Twenty (20) Common Compliance Questions & Answers in Health Reform

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Question 1: Wellness Programs and Grandfathered Status

One of my clients sponsors a wellness program. If an employee participates in the program, his or her group medical coverage premium will be reduced from 10% to 15%. If for any year, an employee does not qualify for the discount under the wellness program and his or her premium increases from 10% to 15%, will such an increase affect the grandfathered status of the employer's group medical plan?

Yes. The various federal agencies caution that penalties related to wellness programs (such as cost-sharing surcharges) should be examined carefully as they could jeopardize the plan's grandfather status. For example, by decreasing the employer's contribution percentage by more than 5 percentage points below the contribution rate on March 23, 2010.

Question 2: Grandfathered Status and the Elimination of a Benefit

My client currently sponsors a PPO, an HMO and an HDHP. For the next policy year, it wants to eliminate the PPO for cost reasons and transfer all the employees to the remaining two plans it sponsors. Will such elimination affect the grandfathered status of the other two plans it sponsors?

It may. See the discussion below:

A plan will lose its grandfathered status if a plan transfers employees to another plan in a circumstance where the transfer, if treated like a plan amendment to the transferor plan, would cause that plan to lose its grandfathered status, unless there is a bona fide employment-based reason for the transfer, as provided in Treasury Regulations Section 54.9815-1251T(b)(2)(ii); Department of Labor ("DOL") Regulations Section 2590.715-1251(b)(2)(ii); and HHS Regulations Section 147.140(b)(2)(ii). However, employees may voluntarily change from one grandfathered health plan to another without endangering the grandfathered status of either plan, as provided in Treasury Regulations Section 54.9815-1251T(b)(3), Example 1; DOL Regulations Section 2590.715-1251(b)(3), Example 1; and HHS Regulations Section 147.140(b)(3), Example 1.

What is a bona fide employment-based reason for this purpose?

Treasury Regulations Section 54.9815-1251T(b)(2)(ii)(C); DOL Regulations 2590.715-1251(b)(2)(ii)(C); and HHS Regulations Section 147.140(b)(2)(ii)(C) specifically note that changing terms or cost of coverage is not a bona fide employment-based reason. Similarly, dropping one of two benefit options solely for cost reasons is impermissible, although dropping a benefit option following a plant closure may be permissible, as provided in Treasury Regulations Section 54.9815-1251T(b)(3), Examples 2 and 3; DOL Regulations Section 2590.715-1251(b)(3), Examples 2 and 3; and HHS Regulations Section 147.140(b)(3), Examples 2 and 3.

Agency FAQs provide further guidance, describing several circumstances under which an employer may transfer employees from one grandfathered benefit package to another without causing a loss of grandfathered status:

- when the insurance issuer is exiting the market or will no longer offer the product to the employer;
- when low or declining participant enrollment makes it impractical for the employer to continue to offer the benefit package;
- when the benefit package is eliminated under a multiemployer plan as part of a collective bargaining process; and
- when the benefit package is eliminated for any reason, provided multiple benefit packages covering a significant number of other employees remain available to the transferring employees, as provided in FAQs About the Affordable Care Act Implementation Part VI, Q/A-1.

To view these FAQs, please click on the link below:

http://www.dol.gov/ebsa/faqs/faq-aca6.html

In the FAQs, the DOL indicates that the list is not intended to be an exhaustive list of circumstances that will be deemed to satisfy the bona fide employment-based reason condition. There may be many other circumstances in which a benefit package is considered to be eliminated for a bona fide employment-based reason.

Question 3: Tax Free Health Coverage

Under the Health Care Reform laws, which individuals qualify for tax free health coverage?

The Health Care Reform laws expanded the group of individuals who can receive accident or health benefits on a tax-free basis to include children "of the taxpayer" who have not attained age 27 as of the end of the taxable year, as provided in Code Section 105(b). This change means that, in addition to the employee and his or her spouse, the following individuals may now receive employer-provided health coverage on a tax-free basis:

- any child of the employee, until the end of the year the child turns age 26;
- an employee's qualifying child; and
- an employee's qualifying relative.

Question 4: Tax Free Health Coverage

For this purpose, who qualifies as a “child”?

For purposes of this exclusion, a "child" means "a son, daughter, stepson, or stepdaughter of the taxpayer, or an eligible foster child of the taxpayer,” as provided

under Code Section 152(f)(1). The terms "qualifying child" and "qualifying relative" are defined using the modified Code Section 105(b) definition.

Please remember that the tax treatment provisions apply to all employer-provided accident or health coverage, including plans that provide only HIPAA-excepted benefits, such as limited-scope dental or vision benefits and most health FSAs.

Special Note: Under these new rules, coverage for a child of a civil union spouse or domestic partner will only be tax free if he or she meets the requirements for being a qualifying relative. In many situations, the child of a civil union spouse or domestic partner may not be the "child" or the "qualifying child" of the employee.

Question 5: Health Savings Accounts

For distributions from a Health Savings Account ("HSA") to be tax free for account holder, which individual's expenses can be reimbursed tax free?

For distributions from a Health Savings Account ("HSA") to be tax free for account holder, the medical expense must be incurred by an individual who meets the requirements for being either a "qualifying child" or a "qualifying relative," as defined using the modified Code Section 105(b) definition. Code Section 223 was not amended by the Health Care Reform laws to add a provision allowing expenses for children under age 27 who are not Code Section 105(b) dependents, so unlike health FSAs, HRAs, and HDHPs, HSAs cannot pay the expenses of such children tax-free.

Question 6: Form W-2 Reporting

Which employers are required to report "applicable employer-sponsored coverage" on an employee's Form W-2 for 2012?

No. All employers that provide "applicable employer-sponsored coverage" during a calendar year are subject to the reporting requirement-including federal, state, and local government entities (a few exceptions apply, such as federally recognized Indian tribal governments).

For 2012 Forms W-2 and until the issuance of further guidance, the IRS indicated in Notice 2011-28, Q/A-3 that an employer is not subject to the reporting requirement for any calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year. Therefore, if an employer files fewer than 250 Forms W-2 in 2011, the employer would not be subject to the reporting requirement for the 2012 calendar year.

Question 7: Form W-2 Reporting

In meeting the new Form W-2 Reporting requirements, what coverages provided by the employer to employees must be reported?

The Form W-2 reporting requirement applies only to "applicable employer-sponsored coverage," a term that generally includes any employer-provided group health plan coverage under an insured or self-insured health plan that is excludable from the

employee's gross income under Code Section 106, or that would be excludable if it were paid for by the employer. It is subject to numerous exceptions, including exceptions for:

- any coverage for long-term care;
- any coverage (whether through insurance or otherwise) described in Code Section 9832(c)(1), which includes accident and disability coverage, but no exception applies for coverage for on-site medical clinics;
- certain stand-alone vision or dental coverage (as discussed below); and
- any coverage described in Code Section 9832(c)(3) (i.e., coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance) where such coverage is funded by the employee on an after-tax basis for which a deduction under Code Section 162(l) is not allowable as provided in PPACA, Pub. L. No. 111-148, Section 9002 (2010) (cross-referencing Code Section 4980I(d)(1), which was added by PPACA, Pub. L. No. 111-148, Section 9001(2010)).

For purposes of determining whether a specific arrangement is a group health plan, employers may rely upon a good faith application of a reasonable interpretation of the statutory provisions and applicable guidance, including the definition under the IRS COBRA regulations as provided in Treas. Regulations Section 54.4980B-2, Q/A-1(a). Thus, any coverage subject to the COBRA regulations' definition of group health plan would, in the absence of an exception or transition rule, be subject to the W-2 reporting requirement, as provided in IRS Notice 2011-28, 2011-16 I.R.B. 656, Q/A-13.

Dental and Vision Coverage

Applicable employer-sponsored coverage subject to the reporting requirement does not include stand-alone, insured dental, or vision coverage, as provided in Code Section 4980I(d)(1)(B). Based on a plain reading of the statutory language, it appears that the cost of insured dental or vision coverage which is offered “under a separate policy, certificate, or contract of insurance” is excluded from the aggregate cost of employer-sponsored coverage to be reported on the employee's Form W-2, as provided in Code Section 4980I(d)(1)(B)(ii). By contrast, under the literal language of the statute, the cost of self-insured dental or vision coverage (whether a limited-scope stand-alone benefit or bundled with medical) appears to be included on the employee's Form W-2. Interim guidance issued in IRS Notice 2011-28 conforms the treatment of self-insured and fully insured dental/vision plans by providing transition relief.

Transition Relief for Stand-Alone Dental or Vision Coverage (Whether Insured or Self-Insured).

IRS Notice 2011-28 provides transition relief by not requiring employers to include the cost of coverage under a dental or vision plan (provided on an insured or self-insured basis) if such plan is not integrated into a group health plan providing additional health

care coverage subject to the reporting requirement, as provided under IRS Notice 2011-28, 2011-16 I.R.B. 656, Q/A-20.

Health Savings Account ("HSA") and Archer MSA Contributions

HSA and Archer MSA contributions are included in the definition of applicable employer-sponsored coverage, but they are explicitly excluded from the W-2 reporting obligation, as provided in Code Section 4980I(d)(2)(C). A special rule applies to health FSAs .

Special Rules for Health FSA Contributions

Health FSA contributions are included in the definition of applicable employer-sponsored coverage, but special rules apply with respect to the W-2 reporting obligation, as provided in Code Section 4980I(d)(2)(B). The amount of any salary reduction election to a health FSA is excluded from the aggregate reportable cost and is not reported on Form W-2, as provided in IRS Notice 2011-28, 2011-16 I.R.B. 656, Q/A-16. Where the health FSA is offered through a cafeteria plan under which optional employer flex credits (expressed as a fixed amount, or as a formula such as matching salary reduction) can be applied to the health FSA, special rules must be applied to determine whether any amount must be included in the aggregate reportable cost as follows:

- If the amount of the employee's salary reduction (for all qualified benefits) equals or exceeds the amount of the health FSA for a plan year, then the amount of the employee's health FSA is not included in the aggregate reportable cost.
- If the amount of the employee's health FSA for a plan year exceeds the employee's salary reduction for that plan year, then the amount of the employee's health FSA minus the employee's salary reduction election for the health FSA must be included in the aggregate reportable cost.

Coverage Under a Health Reimbursement Arrangement ("HRA")

Under transition relief provided in IRS Notice 2011-28, 2011-16 I.R.B. 656, Q/A-18, an employer is not required to include the cost of coverage under a HRA in determining the aggregate reportable cost. Thus, if the only applicable employer-sponsored coverage provided to an employee is a HRA, no reporting is required on the Form W-2.

Transition Relief for Certain Employers and Coverage

For instances in which transition relief is provided under IRS Notice 2011-28, the IRS has indicated that future guidance may prospectively limit the availability of some or all of this transition relief—but it will not apply earlier than January 1 of the calendar year beginning at least six months after it is issued and will not limit the availability of the transition relief for the 2012 Forms W-2. Transition relief is available for the following:

- employers filing fewer than 250 Forms W-2,

- certain Forms W-2 furnished to terminated employees before the end of the year,
- relief with respect to multiemployer plans,
- HRAs,
- certain dental and vision plans, and
- self-insured plans of employers not subject to COBRA continuation coverage or similar requirements.

Question 8: Summary of Benefits and Coverage

When must the Summary of Benefits and Coverage ("SBC") be distributed?

Group health plans and insurers are required to provide an SBC to a participant or beneficiary with respect to each "benefit package" offered for which the participant or beneficiary is eligible. The requirement applies beginning with the first open enrollment period beginning on or after September 23, 2012 for participants and beneficiaries enrolling or re-enrolling through open enrollment. For individuals enrolling other than through open enrollment (e.g., newly eligible individuals or special enrollees), the requirement applies beginning on the first day of the first plan year that begins on or after September 23, 2012. For calendar-year plans, this means that SBCs will first be required during open enrollment in 2012 for the 2013 plan year. But for some non-calendar-year plans, the SBC rules may first apply to newly eligible individuals and special enrollees.

The SBC must be distributed at various times, as outlined below.

At Open Enrollment (Renewal): The SBC must be included with open enrollment materials. If the plan or insurer requires participants or beneficiaries to renew in order to maintain coverage for a succeeding plan year, a new SBC must be provided no later than the date the renewal materials are distributed. If renewal is automatic, the SBC must be furnished no later than 30 days prior to the first day of the new plan year. For insured plans, if the new policy has not yet been issued 30 days prior to the beginning of the plan year, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the policy.

In an effort to reduce unnecessary duplication with respect to group health plans that offer multiple benefit packages, in connection with renewal, the plan or insurer only need to automatically provide a new SBC with respect to the benefit package in which a participant or beneficiary is enrolled. SBCs are not required to be provided automatically with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests a SBC with respect to another benefit package for which the participant or beneficiary is eligible, the SBC must be provided as soon as practicable, but in no event later than seven business days following the request.

At Initial Enrollment: The SBC for each benefit package offered for which the participant or beneficiary is eligible must be provided as part of any written application

materials that are distributed by the plan or insurer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries. In the unlikely event that there is any change to the information required to be in the SBC before the first day of coverage (e.g., prior to the end of the plan's waiting period), the plan or insurer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

At Special Enrollment: The plan or insurer must also provide the SBC to special enrollees (employees and dependents with the right to enroll in coverage midyear upon specified circumstances) within 90 days after enrollment pursuant to a special enrollment right, which is the timeframe for providing SPDs.

Upon Request: The plan or insurer must provide the SBC to a participant or beneficiary upon request, as soon as practicable, but in no event later than seven business days following the request.

Question 9: Summary of Benefits and Coverage

Who must be furnished the Summary of Benefits and Coverage ("SBC")?

The SBC must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy), and enrollees (at initial enrollment and annual enrollment). The plan (including the plan administrator) and the insurer must automatically provide a SBC to participants and beneficiaries with respect to each "benefit package" offered for which the participant or beneficiary is eligible. Information can be combined for different coverage tiers (self-only, employee-plus one coverage and family coverage) in one SBC, provided the appearance is understandable.

Question 10: Summary of Benefits and Coverage

Does an employer have to provide a copy of the Summary of Benefits and Coverage ("SBC") to enrollees of Health Flexible Spending Accounts ("Health FSA") or Health Reimbursement Arrangements ("HRA")?

The SBC requirement applies to group health plans (both insured and self-insured) and insurers (as defined by applicable provisions of the PHSA, ERISA, or the Code) but not to certain "excepted benefits," PHSA Section 2715(a), as added by PPACA, Pub. L. No. 111-148 (2010). Grandfathered group health plans must comply with this mandate, as provided in PPACA, Pub. L. No. 111-148, Section 1251(a)(3) (2010), as amended by PPACA, Pub. L. No. 111-148, Section 10103(d)(1) (2010).

When is a Health FSA or a HRA considered an excepted benefit?

Health FSA:

A health FSA is considered an excepted benefit for a "class of participants" if the health FSA is a health FSA under Code Section 106(c)(2) and satisfies two conditions:

- Maximum Benefit Condition: The maximum benefit payable under the health FSA to any participant in the class for a year cannot exceed two times the employee's salary reduction election under the health FSA for the year (or, if greater, the amount of the employee's salary reduction election for the health FSA for the year, plus $500), as provided in Treasury Regulations Section 54.9831-1(c)(3)(v)(B); DOL Regulations Section 2590.732(c)(3)(v)(B); and HHS Regulations Section 146.145(c)(3)(v)(B); and

- Availability Condition: Other nonexcepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment, as provided in Treasury Regulations Section 54.9831-1(c)(3)(v)(A); DOL Regulations Section 2590.732(c)(3)(v)(A); and HHS Regulations Section146.145(c)(3)(v)(A).

Neither the regulations nor the preamble to the regulations explains what is meant by the term “class of participants.” The term appears to preclude a “participant-by-participant” approach to determining whether benefits under a health FSA are excepted benefits.

Examples of Health FSA Funding That Meet the Maximum Benefit Condition:

- A one-for-one employer match (employer $600, employee $600).

- An employer contribution of $500 or less (employer $500, employee $200).

Examples of Health FSA Funding That Do Not Meet the Maximum Benefit Condition:

- An employer contribution of more than $500, if the employee contributes $500 or less (employer $600, employee $400).

- An employer contribution in excess of a one-to-one match, if the employee contributes more than $500 (employer contributes $700, employee contributes $600).

Remember: Health FSAs funded exclusively by employee salary reduction contributions (with annual coverage capped by the amount of the annual salary reduction election) will, by definition, satisfy the Maximum Benefit Condition.

HRA:

A 100% employer-paid stand-alone HRA with an annual limit less than or equal to $500 and no carryovers will be considered an excepted benefit if the employer makes major medical insurance available to all employees who are eligible for the HRA. This is the same requirement as provided above for Health FSAs. This is because such a HRA may be considered a health FSA and would qualify as an excepted benefit. Likewise, a

retiree-only HRA or limited-purpose HRA (i.e., that provides only vision and dental benefits) would also be considered an excepted benefit

The above HIPAA exceptions will not apply to most HRAs. HRAs that can be used for medical expenses generally and that permit carryovers or that provide an employer-funded benefit of more than $500 will not be considered excepted benefits.

Question 11: Essential Health Benefits

What are Essential Health Benefits under Health Reform?

Under Section 1302(b) of the Affordable Care Act, “essential health benefits” include minimum benefits in ten general categories and the items and services within those categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Question 12: Essential Health Benefits

Who is required to provide Essential Health Benefits?

Beginning in 2014, health plans offered in the small group and individual market will be required to cover essential health benefits. The scope of coverage for these items must be equal to that provided under a "typical employer plan."

In a bulletin released in December, the Department of Health and Human Services (“HHS”) indicated that each state will establish its own essential health benefit package by selecting a benchmark plan that reflects the "typical employer plan" in the state. A state can choose as its benchmark one of the following based on enrollment: the largest HMO offered in the state, one of the three largest small group health plans in the state, one of the three largest state employee health plans, or one of the three largest federal

employee health plan options. The default election will be the largest small group market plan in the state.

In a series of frequently asked questions released in February 2012 by HHS, it indicated that it intended to identify each state's default benchmark in the fall of 2012.

Question 13: Essential Health Benefits

Are large group market health plans, grandfathered plans or self-insured group health plans required to provide Essential Health Benefits?

Large group market health plans, grandfathered plans and self-insured group health plans are not required to cover essential health benefits. However, these plans are subject to the Affordable Care Act's prohibition against imposing annual and lifetime dollar limits on benefits that fall within the definition of essential health benefits. These rules were effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans).

These plans are permitted to impose non-dollar limits, consistent with other guidance, on essential health benefits as long as they comply with other applicable statutory provisions. In addition, these plans can continue to impose annual and lifetime dollar limits on benefits that do not fall within the definition of essential health benefits.

How are large group market health plans, grandfathered health plans or self-insured group health plans to determine which benefits offered are essential health benefits?

In the series of frequently asked questions, HHS indicated that it will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of essential health benefits if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories).

In addition, HHS indicated that the Departments of Labor, Treasury and HHS intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of essential health benefits to ensure there are no annual or lifetime dollar limits on essential benefits.

Question 14: Essential Health Benefits

Are employers required to cover abortions as part of Essential Health Benefits?

No. The health reform law outlines specific provisions regarding coverage for abortions. Under current law, the federal Hyde Amendment limits the use of federal funds for abortion only to cases when the pregnancy is a result of rape or incest or is a threat to

the woman's life. This rule limits abortion coverage for federal employees, Medicaid enrollees, the Indian Health Service, and women in the military, and will remain in force under health reform. Furthermore, abortion coverage is specifically banned from being required as part of the essential benefits package offered by plans in exchanges and all of the exchanges must offer consumers the choice of at least one plan that does not provide abortion coverage. States may also enact legislation to ban any plan from offering abortion coverage, either in the exchange or more broadly in the private market and several states either have laws or are pressing forward with new laws that do that, as provided in Center for Reproductive Rights. Abortion Access: Restrictions on Public Funding and Insurance Coverage, 2009. In addition, plans participating in the exchanges may not discriminate against any provider because of unwillingness to provide, pay for, cover, or refer for abortions.

In states that will have exchange plans that cover abortion, federal subsidy dollars will be limited to covering abortions only when the pregnancy endangers the life of the woman, or is the result of rape or incest, consistent with the current Hyde Amendment. Coverage for other abortions can be paid for with private, state or local funds. To ensure that federal funds are not used for abortion coverage, plans that do cover abortions beyond Hyde limitations must segregate funds and estimate the actuarial value of such coverage by taking into account the cost of the abortion benefit. This separate premium must be charged to all individuals who enroll in the plan (including men and women of all ages). For women on Medicaid, the state rules for Medicaid coverage will be in effect.

Currently, 17 states go beyond the federal limits on abortion coverage and offer coverage for other medically necessary abortions with state-only funds, as provided in the Guttmacher Institute, State Policies in Brief, March 2012.

Question 15: Health Reimbursement Arrangements

My client wants to establish a "free standing" Health Reimbursement Arrangement ("HRA") for its employees for medical, dental and vision expenses incurred after December 31, 2011. Under this plan, participants would be reimbursed up to $5,000 for medical, dental and vision expenses and/or premiums for individual insurance premiums. Is it possible for an employer to sponsor such a plan considering the changes under Health Reform?

No, unless the employer amends the HRA to only reimburse dental and vision expenses and/or premiums. See the discussion below:

The health care reform law prohibits group health plans from establishing "lifetime limits on the dollar value of benefits for any participant or beneficiary" for plan years beginning on or after September 23, 2010, as provided under PHSA Section 2711(a)(1)(A). For plan years beginning on or after September 23, 2010 and prior to January 1, 2014, the health care reform law allows "restricted annual limits" on essential health benefits, but

for plan years beginning on or after January 1, 2014, no annual limits on essential health benefits are permitted.

HRAs are group health plans that provide reimbursements up to a maximum dollar amount for a coverage period and generally, though not always, allow unused amounts to be carried forward to increase the maximum reimbursement in subsequent coverage periods as provided in IRS Notice 2002-45, 2002-28 I.R.B. 93. In essence, then, HRAs are account-based benefits which by their very nature impose upper limits on the dollar value of benefits.

There are three exemptions for HRAs from these annual limit requirements. These include:

- Retiree-only HRAs, as provided in 75 Fed. Regulations 34537.
- Those HRAs that provide excepted benefits under the HIPAA portability rules, as provided in Treasury Regulations Section 54.9831-1(c); DOL Regulations Section 2590.732(c); and 45 CFR Section 146.145(c). HRAs that provide only limited-scope dental or vision benefits will not be subject to the annual limit rules.
- HRAs that are integrated with other coverage as part of a (more comprehensive) group health plan will not violate the annual limit rules so long as the other coverage on its own would comply, as provided in Preamble to Interim Final Rules Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under PPACA, 75 Fed. Regulations 37188, 37190.

For any HRA that does not come under one of the above exemptions, there are two other ways to obtain a temporary exemption from the annual limit restrictions: by applying for a waiver or by satisfying the requirements of a class exemption. The window of opportunity for filing waiver applications closed on September 22, 2011; and both the waiver and class exemption apply only to HRAs that were in effect prior to September 23, 2010. This is provided in the CCIIO Supplemental Guidance (CCIIO 2011-1D): Concluding the Annual Limit Waiver Application Process; CCIIO Supplemental Guidance (CCIIO 2011-1E): Exemption for Health Reimbursement Arrangements that are Subject to PHS Act Section 2711.

A copy of each guidance can be obtained by clicking on the link below:

CCIIO Supplemental Guidance (CCIIO 2011-1D): Concluding the Annual Limit Waiver Application Process:

http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf

CCIIO Supplemental Guidance (CCIIO 2011-1E): Exemption for Health Reimbursement Arrangements that are Subject to PHS Act Section 2711:

http://cciio.cms.gov/resources/files/final_hra_guidance_20110819.pdf

For the purpose of the waiver and the class exemption, the term “in effect” is not defined, but it presumably means the HRA had been formally adopted (and perhaps even providing benefits or accumulating account balances) prior to September 23, 2010. The exemption clearly does not apply to a HRA that was created significantly after that date—for example, a company that designs a HRA in 2011 to be effective January 1, 2012.

In order for any “free standing” HRAs adopted prior to September 23, 2010 to rely on the exemption, they must comply with the record retention and annual notice requirements that apply under the waiver program (which are discussed above). This is true even though that waiver program may not be available to the HRA (e.g., because the HRA did not submit an application prior to September 22, 2011).

Question 16: Nondiscrimination Rules for insured Health Plans

If an insured health plan losses grandfathered status, it must now pass the nondiscrimination tests under Code Section 105(h) for plan years beginning after September 23, 2010. What are these tests?

Nongrandfathered insured health plans must pass two tests under Code Section 105(h), the Eligibility Test and the Benefits Test. The purpose behind these tests is to prohibit discrimination in favor of the prohibited group, highly compensated individuals or HCIs.

An individual is a HCI for these purposes if he or she is (a) one of the five highest-paid officers; (b) a more-than 10% shareholder; or (c) among the highest-paid 25% of all employees (other than excludable employees who are not participants).

Eligibility Test

Health Plans may not discriminate in favor of HCIs as to eligibility to participate, i.e., an employer must cover more than just the top earning employees to the plan. Certain employees may be excluded, e.g., those who have not completed three years of service; have not attained age 25; are part-time or seasonal; are collectively bargained; or are nonresident aliens who receive no U.S. source earned income. Permitted exclusions must be applied uniformly, and not just for testing.

To satisfy eligibility criteria, a plan must benefit one of the following: (1) 70% or more of all non-excludable employees; (2) 80% or more of all employees who are eligible to benefit, if 70% or more of all non-excludable employees are eligible to participate under the plan; or (3) employees qualifying under a classification that does not discriminate in favor of HCIs (the nondiscriminatory classification test).

Exactly what "to benefit" means in a health plan is not clear. Does it mean that someone is merely eligible to elect health plan coverage, or does it mean that the person has actually elected such coverage? Many employers take the approach that being eligible to elect health plan coverage is enough. This interpretation makes it easier to pass the test (e.g., if more than 70% of all employees are eligible, but only 25% of employees elect health plan coverage, the test would be passed). However, the more cautious

approach is that in order to benefit, an employee must have elected health plan coverage or have been provided free health plan coverage by plan design.

Benefits Test

Under the benefits test, the benefits provided to HCIs under the plan must be provided to all other participants. Required contributions should be identical for each benefit level. The maximum benefit level that can be elected cannot be based on percent of compensation, age, or years of service. The type of benefits reimbursable must be identical for all participants. The health plan must not have different waiting periods.

Penalties for Noncompliance

The consequences of an insured plan's failure to comply with the nondiscrimination rules are different from the consequences for a plan that is self-insured. An insured plan that fails to comply with the nondiscrimination rules is subject to a civil action to compel it to provide nondiscriminatory benefits and, for each day that the plan fails to comply, the plan or plan sponsor is subject to excise taxes or civil money penalties of $100 per day per individual discriminated against. In contrast, if a self-insured plan fails to comply with the rules, then amounts paid to HCIs that are considered to be "excess reimbursements" will be taxable. This difference in penalties exists because the Code provision under which HCIs are taxed was not made applicable to insured plans by the health care reform laws.

Delayed Application Date

Although the health care law initially required compliance with the nondiscrimination rules for insured plans for plan years beginning on or after September 23, 2010, the IRS announced in IRS Notice 2011-1 that compliance with the rules will not be required until the agencies have issued regulations or other guidance regarding the rules. Until that time, sanctions for failure to comply with the rules (discussed below) will not apply. Furthermore, the agencies expect that when regulations or other guidance is issued, its effective date will be delayed in order to allow for time to implement any changes that are required as a result of the guidance, and plan sponsors will not be required to file IRS Form 8928 with respect to excise taxes resulting from failure to comply with the nondiscrimination rules for insured plans until the effective date of the guidance.

Question 17: Nondiscrimination rules for Insured Health Plans

As a part of an executive's severance pay agreement, my client promises to pay part or all of his or her COBRA premiums under the employer's insured group health plan after his or her termination.

Would such payment by the employer be a violation of the new Code Section 105(h) nondiscrimination rules?

Yes. If such arrangement is only made for executives and not at the termination of other employees, it is a violation of the nondiscrimination rules under Code Section 105(h). This is because it is made for a group that contains a concentration of highly compensated individuals. If the group receiving this payment included a cross-section of

employees, then there would be no violation. These new nondiscrimination rules will only be effective for the plan year beginning after any new guidance is released by the IRS.

It is suggested that employers review its severance pay policies and all employment and severance pay agreements of employees and renegotiated them before the effective date of these rules. If after the effective date of these new nondiscrimination rules, if any arrangement is found in violation, the employer could face a penalty of $100 per day for each employee that was discriminated against.

Question 18: Health Flexible Savings Accounts

Health Reform imposes a new $2,500 limit on annual salary reduction contributions to health FSAs offered under cafeteria plans. When is this change effective?

Under Code Section 125(i), as amended by PPACA, Pub. L. No. 111-148 (2010) and HCERA, Pub. L. No. 111-152 (2010), this change is effective for Plan years beginning after December 31, 2012. Also, Code Section 125(i) provides that in order for the health FSA to be a qualified benefit under the cafeteria plan; consequently, it must be set forth in the applicable plan documents.

Code Section 125(i)(2) provides that the $2,500 amount will be indexed for inflation for plan years beginning after December 31, 2013. All health FSAs offered under cafeteria plans must comply with this new requirement

On May 30, 2012, the IRS released Notice 2012-40 which provides guidance on the effective date of the $2,500 limit (as indexed for inflation) on salary reduction contributions to health FSAs under Code Section 125(i) and on the deadline for amending plans to comply with that limit. This notice also provides relief for certain contributions that mistakenly exceed the $2,500 limit and that are corrected in a timely manner.

Specifically, Notice 2012-40 provides that:

- the $2,500 limit does not apply for plan years that begin before 2013;
- if the a cafeteria plan has a short plan year, the $2,500 limit must be prorated based on the number of months in the short plan year
- the term “taxable year” in Code Section 125(i) refers to the plan year of the cafeteria plan as this is the period for which salary reduction elections are made;
- the $2500 limit is applied on an employee-by-employee basis and is applied separately for each unrelated employer that an individual may be working for during the year;
- plans may adopt the required amendments to reflect the $2,500 limit at any time through the end of calendar year 2014;

- in the case of a plan providing a grace period (which may be up to two months and 15 days), unused salary reduction contributions to the health FSA for plan years beginning in 2012 or later that are carried over into the grace period for that plan year will not count against the $2,500 limit for the subsequent plan year; and

- relief is provided for certain salary reduction contributions exceeding the $2,500 limit that are due to a reasonable mistake and not willful neglect and that are corrected by the employer.

The statutory $2,500 limit under Code Section 125(i) applies only to salary reduction contributions under a health FSA, and does not apply to certain employer non-elective contributions (sometimes called flex credits), to any types of contributions or amounts available for reimbursement under other types of FSAs, health savings accounts, or health reimbursement arrangements, or to salary reduction contributions to cafeteria plans that are used to pay an employee's share of health coverage premiums (or the corresponding employee share under a self-insured employer-sponsored health plan).

A copy of Notice 2012-40 is provided by clicking on the link below:

http://www.irs.gov/pub/irs-drop/n-12-40.pdf

Question 19: Comparative Effective Research Fees

What are Comparative Effective Research Fees and who are subject to them?

On April 13, 2012, the Internal Revenue Service released proposed regulations that provide that the first potential date to pay the new comparative effectiveness research fees that apply to insured and self-insured health coverage for plan years ending on or after October 1, 2012 will be July 31, 2013.

In the proposed regulations, the IRS also provides:

- These fees apply to insured and self-funded group health plans for active or former employees, as well as some health reimbursement arrangements and health flexible spending arrangements. These fees do not apply to plans that provide "excepted benefits." Excepted benefits include such benefits as stand-alone dental or vision plans; employee assistance, wellness and disease management programs that don't offer "significant benefits in the nature of medical care or treatment"; most expatriate plans; and stop-loss insurance. Retiree-only plans, however, are not exempt from these fees.

- These fees will be paid by insured and self-insured plans. While insurers will file reports and pay the fees for insured policies, self-insured plan sponsors must file the reports and pay these fees. They cannot delegate this work to third parties or vendors. Plan sponsors and insurers will file IRS Form 720 to report the fees and make annual payments. The form has yet to be updated to reflect the comparative effectiveness fees. This return must be filed each year by July 31 of

the calendar year immediately following the last day of the policy year (for insured plans) or the plan year (for self-insured plans). If a plan or policy year ends on December 31, 2012, Form 720 must be filed by July 31, 2013. If the plan or policy year ends on January 31, 2013, Form 720 must be filed by July 31, 2014.

- These fees will be calculated as the average number of covered lives under a policy or plan multiplied by $1 for plan years ending after October 1, 2012. The multiplier increases to $2 for the next plan year, then may rise with health care inflation through plan years ending before Oct. 1, 2019, when the fees are slated to end. To determine the average number of covered lives, plan sponsors generally can use any reasonable method in the first plan year and will choose from several proposed approaches in later years.

- These fees will fund an institute set up by the health care reform law to perform and promote research on the effectiveness and outcomes of various medical treatments, services, procedures and drugs. This comparative effectiveness research aims to broaden patient, clinician, payer and other access to evidence-based medical information.

To view a copy of the proposed regulations, please click on the link below:

http://www.ofr.gov/(S(4baaog3fssmhvg1ooppcvu50))/OFRUpload/OFRData/2012-09173_PI.pdf

Question 20: Medical Loss Ratio Rebate

My employer has just indicated that it will receive a Medical Loss Ratio (MLR) rebate from the insurer for group health coverage provided in 2011. It will distribute the rebate to employees in the form of a cash payment for any amounts contributed by employees. Will these cash payments be taxable to employees when they receive them?

It will depend if employees made pre-tax or after-tax contributions for their share of premium. See the discussion below:

Pre-tax Contributions: In frequently asked questions (FAQs), the IRS clarified the tax treatment of rebates for group health plan enrollees. Employees who paid for health coverage with pretax contributions will be taxed on any cash MLR rebate they receive. Rebates used to reduce employee pretax contributions will lower employees' salary reduction amounts, resulting in higher wages subject to income and employment taxes.

If an employer uses the MLR rebate received this year to make cash payments to employees who made pretax contributions, the rebate payment will be taxable income to those employees and subject to employment taxes. If the employer instead uses the MLR rebate to reduce employees' 2012 health plan premiums, each employee's pretax plan contribution will shrink, causing wages subject to income and employment taxes to increase by the same amount.

Example. For 2011 and 2012, Betty participated in her employer's insured group health plan, making pretax contributions for coverage. In 2012, her employer sends Betty a check for her share of the MLR rebate after income and employment tax withholding.

Example. John participates in his employer's group health plan, electing under its cafeteria plan to make $6,500 in pretax contributions for coverage in 2012. John's employer receives a MLR rebate in July 2012 and applies it to reduce each group health plan participant's 2012 premiums by $1,000. This requires adjusting the payroll system to lower pretax deductions for the rest of the year. As a result, John's total pretax cafeteria plan contributions will decrease to $5,500, and his taxable income will increase by $1,000 for 2012. Both John and his employer will have to pay employment taxes on that additional taxable amount.

After-tax Contributions. When employees pay group health plan premiums with after-tax contributions, MLR rebates typically won't be taxable. Whether used to reduce 2012 premiums or paid in cash, any MLR rebates for these employees simply refund their after-tax premium payments. The rebate will be taxable, however, if employees – such as partners in a partnership – deducted the after-tax premiums on their 2011 federal income tax returns. Individuals in this position should work with their personal tax advisers.

The FAQs don't address the tax treatment of MLR rebates for former employees participating in an employer's plan, such as COBRA beneficiaries or retirees. Although the tax treatment of rebates presumably would be the same for former and current employees paying with after-tax contributions, any guidance would be helpful.