Inform on Reform©:

Health Care Reform FAQs for Employers

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SEITLIN
EMPLOYEE BENEFITS & HUMAN CAPITAL MANAGEMENT

Miami
9800 NW 41st Street, Suite 300
Miami, FL 33178
Phone: 305.591.0090

Fort Lauderdale
6700 North Andrews Avenue, Suite 300
Ft. Lauderdale, FL 33309
Phone: 954.938.8788

www.seitlinbenefits.com

Benefit Advisors NETWORK

Introduction:

This FAQ is offered for informational purposes only. The information provided herein is not intended to be a comprehensive legal review of the issues covered and does not constitute legal advice. Benefit Advisors Network and/or Proskauer assume no responsibility for clearly interpretative information and undertake no responsibility to update these FAQs as more information is available.

The FAQs for the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (the "Reform Act" and "Reconciliation Act," respectively, and, collectively, the "Act") focus on certain issues of immediate interest to employers.

Many of the Act's provisions remain unclear. This FAQ represents Proskauer's understanding of the law as of April 30, 2010 and our interpretation of the law as it exists to date (based on analysis as well as informal guidance from Washington, D.C.).

Congress may pass Technical Amendments to the Act and the federal agencies charged with implementing the Act's provisions will issue formal guidance over the coming months. The answers to many of the FAQs included herein may change—sometimes dramatically—based on future anticipated guidance.

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Effective Dates and Grandfathering

Q1.1: What is the Effective Date of the Act?

A1.1: The Act has many different requirements and many different effective dates. Some changes are effective now; some are effective later in 2010; and some are effective as of the first day of the first plan year following September 23, 2010. Other provisions are not applicable until 2011, 2012 or 2013. Some of the employer mandates are effective in 2014. The so-called Cadillac Tax is not effective until 2018.

Q1.2: Some of the requirements are effective as of the first day of the first plan year following September 23, 2010. What is the significance of September 23, 2010?

A1.2: The Act provides that certain of its provisions are effective on "the first day of the first plan year following the date that is six months from the enactment" of the Act. The President signed the Act into law on March 23, 2010, so September 23, 2010 is simply six months from that date.

Q1.3: What is my plan's "plan year"?

A1.3: The plan sponsor determines the plan year. Plan years are always no longer than 12 months. The plan year does not necessarily commence with the date of open enrollment, although some employers treat that as the commencement of their plan year. It is not uncommon (and often administratively simpler) to commence the plan year on January 1.

Q1.4: What is a "grandfathered plan"?

A1.4: Under the Act, a grandfathered plan is a plan that is in effect as of March 22, 2010 (the day preceding the day the President signed the Act into law). Some of the mandates under the Act do not apply to grandfathered plans. Some of the mandates apply to grandfathered plans only in a very limited manner. However, some of the mandates will apply irrespective of whether the plan is grandfathered or not.

Q1.5: How long does a plan's grandfathered status last?

A1.5: As of the date of this FAQ, it is unclear. It is possible that grandfathered status lasts indefinitely. There are also some arguments that grandfathering lasts only until 2014. It is unclear what (if anything) could terminate a plan's grandfathered status. The Act provides that adding new employees or new dependents will not alter or terminate a plan's grandfathered status. However, as of the date of this FAQ, it is unclear whether grandfathering with respect to certain mandates is indefinite and whether and to what extent a change or a modification to a grandfathered plan will alter or terminate its grandfathered status.

Extension of Coverage for Children Up to Age 26

Q2.1: Are group health plans required to cover children up to the age of 26?

A2.1: Employer-sponsored plans are not required to cover dependents under the Act. However, if a plan does cover dependents, it will be required to cover children up to the age of 26.

Q2.2: When does this the new requirement to extend coverage for adult children up to age 26 become effective?

A2.2: For both active and retiree plans, the extension of coverage is effective as of the first day of the first plan year following September 23, 2010 (i.e., January 1, 2011 for calendar year plans).

Q2.3: Do these requirements apply to dental and vision plans as well?

A2.3: No, but only if the dental and vision plans qualify as "HIPAA-excepted benefits". Generally speaking, stand-

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alone dental and vision plans qualify as HIPAA-excepted benefits and therefore the extended age dependent law will not apply to them. Consult with ERISA counsel to determine whether your dental or vision plan is a HIPAA-excepted benefit plan.

Q2.4: Are children under age 26 eligible if they are married?

A2.4: Yes. However, under the Act the plan is not required to offer coverage to a dependent child's child or the dependent child's spouse. (Note: Some state laws applicable to fully insured plans may require coverage of a child's child. Consult with ERISA counsel.)

Q2.5: Is a plan required to offer coverage to adult children up to age 26 who are eligible for other employer-sponsored coverage?

A2.5: From January 1, 2011 through December 31, 2013, grandfathered group health plans may exclude adult dependent children who are eligible for other employer-sponsored coverage. After January 1, 2014, grandfathered plans must offer coverage to all adult dependent children up to age 26 regardless of whether they are eligible for other health coverage (employer-sponsored or otherwise). Note that "employer sponsored health plan" coverage does not include student coverage from a college or university, individual policy, alumni association or similar source. However, it arguably applies to a child's spouse's employer's group health plan.

Q2.6: May a group health plan continue to impose a "full-time student" status requirement for eligibility or a "majority of support" rule?

A2.6: No, for adult children under age 26. All of the old rules about student status and support from the parents and similar rules are no longer applicable and may not be imposed.

Q2.7: Will income need to be imputed to employees for the value of their adult dependent children coverage up to the age of 26?

A2.7: No. The Act has amended the Internal Revenue Code to provide that coverage provided to adult children through the calendar year in which they turn age 26 is not includible in income and employees may pay for their share of the cost on a pre-tax basis. This provision of the Act is effective as of March 30, 2010.

Q2.8: Can employers adopt the dependent age 26 rule prior to the effective date applicable to their plan?

A2.8: Yes, but employers sponsoring fully insured plans should consult with their broker or carrier to determine whether the carrier will permit this. Certain national carriers have announced that they are adopting this provision early. Self-insured plans should consult with their stop-loss or risk carrier, if they use one, before implementing this change.

Q2.9: May employers charge more for adult dependent children coverage?

A2.9: This is currently unclear. The Act does not include a specific prohibition with respect to an extra premium. Until further guidance is provided, however, Proskauer has been advising its clients to avoid implementing a flat charge (e.g., $100 per month per employee covering adult children dependents) that is not actuarially sound. Plan sponsors considering charging an extra amount for children up to the age of 26 should consult ERISA counsel.

Q2.10: Does the plan sponsor have an obligation to re-admit children who are on COBRA but under the age of 26?

A2.10: The Act does not specifically include this requirement, but we believe the likely answer is "Yes". It is likely that either the Internal Revenue Service ("IRS") or Department of Labor ("DOL") will issues guidance and notices

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regarding this re-enrollment right.

Q2.11: How long does coverage continue for adult dependent children?

A2.11: Under the Act, coverage continues until date of the child's 26th birthday. (Some insurers and plan sponsors may opt to simplify administration by continuing coverage until either the end of the month in which the child turns 26 or even until the end of the year in which the child turns 26. Fully-insured group health plans are also subject to state insurance law mandates regarding dependent coverage. We believe that children must be provided with the better of the two laws. For instance, under New Jersey State law, fully-insured plans must cover dependents up to age 30 (or until the child turns 31 if he is actively on coverage when he attains age 30), so in New Jersey fully insured plans would continue to observe this rule. Remember that income must be imputed to the employee for the value of the adult dependent coverage starting in the first year in which he or she turns 27.

Q2.12: When adult coverage ends at age 26, is that a COBRA qualifying event?

A2.12: Yes, we believe that the loss of dependent status under the terms of the plan is a COBRA qualifying event and these adult children would be eligible for up to another 36 months of continuation coverage.

Q2.13: Is the availability of coverage for a child who is not yet 26 considered to be a "change of status" that would permit an employee to increase his or her deduction for premium through a flexible benefit or 125 plan?

A2.13: Yes, the IRS has released guidance (Notice 2010-38) which clarifies that new eligibility because of the dependent age change to the law is a "change of status" for 125 plan purposes. In general, flexible benefit plans must be amended first before any change can take effect. However, in its guidance, the IRS will permit plan sponsors to implement this change operationally prior to an amendment as long as the plan is amended prior to December 31, 2010. Remember that this is a change of status for the deferral only; this is not a change of status for purposes of increasing or decreasing the amount contributed to a health care reimbursement account.

Elimination of Lifetime Limits

Q3.1: What are the rules regarding elimination of lifetime limits?

A3.1: Today, many individual and group health plans establish a lifetime maximum on the value of the benefits that may be provided under the plan. It is not uncommon for these lifetime maximums to be at $1M, $2M or even $3M. Unfortunately, the spiraling cost of health care sometimes results in individuals or families exceeding this lifetime limit due to a catastrophic illness or injury. When they reach that limit, no further benefits are available under the plan. Under the Act, as of the effective date for this provision (see Q3.2 below), all individual and group health plans must eliminate maximum lifetime limits. This means that plans will no longer be permitted to cap benefits to an established amount (such as $1M, $2M or $3M).

Q3.2: When does this abolition of lifetime limit rule go into effect?

A3.2: This requirement is applicable to active and retiree health plans and is effective as of the first day of the first plan year on or after September 23, 2010 (i.e., January 1, 2010).

Q3.3: Does this rule apply to grandfathered plans?

A3.3: Yes, this rule applies as of the date described in Q3.2 whether or not the plan is grandfathered; that is, the grandfathering rules do not apply to this mandate.

Q3.4: Will insurance companies be adjusting their insurance plans to account for this?

A3.4: Probably. Insurance carriers are likely currently reviewing the impact of this change (and others on cost of

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coverage) and will be advising employers what impact the elimination of lifetime caps may have on premium cost.

Q3.5: Will stop-loss carriers have to remove lifetime caps from their policies?

A3.5: As drafted, the Act applies to group health plans and group insurance products. Stop-loss carriers are expected to characterize their product as "risk insurance" and not group health insurance for purposes of the Act. Therefore, it is unlikely that stop-loss carriers will remove lifetime maximums from their umbrella insurance contracts. It is unclear whether the federal agencies will draft regulations with respect to the "risk insurance" position.

Q3.6: What penalty is imposed if a plan is not amended to observe the annual limits?

A3.6: $100 per beneficiary per day.

Q3.7: Do these annual limit rules preclude dollar limits on certain treatments (e.g., infertility, TMJ) or caps on numbers of visits (e.g., 12 chiropractic visits per year)?

A3.7: It is not entirely clear. It is expected that regulations will clarify.

Q3.8: Do the annual limit rules apply to stand alone dental and vision plans?

A3.8: No.

Q3.9: Do the annual limit rules apply to retiree-only plans?

A3.9: Probably yes. We believe that these provisions apply to retiree-only plans just as they do to active plans.

Annual Limits

Q4.1: Will plans be permitted to impose "annual limits" on benefits?

A4.1: Effective in 2014, plans will be restricted from imposing annual limits on benefits. However, prior to 2014 (and probably this year), the Department of Health and Human Services ("HHS") will release regulations imposing prohibitions on annual limitations on certain "essential health benefits."

Q4.2: Does the annual limit rule apply to grandfathered plans?

A4.2: Yes.

Q4.3: What are "essential benefits"?

A4.3: They include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse
- Prescription drugs
- Rehabilitative and devices
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

Q4.4: What penalty is imposed if a plan is not amended to observe the annual limits?

A4.4: $100 per beneficiary per day.

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Q4.5: Do these annual limit rules preclude dollar limits on certain treatments (e.g., infertility, TMJ) or caps on numbers of visits (e.g., 12 chiropractic visits per year)?

A4.5: It is not entirely clear. It is expected that regulations will clarify.

Q4.6: Do the annual limit rules apply to stand alone dental and vision plans?

A4.6: No.

Q4.7: Do the annual limit rules apply to retiree-only plans?

A4.7: Probably yes. We believe that these provisions apply to retiree-only plans just as they do to active plans.

Limits on Reimbursement of Over the Counter (OTC) Drugs

Q5.1: May Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and health Flexible Spending Accounts (health FSAs) continue to reimburse participants for OTC drugs?

A5.1: Effective January 1, 2011, no, except for insulin or prescribed medications, whether or not the drug would otherwise have been available without a prescription.

Q5.2: Will HSAs, HRAs, and health FSAs need to be amended prior to 2011 to make this change?

A5.2: The plan documents and summary plan descriptions should be reviewed by qualified ERISA counsel. Some plans may have to be amended if they specifically refer to the ability to reimburse OTC drugs.

Q5.3: Does the participant need to present the prescription at the pharmacy for the OTC drugs to be reimbursable?

A5.3: No. The participant would, however, need to submit the prescription with his or her reimbursement request.

Q5.4: How does this restriction affect claims submitted during a health FSA's runout period in 2011?

A5.4: A runout period gives participants a certain period (typically 90 days) after the plan year ends to submit the expenses they incurred during the plan year for reimbursement. Any OTC drugs purchased in 2010 do not require a prescription. Therefore, claims submitted during a runout period that ends after January 1, 2011 will not require a prescription. On the other hand, any OTC drugs purchased in 2011 require a prescription for reimbursement.

Q5.5: How does this affect claims submitted during 2½ month grace period?

A5.5: Absent guidance to the contrary, we believe that OTC drugs purchased during a 2½ month grace period that extends or begins in 2011 will not be eligible for reimbursement.

Q5.6: Can participants make election changes to their 2010 health FSA elections (to decrease their elections) because of the new limits on reimbursement of OTC drugs effective January 1, 2011, which will apply to claims incurred in the 2010 plan year grace period?

A5.6: No, absent guidance by the IRS this will not be permitted because the change in the law is not a "change of status" that permits an election change under existing law.

Early Retiree Insurance Program

Q6.1: What is the Early Retiree Insurance Program?

A6.1: A government reinsurance program that begins June 23, 2010 and provides a pool of $5 billion that will be used to provide employers with assistance toward the cost of coverage for early retirees (between ages 55 and 64,

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not on Medicare and not actively working for another employer providing health insurance).

Q6.2: Who is eligible for reimbursements under the Program?

A6.2: Self-funded and fully-insured employer-sponsored plans.

Q6.3: Who applies for the program and when?

A6.3: Employers will submit applications (available in June) in a manner that is anticipated to be similar to the on-line form for retiree drug subsidy. Application will be to HHS.

Q6.4: What types of services qualify for reimbursable services under the program?

A6.4: Plans may be reimbursed for medical, surgical, hospital and prescription drug costs; but must use the proceeds to lower health costs for enrollees (e.g., premium contributions, co-payments, deductibles, etc.).

Q6.5: Are proceeds from the program taxable to employers?

A6.5: No. The information provided in this FAQ is not intended to be, and shall not be construed to be, either the provision of legal advice or an offer to provide legal services. Rather, the content is intended as a general overview of the subject matter covered. Proskauer Rose LLP (Proskauer) is not obligated to provide updates on the information presented herein. Those reviewing this material are encouraged to seek direct counsel on legal questions. To ensure compliance with requirements imposed by U.S. Treasury Regulations, Proskauer informs you that any U.S. tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

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