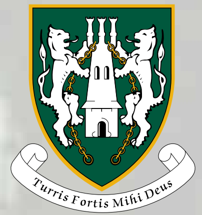
Kelly & Associates Insurance Group, Inc. (KELLY)

An Employer's Guide to Health Care Reform



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DISCLAIMER: This material is intended only to provide brief commentary on the laws and issues of Health Care Reform. Due to the general nature of this content and because Healthcare Reform is still being developed, the information contained herein may not be applicable in all situations and may not, beyond the date of this communication, even reflect the most recent authority. For these reasons, nothing contained in this communication should be relied or acted upon without the benefit of legal counsel, and nothing herein should be construed as an admission.

Answers to Your Group Benefit Questions on Health Care Reform

What is the list of changes that went into effect on 9/23/10? (Beginning first plan year on or after 9/23/10)

- No pre-existing condition exclusion for children under 19
- No lifetime limits
- Restrictions on annual limits
- Must cover preventive health services' first dollar (Grandfathered)
- Cover children to age 26 (Grandfathered group plans, before 2014, can exclude young adults who are eligible for other employer coverage)
- Loss ratio of claims 80%/85% (Fully Insured plans only)
- Small group tax credit
- Emergency service coverage - A group health plan or health insurance issuer offering group health insurance coverage that provides any benefits for emergency services must :
  - Not require prior authorization
  - Provide service without regard to whether the provider furnishing the emergency services is an in-network provider
- Nondiscrimination rules now apply to Fully-Insured plans
- Establishment of internal and external appeals process
- Choice of provider—network plans
  - **Primary Care Provider:** A group health plan or a health insurance issuer that permits or requires designation of a participating primary care provider must permit each participant to designate any participating primary care provider participant.
  - **Pediatrician:** A group health plan or health insurance issuer that permits or requires designation of a primary care provider for a child must permit the designation of any participating physician who specializes in pediatrics as the child's primary care provider.
  - **Obstetrical or Gynecological Care – Direct Access:** A group health plan or health insurance issuer that provides coverage for obstetrical or gynecological care may not require authorization or referral for a female participant who seeks obstetrical or gynecological care provided by an in-network provider who specializes in obstetrics or gynecology.

What are my penalties, as an employer, if I do not offer coverage?

Beginning in 2014, if an employer with 50 or more full-time employees does not offer coverage, there is a penalty of $2,000 annually for each full-time employee (as long as one employee is receiving a tax credit).

What are my penalties, as an employer, if the coverage I offer just is not good enough?

If an employer with 50 or more full-time employees does offer coverage but some of its employees receive a tax credit voucher because they cannot afford coverage, there is a penalty of $3,000 for each employee receiving a tax credit.

What are the "premium assistance" and the "small business" tax credits?

Premium Assistance:

For tax years ending after 2013, the new law creates a refundable tax credit for eligible individuals and families who purchase health insurance through an exchange. This credit will be available for individuals and families with incomes up to 400% of the federal poverty level who are not eligible for Medicaid, employer-sponsored insurance, or other acceptable coverage.

Small Business Tax Credit:

The small business tax credit is already in effect (March 23, 2010) and includes both non-profit and profit organizations. The Business must have fewer than the equivalent of 25 full-time employees (can have 50 part-time workers), pay an annual average of wages lower than $50,000 and must cover at least 50% of the premium cost of Health Care Coverage for employees to be eligible. Profit Organizations with fewer than 10 employees can receive the full tax credit of 35% for premium costs in 2010, which increases to a 50% credit starting 1/1/2014, and Non-Profit Organizations with fewer than 10 employees can receive the full tax credit of 25% for premium costs in 2010, which increases to a 35% credit starting 1/1/2014. The credit will gradually phase out. Owners and family members are generally not counted as employees

What preventive services are required?

Group health plans and insurers that are subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
  - Obesity screening and counseling for all adults
  - Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
  - Tobacco Use screening for all adults and cessation interventions for tobacco users
  - Syphilis screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenza type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

What is the definition of a "qualified health plan"?

A qualified health plan (QHP) is an exchange-certified "health plan" that offers an "essential health benefits package." A QHP must be offered by an insurer that:

- is licensed and in good standing to offer health insurance coverage in each state in which it offers health coverage;
- agrees to offer at least one QHP in the silver level, and at least one QHP in the gold level, in each exchange;
- agrees to charge the same premium rate for each QHP, whether offered through an exchange or offered directly from the insurer or through an agent; and
- complies with regulations to be issued by HHS and any requirements established by an applicable exchange. A QHP may vary premiums by rating area.

What about COBRA? Will that change?

No, there will be no changes to COBRA.

What is a grandfathered plan?

Group health plans and health insurance coverage that had at least one participant on the day health care reform was enacted (March 23, 2010) are grandfathered health plans. To remain grandfathered, the plan or coverage must have continuously covered someone (although not necessarily the same person) since March 23, 2010. The term "grandfathered health plan" also includes individual insurance coverage that otherwise meets the criteria.

How does a grandfathered plan help me?

Grandfathered health plans are excused from some, but not all, of the reforms set by the Patient Protection and Affordable Care Act (PPACA). The mandates below would not apply to grandfathered plans:

- Fair health insurance premiums
- Guaranteed availability
- Nondiscrimination against health care providers
- Coverage for clinical trials
- Transparency in coverage
- Quality of care reporting
- Patient protections
- Guaranteed renewability
- Nondiscrimination based on health status
- Comprehensive health insurance coverage
- Coverage of preventive health services
- Nondiscrimination for insured plans
- Appeals process

Do plans lose their grandfathered status if they make coverage changes?

Changing Insurance Carriers

Changing the insurance contract or policy under an employer plan will cause the plan to lose its grandfathered status.

Changes to Benefits

The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan or insurance to lose its grandfathered status. For this purpose, elimination of any element necessary to diagnose or treat the condition is considered elimination of all or substantially all of the benefits for that condition.

Increases in Cost-Sharing

Any increase (measured from March 23, 2010) in percentage cost-sharing (e.g., an increase in co-insurance) will cause a group health plan or coverage to lose its grandfathered status.

Any increase (measured from March 23, 2010) in fixed-amount cost-sharing (other than co-payments) of more than 15% above medical inflation will cause a group health plan or insurer to lose its grandfathered status.

Any increase (measured from March 23, 2010) in fixed-amount co-payments above the greater of (a) $5, increased by medical inflation; or (b) 15% above medical inflation, will cause a group health plan or insurer to lose its grandfathered status.

Decrease in Employer Contributions
A grandfathered plan will lose its grandfathered status if the employer (or employee organization) decreases its contribution rate (whether based on a formula or on cost of coverage) for any tier of similarly situated individuals by more than 5% below the contribution rate on March 23, 2010.

Certain Changes to Annual Limits
A grandfathered plan that did not impose an annual or lifetime limit on March 23, 2010, will lose its grandfathered status if it imposes an annual limit. A plan that had a lifetime limit but no annual limit will lose its grandfathered status if it imposes an annual limit at a value that is lower than the lifetime limit in place on March 23, 2010. For plans with an annual limit on March 23, 2010, the grandfathered status will be lost if that annual limit is lowered (regardless of whether the plan had a lifetime limit).

Transition Rule for Certain Changes Effective After March 23, 2010
Under a transition rule, certain amendments that are effective after March 23, 2010 will not cause a grandfathered plan to lose its grandfathered status. These amendments are: (a) changes effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010; (b) changes effective after March 23, 2010, pursuant to a filing on or before March 23, 2010, with a State insurance department; or (c) changes effective after March 23, 2010, pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

Furthermore, if plan changes that would cause a plan to lose grandfathered status were adopted after March 23, 2010, but before June 14, 2010 (the date the regulations were made publicly available), they will not cause the plan to lose grandfathered status if the plan modifies or revokes the changes as of the first day of the first plan year beginning on or after September 23, 2010.

Finally, according to the preamble to the regulations, the agencies will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan terms that "only modestly exceed" the changes that are not permitted and that occur before June 14, 2010 (the date the regulations were made publicly available).

Does the prohibition on waiting periods apply to grandfathered plans?

YES, this will be effective January 1, 2014

What are "Essential Benefits"?

"Essential health benefits" are minimum benefits in general categories and the items and services within those categories. The general categories are items such as:

- Ambulatory patient services
- Emergency services
- 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.

HHS has yet to issue regulations on what is exactly considered an "essential benefit" within these categories, so there is no way to exactly say which benefits will be considered "essential" within the categories listed above.

What are the criteria for an "affordable" Plan?

- Employer contribution of at least 60%
- Employees contribute no more than 8% of their household income

What Is a Grandfathered Health Plan?

A grandfathered health plan is a group health plan or health insurance coverage that was in existence and had at least one participant in the plan on March 23, 2010. These plans are excused from some, but not all, of the health care reform requirements added by the Patient Protection and Affordable Care Act (PPACA). To remain grandfathered, the plan or coverage must have continuously covered someone (although not necessarily the same person) since March 23, 2010.

Grandfathered Status Applies on a "Benefits Package" Basis

Neither the statute nor the regulations define the term "plan" for purposes of the grandfather rules. However, the regulations state that the grandfather rules apply separately to "each benefit package made available under a group health plan or health insurance coverage." This means that a plan may lose its grandfathered status with respect to one of its benefit packages, but keep its grandfathered status for other benefit packages.

What Is the Significance of Grandfathered Plan Status?

Grandfathered health plans are excused from some, but not all, of the reforms added by the Patient Protection and Affordable Care Act (PPACA).

The following list shows the requirements that **do not apply** to grandfathered plans:

- Fair health insurance premiums
- Guaranteed availability
- Guaranteed renewability
- Nondiscrimination based on health status
- Nondiscrimination against health care providers
- Comprehensive health insurance coverage
- Nondiscrimination for insured plans
- Coverage for clinical trials
- Coverage of preventive health services
- Transparency in coverage
- Quality of care reporting
- Appeals process
- Patient protections

The following is a list of requirements that **apply** to grandfathered health plans:

- Pre-existing Condition Exclusion (PCE) prohibition
- Annual/lifetime limits
- Dependent coverage for children under age 26
- Excessive waiting periods
- Rescission prohibition
- Four-page summary of benefits and coverage

Who May Participate in a Grandfathered Health Plan?

New Enrollees

Individuals who were enrolled in a grandfathered health plan on March 23, 2010, may enroll his or her family members in the grandfathered health plan after March 23, 2010. In addition, new employees and their families may enroll in a grandfathered health plan, including newly hired employees and newly enrolled existing employees. Existing employees may also move into a grandfathered health plan option at open enrollment without jeopardizing the grandfathered status of that option.

Transferees From Another Plan May Cause Loss of Grandfathered Status

A plan will lose its grandfathered status if a plan transfers employees to another plan automatically, unless there is a legitimate employment-based reason for the transfer. The regulations specifically note that changing terms or cost of coverage is not a legitimate employment-based reason.

However, employees may voluntarily change from one grandfathered health plan to another without endangering the grandfathered status of either plan.

The regulations clarify that dropping one of two benefit options solely for cost reasons is not permitted, whereas dropping a benefit option following a plant closure, for example, may be permitted.

Example: Employees voluntarily switch to another benefit package. A group health plan offers two benefit packages, Options F and G. During open enrollment, some of the employees move from Option F to Option G.

This change does not endanger the grandfathered status of Option G since the employee voluntarily changed plans.

Example: Employer eliminates high-cost option. A group health plan offers two benefit packages, a more generous PPO and a less generous HMO. The plan eliminates the PPO due to its high cost and transfers the employees to the HMO.

Since the plan did not have a valid employment-based reason for this transfer and since the PPO would have lost its grandfathered

status if instead its terms had been modified to match the terms of the HMO, the HMO will lose its grandfathered status. This loss of grandfathered status applies to all enrollees in the HMO, including those in the plan before the employees were transferred from the PPO. Similarly, if the employer had amended the PPO to match the terms of the HMO, the PPO would have lost its grandfathered status.

Example: Closing of plant provides legitimate employment-based reason for transfer. A group health plan offers two benefit options, Option H and Option I. Option H covers employees in one manufacturing plant. When that plant closes, the employer transfers some employees to another location. The employer eliminates Option H and places the employees in Option I.

The plan has a legitimate employment-based reason to transfer these employees, so this transfer does not endanger the grandfathered status of Option I, even if an amendment to Option H to match the terms of Option I would have caused the loss of grandfathered status for Option H.

Anti-abuse Provisions
Two provisions intended to prevent avoidance or abuse of grandfathered status are included in the regulations.

• **Mergers and Acquisitions:** If the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

• **Change in Plan Eligibility:** If an employer maintains two or more plans and transfers employees from one plan into another for purposes of reducing benefits and there is no legitimate employment-based reason for the transfer, the plan will lose its grandfathered status

What Changes Will Cause Loss of Grandfathered Status?

The regulations released on June 14, 2010 contain detailed rules for determining whether particular changes will cause a loss of grandfathered status. Changes that are not prohibited by the regulations would not cause a loss of grandfathered status. Below are changes that will cause loss of grandfathered status:

1) **Changing Insurance Contracts or Carriers**
Changing the insurance contract or policy under an employer plan will cause the insurance coverage to lose its grandfathered status.

Example: Three benefit options; one changes insurance carrier. A grandfathered group health plan offers three benefit packages: Options G and H are insured, and Option F is self-insured. The plan enters into a new insurance policy for Option H. Option H loses its grandfathered status, but Options G and F will remain grandfathered if they do not take other actions to lose grandfathered status.

Note: Plans maintained under a collective bargaining agreement may change insurers during the period of the agreement without endangering their later grandfathered status.

2) **Elimination of Benefits**
The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan or insurance to lose its grandfathered status. For this purpose, elimination of any element necessary to diagnose or treat the condition is considered elimination of all or substantially all of the benefits for that condition.

Example: Elimination of counseling benefits. Before March 23, 2010, a group health plan provides benefits for a particular medical condition which is treated by a combination of counseling and prescription drugs. The plan later eliminates coverage for counseling. This plan ceases to be a grandfathered health plan because counseling is a necessary element for treating the condition. Therefore, the plan is treated as eliminating substantially all the benefits for the condition.

Example: Elimination of one of a number of potential treatments. Before March 23, 2010, a plan covered gastric stapling as a treatment for morbid obesity. After a number of adverse medical outcomes, the plan has eliminated coverage for gastric stapling completely. However, the plan provides for a number of alternative and more effective treatments for the same condition. While not specifically addressed in the regulations, it would appear that elimination of this particular treatment should not adversely impact grandfathered status since alternate treatments are available.

3) **Any Increase in Percentage Cost-Sharing**
Any increase (measured from March 23, 2010) in percentage cost-sharing (e.g., an increase in co-insurance paid by covered employees) will cause a group health plan or coverage to lose its grandfathered status.

Example: Co-Insurance increased from 20% to 25%. *A grandfathered health plan has a co-insurance of 20% for inpatient surgery. The plan is later amended to increase the co-insurance to 25%.*

The increase in co-insurance from 20% to 25% causes the plan to lose its grandfathered status.

4) Increases in Fixed-Amount Cost-Sharing
Any increases in fixed-amount cost-sharing requirements (deductibles, out-of-pocket maximums), other than co-payments, by a percentage that is more than the sum of medical inflation plus 15% (measured from March 23, 2010) will cause a group health plan or coverage to lose its grandfathered status.

5) Increase in Co-Payments
Any increase (measured from March 23, 2010) in fixed-amount co-payments above the greater of (1) $5, increased by medical inflation; or (2) 15% above medical inflation will cause a group health plan or coverage to lose its grandfathered status.

Example: Co-Payment Increase. *On March 23, 2010, a grandfathered health plan has a co-payment requirement of $30 per office visit for specialists. The plan is subsequently amended to increase the co-payment requirement to $40. The increase in the co-payment from $30 to $40, expressed as a percentage, is 33.33%. The maximum percentage increase permitted is 37.69% (Medical inflation from March 23, 2010, 22.69%+ 15%). Because 33.33% does not exceed 37.69%, the change in the co-payment requirement at that time does not cause the plan to cease to be a grandfathered health plan.*

6) Decrease in Rate of Employer (or Employee Organization) Contributions
Decrease in employer contribution rate for any tier of similarly situated individuals by more than 5% below the contribution rate on March 23, 2010 will cause a group health plan or coverage to lose its grandfathered status.

Example: Increase in cost-sharing. Prior to March 23, 2010, an employer contributed 80% of the cost of single or family coverage. Due to higher than normal cost increases, the employer decides to change its cost-sharing so that its subsidy for family coverage is only 50% but leaves the single coverage subsidy unchanged. The increase in cost-sharing for family coverage by the employer would cause the plan to lose grandfathered status.

Assume that the employer decides to change its coverage categories so that it now offers employee coverage, employee plus spouse coverage, and family coverage. If the cost-sharing for any category is less than 75%, then presumably the grandfathered status would be jeopardized.

The result would be the same if all or part of the employee contributions were made through the employer's cafeteria plan.

7) Certain Changes to Annual Limits
Imposes or lowers annual or lifetime limits on the dollar value of benefits, as follows:

- If on March 23, 2010, the Plan had no overall annual or lifetime limit, the Plan imposes an annual limit
- If on March 23, 2010, the Plan had an overall lifetime limit, but did not have an annual limit, the Plan imposes an annual limit that is lower than the lifetime limit that was in place on March 23, 2010
- If on March 23, 2010, the plan had an annual limit, the plan decreases that limit.

Good Faith Compliance and Grace Periods
The regulations also provide that certain changes made between March 23, 2010, and June 14, 2010, that were made in good faith but do not comply with the regulations, may not jeopardize a plan's grandfathered status. Additionally, a grace period permits employers and insurers to revoke or modify changes adopted prior to June 14, 2010, that would otherwise cause the plan to lose its grandfathered status. If plan changes that would cause a plan to lose grandfathered status were adopted after March 23, 2010, but before June 14, 2010, (the date the regulations were made publicly available), they will not cause the plan to lose grandfathered status if the plan modifies or revokes the changes as of the first day of the first plan year beginning on or after September 23, 2010.

What Changes May Be Made to a Grandfathered Health Plan?

- Enrolling new employees
- Enrolling family members of current or new employees
- Plan changes made to comply with state or federal law
- Plan changes made to voluntarily comply with the Act
- Plan changes that expand or increase benefits
- For self-funded plans, changing their third party administrator.
- Changes to the terms of the Plan (effective after March 23, 2010) if those changes were:
- Pursuant to a legally binding contract entered into before March 23, 2010
- Pursuant to Plan amendment adopted before March 23, 2010
- Made to the terms of a health insurance plan filed with the state insurance regulator prior to March 23, 2010.

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Notice and Recordkeeping Requirements

Notice to Participants

To maintain grandfathered status, a plan or coverage must provide, in any plan materials describing benefits for participants or beneficiaries, (a) a statement that the plan or coverage is believed to be a grandfathered plan, and (b) contact information for questions or complaints.

The following model language is provided for this purpose:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Note that this special notice requirement is in addition to the four-page summary requirement also added by health care reform.

Documentation and Recordkeeping

To maintain status as a grandfathered health plan, the plan or coverage must document the terms in existence on March 23, 2010. Such documentation, plus any additional documentation needed to verify, explain, or clarify grandfathered health plan status must be retained for so long as the plan or coverage takes the position that it is a grandfathered health plan. Such documentation may include current plan documents, health insurance policies, certificates or contracts of insurance, Summary Plan Descriptions (SPDs), and other cost and cost-sharing documentation. In addition, the plan must make those records available for examination upon request.

Insured Plans under a Collective Bargaining Agreements: Special Grandfathered Plan Status

In the case of "health insurance coverage" maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, the regulations provide that the coverage will be treated as grandfathered until the last collective bargaining agreement terminates, regardless of whether there is a change in insurers or one of the other changes that would otherwise destroy grandfathered status. The regulations and preamble make it clear that the special rule for collectively bargained plans is limited to insured arrangements. Thus, self-funded collectively bargained plans will be treated the same as non-bargained plans and will need to comply with the grandfathering rules, including the new mandates and the limitations on plan changes, even before the relevant collective bargaining agreement expires.

The special collectively bargained plan rule does not provide a delayed effective date for collectively bargained plans. Instead, it simply provides an extension of time during which such plans are treated as grandfathered plans. Although the grandfather rule allows collectively bargained plans to maintain grandfathered plan status during the period of the bargained agreement, it does not excuse them from complying with the rules otherwise applicable to grandfathered health plans. Therefore, collectively bargained plans (both insured and self-insured) that are grandfathered plans must comply—by the generally applicable effective dates—with all the health care reforms that apply to grandfathered plans.

Once the collective bargaining agreement expires, the plan may or may not be a grandfathered health plan. Such status will be determined under the otherwise applicable rules, by comparing the plan in existence at the end of the collective bargaining period with the plan in existence on March 23, 2010. If the plan made changes that would take it out of grandfathered status (absent the special collectively bargained rule), then the plan is not a grandfathered plan once the collective bargaining agreement expires. However, a change in insurers alone during the period of the collective bargaining agreement would not take the plan (or the insurer) out of grandfathered status.

Example: Collectively bargained plan may change insurance policy. A group health plan maintained pursuant to a collective bargaining agreement provides coverage through an insurance policy. The bargaining agreement expires on December 31, 2011. The plan enters into a new health insurance policy as of January 1, 2011.

While a change of insurers normally would cause a plan to lose grandfathered status, under the special rule for collectively bargained plans, the group health plan and the policy continue to be a grandfathered health plan despite the change in insurance policy. In addition, once the last collective bargaining agreement terminates, the plan would still qualify as a grandfathered plan, so long as it has not made other changes taking it out of grandfathered plan status.

Lifetime and Annual Dollar Limits

With the passing of Health Care Reform, lifetime dollar limits are prohibited while annual dollar limits are first restricted and then later prohibited in regards to the value of "essential health benefits".

Interim final regulations were issued (jointly by the IRS, DOL, and HHS) to implement the rules regarding lifetime and annual dollar limits. These regulations clarify that an exclusion of all benefits for a condition is not considered to be a lifetime or annual dollar limit. However, if any benefits are provided for a condition, then the annual and lifetime prohibitions apply.

What Are "Essential Health Benefits" for Purposes of Complying With the Lifetime and Annual Dollar Limits?

"Essential health benefits" include minimum benefits in general categories and the items and services within those categories (still to be determined by HHS), such as:

- Ambulatory patient services
- Emergency services
- 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.

Since HHS has yet to issue regulations, there is no way to determine which benefits will be considered "essential" within the categories listed above. Since many plans have lifetime and annual limits on certain benefits such as chiropractic services, until HHS has issued regulations they will take into account "good faith" efforts to comply with a reasonable interpretation of "essential health benefits." The plan, however, must apply this definition consistently throughout the benefits. For example, a plan may not both apply a lifetime limit to a particular benefit, viewing it not an "essential health benefit," and at the same time treat the same benefit as an "essential benefit" for purposes of applying the restricted annual limit.

Who Must Comply?

The rules on lifetime and annual dollar limits apply to group health plans (grandfathered and non-grandfathered) and insurers but not to certain "excepted benefits."

Prohibition on Lifetime Limits

This prohibition relates to a lifetime limit on the dollar value of essential health benefits. A transition rule is provided for individuals whose coverage or benefits previously ended by reason of reaching a lifetime limit.

a. No Lifetime Limit on the Dollar Value of Essential Health Benefits
Effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans), group health plans and insurers may not impose any lifetime limit on the dollar amount of essential health benefits for any individual. Plans can still place a lifetime dollar limit on specific covered benefits that are not essential health benefits as long as such benefits are otherwise permitted under applicable federal or state law.

b. Transition Rule for Re-instating Individuals Who Previously Exhausted a Plan's Lifetime Limit
Individuals who exhausted a lifetime limit on the dollar value of all benefits under a group health plan or insurance coverage before the prohibition became effective and who are otherwise eligible under the plan or coverage must be given a written notice (DOL has issued a model notice) that the lifetime limit no longer applies. If they are no longer enrolled, they must be provided a written notice (no later than the first day of the first plan year beginning on or after September 23, 2010) informing them of a 30-day special enrollment period.

These individuals must be treated as special enrollees (i.e., they must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment). The notice can be provided to an employee on behalf of the employee's dependent and can be included with a plan's enrollment materials, as long as the employee is aware that this notice is in there and that the notice is prominent.

Prohibition on Annual Limits

Restrictions on annual limits with respect to the dollar value of essential health benefits begin with plan years beginning on or after September 23, 2010. Starting with plan years beginning on or after January 1, 2014, annual limits will be **prohibited** for essential health benefits.

a. Three Year Phased Approach for Annual Limits

The interim final regulations adopt a three year phased approach for restricted annual limits, under which the annual limits may be no less than the following: (1) $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011; (2) $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and (3) $2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014. These minimum annual limits apply on an individual basis (i.e., any overall annual dollar limit applied to families may not operate to deny a covered individual the minimum annual essential health benefits for the plan year).

Waiver Program for Certain Plans.

For plan years beginning before January 1, 2014, the interim final regulations allow HHS to establish a program under which the requirements relating to restricted annual limits may be waived if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. This waiver opportunity is likely to be significant for coverage under limited benefit plans or so-called "mini-med" plans.

b. Are Non-monetary Annual Limits Permissible?

The interim final regulations do not specifically address whether non-monetary limits, such as day or visit limits (e.g., annual limits on physical or speech therapy visits) are permissible. On the one hand, the prohibition is specifically on the dollar amount of annual limits. On the other hand, it is arguable that, for all practical purposes, day and visit limits essentially amount to an overall dollar limit. Hopefully, further guidance will be released on this question.

Coverage of Preventive Health Services

General Requirements

The Patient Protection and Affordable Care Act requires that group health plans and insurers in the group and individual markets provide certain preventive services without imposing any cost-sharing (no deductibles, co-pays, co-insurance, or other cost-sharing may be imposed on these services). This mandate is effective for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. Thus, calendar-year plans must comply beginning January 1, 2011.

Interim regulations were jointly released by the IRS, DOL, and HHS which implement the preventive services coverage requirement. The IRS's temporary preventive services regulations expire on July 12, 2013; however, the DOL and HHS regulations do not include an expiration date.

Who Must Comply?

The preventive health services mandate applies to group health plans and insurers but not to certain "excepted benefits" and also does not apply to grandfathered plans.

Which Services Must Be Covered?

Those group health plans and insurers that are subject to this mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adult
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
  - Obesity screening and counseling for all adults
  - Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
  - Tobacco Use screening for all adults and cessation interventions for tobacco users
  - Syphilis screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Folic Acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenza type b
  - Hepatitis A
- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

A plan or insurer that is subject to the preventive services mandate must cover all of the services described in the recommendations and guidelines, even if the plan does not otherwise cover services of that type. The regulations state that when recommendations or guidelines do not specify the frequency, method, treatment, or setting for a particular preventive service, plans and insurers may use reasonable medical management techniques to determine any coverage limitations. Some recommendations and guidelines involve over-the-counter items (e.g., aspirin or folic acid). In those cases, it appears that plans are required to cover the item as well as the related counseling from health care providers. (Reminder: plans cannot provide tax-free reimbursement of expenses for medicines or drugs incurred after December 31, 2010, (other than insulin) unless the medicines or drugs are prescribed drugs, determined without regard to whether the medicine or drug is available without a prescription.) This could result in imputed income for individuals receiving these items.

Application of Cost-Sharing Prohibition to Preventive Services Provided During Office Visits

The newly released regulations explain how the prohibition on cost-sharing applies when preventive services are provided during office visits. Cost-sharing is permitted for office visits when preventive services are billed separately or are not the primary purpose of an office visit. In contrast, cost-sharing cannot be imposed when preventive services are not

Preventive Services Delivered by Out-of-Network Providers

Plans and insurers that use a network of providers to provide preventive services are not required to cover preventive services delivered by out-of-network providers. Plans and insurers with provider networks can also impose cost-sharing requirements on out-of-network preventive services.

Prohibition on Pre-existing Condition Exclusions

What Is a Pre-existing Condition Exclusion (PCE)?

With the release of the interim final regulations (jointly released by the IRS, DOL & HHS), the definition of PCE was revised to mean "a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial)." This means that the prohibition includes both denial of enrollment and denial of specific benefits based on a pre-existing condition. A pre-existing condition can be a serious medical condition (ex., cancer, diabetes, high blood pressure), or something relatively minor (ex., tennis elbow).

The revised definition also provides that a PCE includes any limitation or exclusion based on information relating to an individual's health status, "such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period."

Under health care reform, group health plans and group health insurance issuers are prohibited from imposing any PCEs. This prohibition has two different dates attached to it. For plan years beginning on or after September 23, 2010, (i.e., January 1, 2011 for calendar-year plans) plans must eliminate PCEs for individuals enrolled in the plan who are under 19 years of age. It is not clear whether the prohibition on PCEs expires on the individual's 19th birthday, or whether it applies until the end of the plan year in which the individual turns age 19. Hopefully, more guidance will be released in regards to this. For plan years beginning on or after January 1, 2014, plans must eliminate PCEs for those individuals over age 19.

Application of PCEs Prior to Health Care Reform

Under current HIPAA provisions, a group health plan may impose a PCE period only for a condition (whether physical or mental, and regardless of the cause) for which medical advice, diagnosis, care, or treatment was recommended or received within a "look-back period." The "look-back-period" cannot be more than six months before the enrollment date, and the plan may only exclude coverage for PCEs generally for up to 12 months (or up to 18 months for late enrollees). As a requirement, this period of limitation is to be reduced by one day for every day of creditable coverage the individual has as of the "enrollment date." Creditable coverage does not include periods of health coverage that are followed by a "significant break in coverage" (a period of 63 consecutive days without creditable coverage).

Qualified High Risk Pool

Until the general prohibition on PCEs becomes effective (January 1, 2014), a qualified high risk pool will be created. For individuals who have not been covered under creditable coverage for a 6 month period, they can apply for coverage under this high risk pool.

HHS will establish criteria for determining if a group health plan or insurer has discouraged an individual from remaining enrolled in prior coverage because of his/her health status. Also, sanctions will be imposed if HHS finds that a group health plan or insurer encouraged an individual to disenroll from health benefits coverage prior to enrolling for coverage in the pool.

On July 1, 2010, HHS announced the establishment of a new Pre-Existing Condition Insurance Plan (PCIP), which will be administered either by a state or by HHS. Some states have requested that HHS run their PCIP, while other states have requested that they run the program themselves.

No Change in Requirement to Issue Certificates of Creditable Coverage

Even though health care reform made significant changes to the obligation of PCEs, no changes have been made with respect to the responsibility of group health plans to provide HIPAA Certificates. Plans must continue to comply with the legal requirements and issue HIPAA Certificates to their employees.

Application of PCEs to Newly Eligible Adult Children

Effective for plan years beginning on or after September 23, 2010, group health plans or insurers that provide dependent coverage for the children of a participant must allow coverage to be available until the dependent turns age 26.

These dependents must be given at least 30 days to enroll and are required to be treated as HIPAA special enrollees. If a plan has a PCE provision, it may apply PCEs, for a period of up to 12 months (subject to the creditable coverage requirements), to newly eligible adult children who are over the age of 19.

Restrictions on OTC Medicines and Drugs for Health FSAs, HRAs, HSAs, and Archer MSAs

Beginning January 1, 2011, health FSA, and HRA, plans **cannot** reimburse over-the-counter (OTC) medicines or drugs (other than insulin) without a prescription. Similarly, distributions from HSAs and Archer MSAs for medicines and drugs other than insulin are tax-free only if the medicine or drug is prescribed. This requirement applies to all FSA, HRA, HSA and Archer MSA plans, including those that are grandfathered. "Run-out" claims are not affected by this requirement. For example, if there is a 90-day run-out period following the end of the health FSA plan year during which employees can submit for reimbursement any expenses that were incurred prior to the end of that plan year, the company must carefully review any reimbursement claims for OTC medicines or drugs received during the run-out period (i.e., during the first 90 days of 2011 for a plan year ending 12/31/10). Any claims submitted for expenses incurred during 2010 can be reimbursed without regard to whether the medicines or drugs were prescribed (assuming that all other applicable requirements for reimbursement are met). In contrast, claims for OTC medicine or drug expenses that were incurred in 2011 cannot be reimbursed without a prescription.

Scope of Restriction

On September 3, 2010, the IRS released guidance for the new restrictions. In regards to what constitutes a prescription for a medicine or drug to be reimbursed, the IRS said it must be a written or electronic order that satisfies the legal requirements for a prescription in that state (including that it be issued by someone authorized to issue prescriptions in that state). To show that an OTC drug has been prescribed, employees must submit the prescription or other documentation, along with the other independent third-party substantiation required under IRS rules. According to the guidance, a receipt identifying the purchaser (or the patient), the date and amount of the purchase, and an Rx number would meet these requirements, as would a receipt without an Rx number along with a copy of the prescription.

According to the regulations, the restriction applies only to medicines and/or drugs. It does not extend to items such as bandages, blood-pressure monitors, or crutches. However, not all OTC items will fall neatly into one category. Guidance is needed on what constitutes a medicine or drug for purposes of this restriction and whether items like **medicated** bandages are considered to be medicines/drugs that must be prescribed in order to be reimbursable.

Impact on Debit Card Programs

As a result of the restriction, health FSA and HRA debit card programs cannot reimburse OTC medicines or drugs using an inventory information approval system (IIAS) beginning January 1, 2011, and IIASs must be reprogrammed to reject the use of health FSA or HRA debit cards to purchase such items after that date.

Cards may still be used to purchase prescribed OTC drugs at a 90% pharmacy (i.e., a pharmacy where 90% of the store's gross receipts during the prior taxable year, determined on a store-location-by-store-location basis, consisted of items that qualify as medical care expenses under Code Section 213(d)). As in the past, after-the-fact substantiation of the transaction will be required. After the restriction takes effect, however, the substantiation must include documentation that the item was "prescribed." If such documentation is not provided, the transaction will not be properly substantiated and must be corrected using IRS procedures. Participants can also request reimbursement for OTC medicines and drugs by submitting a traditional reimbursement request (i.e. paper form) that includes appropriate validation.

These card program changes should be communicated to employees well in advance of the January 1, 2011, effective date.

Action Items for Health FSA and HRA Sponsors and Administrators

Health FSAs and HRAs generally will need to be amended before the January 1, 2011, effective date to reflect the restriction on reimbursements for OTC medicines and drugs. In addition, the change must be communicated to employees. If a debit card program is offered, communications should also address the impact on card transactions (e.g., that cards cannot be used after December 31, 2010, to purchase OTC medicines and drugs at IIAS merchants). In many cases, the changes can be communicated during open enrollment for the 2011 plan year. Non-calendar-year plans should communicate the change no later than open enrollment for the 2010 plan year. If this plan year has already begun, the change should be communicated without delay, so that employees can plan accordingly.

Health FSAs with a grace period should also let employees know as far in advance as possible that "grace period" funds cannot be used to reimburse OTC medicines or drugs incurred after December 31, 2010, unless the items have been prescribed.

Restrictions on HSA and Archer MSA Distributions for OTC Medicines or Drugs

Health Care Reform also provides that distributions from HSAs and Archer MSAs to pay for medicines or drugs are only considered to be for qualified medical expenses if the medicine or drug is a prescribed drug or is insulin. The change applies to amounts paid with respect to taxable years beginning after December 31, 2010. For this purpose, the term "taxable year" refers to the taxable year of the HSA or Archer MSA account holder, which in most cases will be the calendar year.

Employer W-2 Reporting; Cost of Employer-Sponsored Health Coverage

Under the Patient Protection and Affordable Care Act, employers (including grandfathered plans) must report the "aggregate cost" of "applicable employer-sponsored coverage" on an employee's Form W-2. This requirement is effective beginning with the 2011 tax year (the value is first reported on the Form W-2 issued in January, 2012, for the 2011 tax year). To comply with this requirement, employers must—

- determine the "applicable employer-sponsored coverage" that is provided to each employee;
- calculate the "aggregate cost" of such coverage for each employee; and
- report that cost on each employee's W-2.

The IRS will issue an updated Form W-2 and instructions for more guidance.

What Is "Applicable Employer-Sponsored Coverage"?

This W-2 requirement only applies to "applicable employer-sponsored coverage," which generally includes any employer-provided coverage under an insured or self-insured health plan. There are, however, some exceptions, including exceptions for (a) accident-only insurance; (b) disability income insurance; (c) long-term care coverage; (d) coverage only for a specified disease; and (e) hospital indemnity or other fixed indemnity insurance. As explained below, the term also does not include stand-alone, insured dental or vision coverage.

Strictly speaking, HSA and Archer MSA contributions, and salary reduction contributions to a health FSA, are included in the definition of "applicable employer-sponsored coverage," but they are explicitly excluded from the W-2 reporting obligation.

What Is "Aggregate Cost"?

After you determine the "applicable employer-sponsored coverage," you need to calculate the "aggregate cost" of such coverage for each employee. This is determined under "rules similar to" the COBRA rules for "applicable employer-sponsored coverage." For plans that charge the same COBRA premium for both single and family coverage, the plan must calculate separate and family premiums for this reporting requirement. As noted earlier, the aggregate cost calculation does not include contributions for HSAs or Archer MSAs and salary-reduction contributions to health FSAs. It does, however, appear to include self-insured dental and vision coverage.

Dental and Vision Coverage

If coverage for dental and/or vision is offered "under a separate policy, certificate, or contract of insurance," then the cost of dental and/or vision is excluded from the aggregate cost. However, if a group has self-insured dental and/or vision coverage (whether a limited-scope stand-alone benefit or bundled with medical), the cost appears to be included on the employee's Form W-2. It is unclear whether this distinction between insured and self-insured dental/vision plans was intentional and whether future guidance or a technical corrections bill will change it so that the treatment of self-insured and fully insured dental/vision plans will be the same.

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Small Business Tax Credit

What Is the Small Business Health Care Tax Credit?

Effective January 1, 2010, eligible small employers that offer health insurance coverage to their employees are entitled to a tax credit of up to 35% of the non-elective contributions they make toward the premium cost.

Which Employers Qualify for the Tax Credit?

To receive a small business health care tax credit in any tax year, an employer must be either an eligible small employer, as defined below, or a tax-exempt eligible small employer:

Definition of Eligible Small Employer

There are three requirements that an employer must satisfy to be an "eligible small employer." With respect to any tax year:

- the employer must have no more than 25 full-time equivalent (FTE) employees for the tax year,
- the employer's FTEs must have average annual wages that do not exceed $50,000 (for 2010 through 2013), and
- the employer must have a contribution arrangement (requires an eligible small employer to make a non-elective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an Exchange in an amount equal to a uniform percentage, not less than 50 percent, of the premium cost of the qualified health plan.) in effect.

Which Employees Are Counted?

Generally, all employees who perform services for the employer during the tax year are taken into account, although, as described below, some individuals are excluded.

Which Individuals Are Excluded?

Business Owners, Partners, and Family Members

When adding up the hours of service of all employees to calculate the number of FTEs, the following categories of individuals are excluded:

- self-employed individuals, including sole proprietors and partners in a partnership;
- individuals owning more than 2% of a subchapter S corporation;
- individuals owning more than 5% of a corporation; and
- certain family members and dependents of these individuals, including children (or descendants of children), siblings or step-siblings, parents (or ancestors of parents), step-parents, nieces, nephews, aunts, uncles, sons-in-law, daughters-in-law, mothers-in-law, fathers-in-law, brothers-in-law, and sisters-in-law, and any member of the household of an owner or partner who qualifies as a dependent.

Many Seasonal Workers' Hours Are Not Counted

The hours of service and wages of a seasonal worker are not counted unless the individual works for the employer on more than 120 days during the taxable year.

Determining the Number of FTEs

Determining the number of FTEs is done by combining the number of hours of service for the tax year for all non-excludable employees (not more than 2,080 hours of service for any employee), and dividing that total number by 2,080. If the result is not a whole number, it is rounded to the next lowest whole number. The wages paid to all non-excludable employees are also aggregated and divided by the number of FTEs to determine average annual wages.

What Is an Hour of Service for Purposes of the FTE Calculation?

An employee's hours of service include each hour the employee is paid, or entitled to be paid, by the employer for the performance of duties and on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (no more than 160 hours for an employee for the period when no duties are performed.)

Hours of service in excess of 2,080 in a tax year (40 hours × 52 weeks = 2,080 hours) are not taken into account when calculating the total hours of service to use in the calculation of FTEs.

IRS Notice 2010-44, issued in May, 2010, gives employers three alternative methods for calculating the total number of hours of service to take into account:

- Actual hours of service. Under this method, actual hours of service are determined using records of hours worked and hours for which payment is due.
- Days-worked equivalency. Under this method, an employee is credited with eight hours of service for each day for which the employee would be credited with at least one hour of service.
- Weeks-worked equivalency. Under this method, an employee is credited with 40 hours of service for each week for which the employee would be credited with at least one hour of service.

Determining Average Annual Wages

Determining the average annual wages is done by dividing the total amount of wages the employer paid to its employees during the tax year by the number of FTEs (wages paid to excludable individuals are not included.) The result is then rounded down to the next lowest $1,000, if it is not a multiple of $1,000.

Transition Relief for the 2010 Tax Year

IRS Notice 2010-44 provides transition relief that is intended to make it easier for employers to meet the contribution arrangement requirements and qualify for the credit for the 2010 tax year. It modifies the contribution arrangement requirements in two ways:

1. “Uniform Percentage” Requirement Loosened

The transition relief allows an employer to satisfy the contribution arrangement requirement for 2010 as long as the employer pays at least 50% of the premium for each employee enrolled in the group health insurance coverage.

2. Base 50% Requirement on Single-Coverage Premium

The requirement of an employer to contribute at least 50% of the premium cost for its employees, applies to the premium for single (employee-only) coverage. So, if an employee is enrolled in family or self-plus-one coverage, the employer will satisfy the 50% requirement because the employer is contributing an amount that is not less than 50% of what the single-coverage premium would be for that employee (even if it is less than 50% of the premium for the coverage the employee is actually receiving).

Eligible Small Employer Credit Prior to 2014

Maximum Credit Is 35% of Employer Premium Contribution

For tax years 2010 through 2013, the maximum tax credit available to an eligible small employer is 35%. The percentage is applied to the lesser of:

(1) the total non-elective contributions the employer made on behalf of its employees during the tax year, or

(2) the total amount of non-elective contributions the employer would have made if each employee had enrolled in the health insurance coverage with a premium equal to the amount that HHS determines is the average premium for the small group market in that State.

Eligible Small Employer Credit in 2014 and After

For tax years beginning in 2014 and later, the maximum small business health care tax credit available to eligible small employers increases to 50%. The requirements, however, for the contribution arrangement are different from earlier tax years. The non-elective contributions for 2014 and later tax years must be made on behalf of employees who enroll in a qualified health plan offered to employees by the employer through an Exchange.

The other change for 2014 and later is that the contributions to which the percentage is applied are the lesser of:

(a) the total non-elective contributions the employer made on behalf of its employees during the tax year toward the qualified health plan premiums, or

(b) the total amount of non-elective contributions the employer would have made if each employee had enrolled in a qualified health plan which had a premium equal to the average premium as determined by HHS for the small group market in the rating area in which the employee enrolls for coverage.

The small business health care tax credit that is available beginning in 2014 is only available to an employer for two consecutive tax years.

Tax-Exempt Small Employer Credit

The credit for a tax-exempt eligible small employer is calculated the same way as the credit for an eligible small employer, except that the maximum credit is 25% for tax years 2010 through 2013 and 35% for tax years 2014 and after.

In addition, the amount of the credit available to a tax-exempt eligible small employer cannot exceed the amount of the payroll taxes (the amounts withheld from employees' wages for income tax withholding and for Medicare tax, as well as the employer's share of Medicare tax for the employees) of the employer during the calendar year in which the tax year begins.

Credit Is Phased Out Based on Number of FTEs or Average Wages

Only employers with 10 or fewer FTEs and average annual wages of $25,000 or less can get the absolute maximum credit. Eligible small employers with more FTEs or average annual wages than these thresholds receive a reduced amount of tax credit.

To calculate the phase out, the credit is first determined based on the full percentage of non-elective contributions, and then reduced (but not below zero) by performing the following calculations:

(a) First, multiply the initial credit amount by a fraction with a numerator equal to the employer's FTEs in excess of 10 and a denominator of 15.

(b) Second, multiply the initial credit amount by a fraction with a numerator equal to the employer's average annual wages above $25,000 and a denominator of $25,000. (For tax years beginning in 2014 and later, $25,000 will be replaced in this calculation by the new dollar amount adjusted for cost-of-living.)

(c) Third, add the amounts arrived at in the first and second steps and subtract that sum from the initial credit amount.

Example: Phaseout of Credit Amount. ABC company is an eligible small employer for the 2010 tax year, with 12 FTEs and average annual wages of $30,000. ABC Company pays $96,000 in health care premiums (which does not exceed the average premium for the small group market in its state), and otherwise meets the requirements for the credit. The credit is determined as follows:

(1) The initial credit amount determined before any reduction is $33,600 (35% × $96,000).

(2) The credit reduction for FTEs in excess of 10 is $4,480 ($33,000 × 2/15).

(3) The credit reduction for average annual wages in excess of $25,000 is $6,720 ($33,600 × $5,000/$25,000).

(4) The total credit reduction is $11,200 ($4,480 + $6,720).

(5) The total 2010 tax credit for ABC Company is $22,400 ($33,600 - $11,200).*

How Is the Tax Credit Claimed?

For an Eligible Small Employer

For an eligible non-tax exempt small employer the tax credit is only available to offset actual tax liability and is claimed on the employer's tax return as a general business credit. It is not payable in advance to the employer, nor is it refundable. A general business credit, under Code § 38, is allowed against tax imposed for the tax year in an amount equal to the current-year business credit, plus the sum of any business credit carry forwards and business credit carry backs applied to the tax year.

For a Tax-Exempt Small Employer

In the case of a tax-exempt eligible small employer, instead of being a general business credit, the small business health care tax credit is a refundable tax credit limited to the employer's payroll taxes.

DISCLAIMER: This material is intended only to provide brief commentary on the laws and issues of Health Care Reform. Due to the general nature of this content and because Healthcare Reform is still being developed, the information contained herein may not be applicable in all situations and may not, beyond the date of this communication, even reflect the most recent authority. For these reasons, nothing contained in this communication should be relied or acted upon without the benefit of legal counsel, and nothing herein should be construed as an admission.

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