we need to focus on today?**

Right now, your main focus should be awareness. Specifically, that the bill has been passed and that it will impact the way you think about and administer health care benefits to employees. We encourage you to read our updates and spend time at our health care reform library to get up to speed. And, to allow us to assist you in adapting the bill’s mandates per the implementation timeline we sent to you earlier this week (you can find it in our online library).

After all, when it comes to compliance, Trion is here to hold your hand every step of the way. In fact, look for an invitation to our informational seminars during the weeks of April 5, 12 and 19. Our colleagues from the Washington-based law firm of Steptoe & Johnson along with members of Trion’s Consulting Practice will present the details of the bill and answer your questions. We’ll be holding sessions in both Pennsylvania and North Carolina—dates will vary depending on where you’re located.

### **I’ve heard that the bill doesn’t affect employers until six months after enactment. What does that mean exactly?**

Under the new legislation there are some benefit mandates that must be implemented at your next plan year following September 23, 2010—which is six months after the date the bill was enacted (on March 23, 2010).

Although there’s a six-month window from the enactment date, that doesn’t mean there’s not work to be done now. Guided by your Trion team, we’ll work with you to understand the bill’s impact on your plans, analyze financials, communicate and develop a transition plan—one that outlines the appropriate strategies and actions necessary to comply with the new regulations.



**How will this legislation affect our health care costs?**

Our experts believe that the bill's provisions will cause a short-term increase in employer costs. We saw this validated prior to the legislation passing with increasing trends in renewals. Now that the health care bill is in effect, we anticipate this trend will continue. And that it will ultimately lead to a rise in premiums even more significant than those we've experienced in previous years.

**Is there a list on the HHS website of how many decisions and definitions need to be made and when?**

Not that we are aware of at present; but our legal advisors at Steptoe & Johnson have put a list together, which is available at [insert link to S&J list]. We note that HHS does have a webpage devoted to health care reform implementation issues, which is <http://www.healthreform.gov>.

**I've heard there is a State Attorneys General lawsuit. Where does it stand now?**

This litigation is presently pending before a federal court and our understanding is that it will be "fast-tracked," although such a procedure does not require a decision by a particular date. Given that some employers and plans will need to begin making decisions almost immediately about plan design (e.g., those with plan renewals that will occur September 24, 2010 and beyond), however, and given the skepticism regarding the likelihood this challenge will succeed, we do not recommend that employers take a wait-and-see approach on the reform issues that will impact them.

###

**Market Reforms/Plan Design Changes**

**We are a large employer with the majority of employees between the ages of 19 and 26. If they're eligible for benefits under our plans, are they also eligible for coverage under their parents' plans?**

That depends on timing and whether the parents' plans are grandfathered. Up until 2014:

- If the parents' plans presently offers dependent coverage and are grandfathered, they're NOT obligated to provide coverage to dependents who are eligible for their own employer-sponsored coverage.
- If the parents' plans presently offers dependent coverage are NOT grandfathered, they would be required to offer coverage—despite employee eligibility for coverage under your company's benefits.

After 2014, these rules change: At that point, parents' plans would be required to offer these employees coverage, regardless of whether a) the plans are grandfathered and b) employees are eligible for coverage under your benefits program.

**What if our plan is not considered grandfathered? Do we need to offer dependent coverage with our next renewal in 2011?**

Yes. If you are currently offering dependent coverage, you will need to extend that coverage to dependents up to age 26 starting with plan years after September 23, 2010. So, if you're renewing in 2011 and that constitutes the beginning of a new plan year for you, you must make the change at that time. Keep in mind that this extension of coverage to older dependents is required regardless of whether your plan is grandfathered. The grandfathering only factors in when you're talking about extending coverage to older dependents who are eligible for their own coverage up until 2014.



**We expect a line of people to come to our human resources department on September 23<sup>rd</sup> requesting that their adult children be added to their plans. Am I correct that this would happen upon renewal of our plans, not just beginning on September 23<sup>rd</sup>?**

The answer depends upon timing. Under the new HHS rules governing coverage of adult dependents, a special enrollment period for dependents will be required, to provide eligible dependents previously not enrolled with a chance to enroll. Notices must be provided to employees about the special enrollment opportunity. The special enrollment period must start no later than the first day of first plan year beginning on or after September 23, 2010, and must last for 30 days. A plan may use its existing annual enrollment period and materials to comply if the annual enrollment fits within both of these time parameters required by the regulation. Coverage for these newly enrolled dependents must begin no later than the first day of the first plan year after September 23, 2010, even if the request for enrollment is made after the first day of the plan year. In subsequent years, dependent coverage may be elected in connection with normal enrollment opportunities.

**For grandfathered plans, do we have to offer coverage for dependents up to age 26 now?**

With respect to dependents who do not have access to their own coverage, a grandfathered plan is required to offer them coverage the first plan year starting after September 23, 2010. At present, a grandfathered plan is not required to cover adult dependents up to age 26 if they have access to their own coverage, but this will change in 2014. That's when all plans will be required to offer this extended dependent coverage regardless of whether the dependent has access to his or her own coverage.

###

### **Notification of Material Plan Changes**

**Could the “material changes” language refer to something as simple as a change in the co-pay amount?**

The HHS has not yet defined the term “material change”. However, we expect rate changes will be included, and that this will require all plan decisions be finalized and announced 60 days or more before renewal.

**Are there any incentives for carriers (other than competition) to provide renewals with greater lead time in providing information to employers?**

Most carriers have to adhere to a 30-day requirement at the state level to provide information, and in many of our markets we aren't getting more notice than that. With that said, we believe this legislation may prompt carriers to take some action to accommodate employers, but it's not mandatory on their part. If it becomes difficult to implement the 30-day requirement, it may be necessary to raise the issue with HHS and seek regulation directing carriers to provide sufficient notice so that employers can meet the bill's 60-day requirement. In the meantime, Trion is already in the process of working with carriers to provide information as early as possible to clients.

###



## Mandated/“Essential” Benefits

**We are a large employer with a January renewal and anticipate a significant increase in premiums. With regard to having to provide “essential benefits” - might we be able to remove coverage such as vision to help manage our costs? What are considered “essential benefits”?**

The categories of benefits listed as “essential” in the legislation will apply only to new plans in the individual and small group markets (so those with less than 100 employees). Large employers are not required to provide the “essential benefits” package.

The only specification for large employers is that they provide “minimum essential coverage,” a term that is only defined as “employer-sponsored coverage” in the statute. The definition is circular, but what it appears to mean from a practical perspective is that whatever an employer provides will satisfy its obligation.

There are three caveats:

1. If your plan is grandfathered (i.e., in existence on March 23, 2010) and you make plan changes now, you may lose your grandfathered status. The rules on grandfathering state that “eliminating all or substantially all benefits to diagnose or treat a particular condition” will cause a plan to lose grandfathered status. It is not clear from the regulations, however, whether the elimination of vision coverage would be considered the elimination of benefits to treat a particular condition, although we believe the most logical interpretation is that it would not. This is an issue that may be clarified by further regulatory guidance, but in the meantime, you should be aware that dropping vision coverage could trigger loss of grandfathered status.
2. If you do not provide coverage with at least a 60 percent actuarial value, you may stray into the realm of providing unaffordable coverage, as this 60 percent is one of the thresholds in the unaffordability calculation.
3. Although large employers are not required to comply with the essential benefits mandate, keep in mind that the ban on annual and lifetime limits applies to “essential benefits,” so it is still necessary to know how the term is defined. The categories of benefits described as “essential” in the statute are:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventative and wellness services and chronic disease management
  - Pediatric services, including oral and vision care.

**We are a single entity with two groups: Our unionized (large group) and non-union (small group) and we provide different benefits for each. What regulations do we follow under the new legislation?**

The legislation does not affect the structure of plans as far as a company offering one plan to union employees and another plan to non-union employees. The only differentiation the law makes with respect to union employees relates to implementation: a collectively bargained plan need not make the applicable market reform changes until the collective-bargaining agreement expires.



With respect to company size, and whether a company is classified as large or small for employer mandate purposes, the employer mandate rules do not distinguish between union and non-union employees. All full-time employees are counted (union or not), and part-timers (union or not) are counted using the “full time equivalent” calculation (the total number of hours worked by part-timers per month divided by 120).

**With regards to the provision that mandates 100 percent coverage for preventive care, how is “preventive care” defined?**

The law does not list specific services (this is another area in which we’re waiting for guidance from HHS), but the statute provides for the following categories of “preventive” services:

- Evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this law.

The statute further states that for its own purposes and those of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current (other than those issued in or around November 2009).

###

**Out-of-Pocket Limits**

**Would the out-of-pocket limitations include co-pays, deductibles, and any other expenses?**

A definition will have to be provided by HHS through rulemaking, but we expect that it will include co-pays, deductibles, and other expenses paid by the employee.

###

**Implementation**

**Our plan renews on October 1st. Do we have to incorporate the mandates that begin in 2010?**

Yes. The mandates noted as effective in 2010 apply to plan years that begin after September 23rd. Since your plan renews in October, you will need to implement the “2010” reforms we’ve identified. Keep in mind, not all of the mandates work this way. Some specify hard compliance dates, such as the ban on waiting periods longer than 90 days, which goes into effect January 1, 2014 regardless of when a plan renews.

###



### **Auto-Enrollment**

(Applies To “Large” Employers -- >200 Employees)

#### **Is the requirement that for the 2011 plan year, all employees working 30 hours or more a week are auto-enrolled in benefits, and then given the option to opt-out?**

The statute is unclear in terms of the effective date for this requirement. We do, however, predict it will go into effect once the Department of Labor (DOL) issues the appropriate regulations, which we expect will happen this year. Those regulations will give the specifics on the auto-enrollment process, although we expect they’ll require all full-time employees (those working at least 30 hours per week) to be automatically enrolled in health coverage, subject to each individual’s right to opt out.

#### **If we offer more than one plan to our employees, which one do we use for the auto-enrollment? Could we choose the plan least expensive to use as the employer?**

While the legislation directs the Secretary of Labor to develop rules to administer this requirement, it also contemplates multi-option plans and directs the employer to automatically enroll employees in any one of them. With that said, in theory, the employer could use the least expensive plan, but we won’t have a more definitive answer until the DOL issues its regulations.

Also, keep in mind that if an employer ends up with different categories of employees enrolled in plans with different rate structures, the ability to do that will be limited by the non-discrimination rule—if the lesser-paid employees are paying more than the higher-paid employees. Note, however, that the non-discrimination rules do not apply to existing plans (other than self-insured plans, which already must comply).

###

### **Other Market Reform/Plan Design Questions**

#### **How does the legislation affect employers with carve-outs or spousal surcharges?**

If you have surcharges for an employee’s spouses or dependents, there is not an explicit requirement that you change this rate structure. But keep in mind that if these surcharges are significant, they could put your plan into the realm of “unaffordable,” because the “unaffordability calculation” will be based on what the entire family must pay for coverage.

If the term “carve-out” means you do not offer coverage to dependents, the employer mandate provision will require that you do offer such coverage or pay a penalty starting in 2014—as the relevant provision requires the offering of coverage to “full-time employees (and their dependents)”.

#### **Does the uniform documents requirement alleviate the Summary Plan Design requirement?**

No, as far as the federal Summary Plan Design (SPD) requirement is concerned. The uniform standards that will be developed by HHS are what will be used by employers and plans to fulfill their SPD obligations. To the extent there are state-imposed requirements for SPDs—especially those that require the provision of less information than the new federal requirements—the legislation says they’ll be preempted by the more rigorous federal standards.



**If we have separate, stand-alone executive benefits plans, are they affected by the non-discrimination requirements?**

Starting on September 23, 2010, the legislation imposes new benefits non-discrimination requirements (that were once only applicable to self-insured plans) on all non-grandfathered group health plans. It is important to note that these new requirements do NOT apply to grandfathered plans that are not self-insured.

Going forward, employers that provide health coverage will be prohibited from limiting eligibility for any coverages to highly compensated individuals. The employer must not make high compensation an eligibility requirement or provide certain benefits only to those who are highly compensated.

Although the details on this may change during the mandated rulemaking process, generally, to meet this requirement, new plans must benefit at least 70 percent of all employees (or at least 80 percent of those eligible to benefit under the plan if 70 percent or more are eligible to benefit under the plan).

Employers may discriminate for employees who have less than three years of service, are not 25 years old, and work part-time or seasonally. The Internal Revenue Service (IRS) may review classifications to determine whether a plan is discriminatory.

###

**Retiree Reinsurance Program**

**Is the retiree coverage mandate voluntary? Or is it the long-term coverage?**

Employers are not required to provide retiree coverage. However, plans that provide such coverage may be eligible for reimbursement under the new law's early retiree coverage reinsurance provisions. Likewise, employer participation is solely voluntary for the long-term care insurance program established by the government.

**Re-insurance for early retirees ends in 2014. Does it apply to 2010?**

The reinsurance program for early retiree coverage will start this year. In fact, HHS has already issued interim final rules governing the program and has announced that applications will be available starting in mid- to late-June. Note that this program will end either in 2014 or when the \$5 billion allocated for it runs out— whichever comes first. For more information on the program, see the HHS website at <http://www.hhs.gov/ociio/regulations/index.html>.

###

**Wellness**

**When you say “less than or more than 100 employees”, is that referring to benefit-eligible employees?**

The statute provides only that employers with less than 100 employees are eligible for grants. It does not specify that those employees be benefit-eligible. This is an issue HHS rules may clarify.

**How is a wellness program being defined according to the new legislation?**

The health care reform legislation does not define a wellness program. As a result, the current definition in federal law continues to govern.