THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
FREQUENTLY ASKED QUESTIONS

SELF-FUNDED PLANS

1. What specific components of H.R. 3590 and the reconciliation bill apply to self-funded groups?

- The reconciliation bill extends the lifetime and annual limit prohibitions found in H.R. 3590 to self-funded groups.
- The reconciliation bill extends the requirement found in H.R. 3590 to cover dependents to age 26 to self-funded plans.
- The reconciliation bill extends the rescission prohibition found in H.R. 3590 to self-funded plans.
- The Department of Labor would begin in 2010 studying self-funded plans based on data collected from Form 5500s.
- All plans must provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees.
- The reconciliation bill (H.R. 4872) extends the guarantee issue and guarantee renewable requirements found in H.R. 3590 to self-funded plans governed by ERISA.
- All plans must provide coverage documentation to both covered individuals and the IRS.
- The so-called Cadillac Plan tax applies to self-insured plan and equates to a 40 percent excise tax on plans with aggregate values that exceed either $10,200 (H.R. 4872) for individuals or $27,500 (H.R. 4872) for families.
- Self-insured plans are subject to an annual fee assessed to fund comparative effectiveness research in an amount equal to $2 times the number of insured lives on each specified health insurance policy / self-insured health plan.

SMALL GROUP TAX CREDIT

1. How is the contribution on the part of the small employer calculated for purposes of the tax credit? Is it based on total invoice or each employee election?

For tax years 2010 through 2013, small employers will receive a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the *total premium* cost or 50 percent of a *benchmark premium*. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases, taking into account what constitutes an "eligible" small employer as explained below.

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

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

A small employer is defined for purposes of the tax credit as an employer with no more than 25 full time equivalent (FTE) employees and includes leased employees. This does not include seasonal workers unless the seasonal workers work more than 120 days per year. There are other types of employees who are not included, such as two percent shareholders and five percent owners of S corporations. FTE employee is determined by dividing the total number of hours of service for which wages were paid by the employer during the taxable year by 2,080, rounded to the next lowest whole number. If an employee works in excess of 2,080 hours of service during any taxable year, the excess is not taken into account.

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

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

LARGE GROUP DISCRIMINATION RULE ON HIGHER WAGE EARNERS

1. Does the large group discrimination rule mean that you can't class out based on titles?

H.R. 3590 states that a plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee that are based on the total hourly/annual salary of the employee; the plan sponsor also may not establish eligibility rules that have the effect of discriminating in favor of higher wage employees. This requirement is similar to the rules already in existence for self funded plans and qualified benefits under a cafeteria plan.

This provision does not prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan that provide for the payment by employees with lower hourly/annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly/annual compensation.

"GRANDFATHERED" PLANS

1. What is meant by "grandfathered plan"?

"Grandfathered" plan refers to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act. Renewal of the plan after such date of enactment does not alter the grandfather status of the plan.

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

However, the grandfathering provision is silent with respect to the impact of plan changes made subsequently, so it is unclear how such plan changes will impact grandfathered status. Some experts believe that if an individual changes his or her level of deductible or co-insurance, then the plan is no longer grandfathered. We will watch for additional guidance in this area.

DEPENDENT AGE

1. When do plans have to change the dependent age to 26? How will this requirement apply if the dependent was already taken off the parent's plan? Would they be re-enrolled?

H.R. 3560 states that the dependent age coverage requirement will become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act. H.R. 3560 was signed into law on March 23rd, so six months following this date would be Sept. 23. Thus, the dependent coverage requirement applies to plan years beginning on Sept. 23, 2010 or thereafter. Enrollment of adult child dependents will occur at the start of the applicable plan year. For plans based on the calendar year, this mandate would be applicable to plan years Jan. 1, 2011 and after.

2. When the dependent marries, can the spouse qualify under the "child's" plan and be added as a result of their qualifying event? Does the requirement to cover children to age 26 come with any other requirements, i.e. the "child" is dependent upon the employee for support?

We will watch for additional guidance on this subject. The Secretary is required to promulgate regulations to define the dependents to which this will be made available. A dependent will include an adult child until the child turns 26 years of age if the child does not have other employer-sponsored coverage. The reconciliation bill permits married children to be included in this provision. There is no mention of the spouse of a dependent adult child, but the provision explicitly excludes a child of an adult child receiving dependent coverage. There does not appear to be a requirement that the adult child be a student or reside with the parents. Again, we will watch for further guidance.

The reconciliation bill amends Section 105 of the Internal Revenue Code and states that the cost of health coverage for dependent children through age 26 is excluded from taxable income.

3. **Will the adult child dependent (up to age 26) be able to enroll under the parent's family plan or will the group be required to enroll the adult child as a 'single'?**

There is no definitive guidance on this, but it is presumed that since the law refers to "dependent coverage," the adult child will need to be enrolled under the family plan and not separately as a single individual. But, we are aware that some states have permitted adult child dependents to enroll as singles, so we will watch for clarification on this issue.

MANDATED PREVENTIVE SERVICES

1. **Does the mandated preventive services apply to HSA and HRA plans?**

The mandated preventive services provision applies to "a group health plan and a health insurance issuer offering group or individual health insurance coverage." The relevant definition for what constitutes a "group health plan" is that set forth in 42 U.S.C. §300gg-91. In that section "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise. An HRA plan is included in this definition of a group health plan. An HSA is not.

2. **The legislation requires all plans to cover preventive services and immunizations, recommended by various Federal agencies, and it also specifically includes certain child preventive services and women's preventive care. Plans are prohibited from imposing any cost-sharing requirements. Does this mean that an employer can not charge a co-payment for these services?**

HR 3590 defines "cost sharing" for purposes of the mandated preventive requirements as including: (i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual which is a qualified medical expense with respect to essential health benefits covered under the plan." There are certain exceptions to "cost-sharing," which include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

DOMESTIC PARTNER

1. **Does H.R. 3590 or the reconciliation bill address domestic partners?**

We are not aware of any provision addressing domestic partners in either HR 3590 or the reconciliation bill.

LONG-TERM CARE ENROLLMENT

1. Is the LTC enrollment requirement under the CLASS Program optional?

By optional, I am not sure if you are referring to the employer providing auto-enrollment or the employee have the option of whether to accept coverage. The "Community Living Assistance Services and Supports Act" or the "CLASS Act" establishes a national voluntary insurance program for purchasing community living assistance services and supports. The Secretary of HHS is required to establish procedures for individuals to automatically enroll in the CLASS program by an employer in the same manner as an employer may automatically enroll employees in a 401(k) plan.

The Secretary is also required to establish an "alternative" enrollment process (other than auto-enrollment) for individuals who are self-employed; who have more than 1 employer; or whose employer does not elect to participate in the automatic enrollment process. However, according to Janet Trautwein, CEO and EVP of NAHU, while this alternative process may be provided for in the bill, the expectation of Congress is that employers will have auto-enrollment (the cost estimates of the bill were based on auto-enrollment). Thus, the alternative procedures will likely be limited to certain employers (i.e., only small employer) or difficult to implement. We will watch for additional details on this subject.

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