Health Care Reform Boot Camp:
An Implementation Survival Guide for Employers and Their Health Plans

September 23, 2010

ALSTON+BIRD LLP
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Agenda

1. Introduction – David Godofsky
2. PPACA and Beyond: What’s an Employer to Do? – John Hickman
4. PPACA Implementation Issues for Group Health Plans – Ashley Gillihan
5. Health Plan Design for Optimal Financial Results in the Age of Health Care Reform (PPACA) – David Godofsky
6. Questions & Answers
7. Reception
Greetings:

Welcome to our Health Care Reform Boot Camp session. We are pleased that you have chosen to spend the afternoon with us.

Implementation of the new compliance and coverage requirements under the Affordable Care Act has proven to be a daunting task, for even the most experienced health benefits professionals. Thousands of pages of regulatory (and sub-regulatory guidance) have been issued and much more is yet to come. We hope that our session proves beneficial to you in addressing your health care compliance obligations. Feel free to ask questions of any of our presenters or any of the other benefits attorneys present today.

As future guidance is issued, we will continue to publish helpful advisories and bulletins. Also, don't forget to watch for our regular monthly health benefits lunch group sessions. These are held the first Thursday of each month (November through June) from 12:30 until 1:30 PM ET. Reminder Notices will be sent prior to each meeting.

Once again, welcome.

[Signatures]

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TAB C
Appendix 1
PPACA and Beyond: What’s an Employer to Do?

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Status

• T’was the night before Christmas and all through the House, not a Senator was sleeping . .
  – U.S. Senate passed the Patient Protection and Affordable Care Act (H.R. 3590)
    • Merged elements of the Senate Finance Committee and the Senate Health, Education, Labor and Pensions Committee bills.
  – U.S. House of Representatives passed its own health care reform bill, the Affordable Health Care for America Act (H.R. 3962), on November 7, 2009
  – All eyes turned to Conference Committee proceedings . . . or not . . . Instead we had the Massachusetts revolution ?
The Affordable Care Act

• On March 23, 2010, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA)
  – This is the version of PPACA passed by the Senate on December 24, 2009 and passed by the House on March 21, 2010

• The House Reconciliation Bill, H.R. 4872, which was approved by Senate and House March 25th, made additional changes as noted herein. It was signed by the President on March 30, 2010.

The New Health Care Coverage Landscape — General Overview

• Health Care Reforms
  – 2 waves of reforms for Group Health Plans

• Health Care Exchange

• Individual Mandate

• Employer “pay or play” mandate

• Tax Provisions
Health Insurance Reforms

- Reforms are added to the HIPAA portability subparts of ERISA and the IRC
- 2 waves of reforms
  - Immediate—generally effective first plan year on or after September 23, 2010
  - Other—effective for plan years beginning on or after January 1, 2014
- Liability for failing to comply w/reforms is same as violating HIPAA portability under ERISA/Code
  - Specific performance under ERISA
  - $100/day penalty under IRC
  - Mandatory Self-Reporting and excise tax for violations (Form 8928)
- The reforms do not appear to apply to:
  - Excepted Benefits (such as dental, vision, Health FSA)
  - Stand alone retiree plans likely exempt as well

Effective in 2010

- Small employer tax credit
  - A new tax credit for eligible small employers equal to a portion of the employer’s cost to provide health insurance
  - Employers with no more than 25 “full-time equivalent” employees and annual average wages of no more than $50,000 are eligible
- Auto-enrollment for employers with more than 200 employees
  - Provision has no separate effective date, so general rule that effective date is date of enactment appears to control
  - But compliance is effectively delayed until regulations are issued
Effective in 2010 (90 days after 3/23/10)

- State high risk pool for individuals with pre-existing conditions but without creditable coverage for 6 mos.
  - Insurer or employer found to have encouraged individuals to disenroll and join high risk pool must reimburse expenses
- Retiree reinsurance for coverage provided to “early” retirees (age 55-65)
  - Only 5 billion made available
  - Established within 90 days of March 23, 2010; ends January 1, 2014
  - Reimbursement for 80% of eligible claims in between 15k and 90k.
  - Reimbursements must be used to lower costs of the plan
  - Employers must apply (copy of application available online)
  - Agreements required with insurers (and likely TPAs)

Immediate Health Reform-effective first plan year six months after enactment:

- Provisions that apply to grandfathered health plans are noted as “NGF”:
  - (NGF) No lifetime limits and only “restricted annual limit” on the value of essential benefits are allowed
  - The bill allows annual or lifetime limits on non-essential benefits
- Interim final regulations
  - Essential benefits: “include at least the following general categories and the items and services covered within the 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; and pediatric services, including oral and vision care
  - Minimum allowable annual restrictions
    » $750k PY before 9/23/2011
    » $1.25M PY before 9/23/2012
    » $2M PY before 9/23/2014
  - Possible waiver process for mini-meds
  - Notice/re-enrollment required for individuals who exceeded limits
Immediate Health Reform—effective first plan year six months after enactment:

- (NGF) No pre-existing condition exclusions on enrollees under age 19
  - Could apply to young employees, spouse or dependent children

- (NGF) No rescission of coverage is permitted except in cases of fraud or intentional misrepresentation
  - What is impact of this rule on dependent audits?
  - Interim final regulations define rescission as any retroactive termination of coverage
  - Permissible rescission (e.g., for nonpayment of premiums) requires at least 30 days notice.

First dollar coverage (i.e., no cost-sharing) must be provided for certain evidence-based preventive care (including well-child care) and certain immunizations
  - Regulations allow for network and medical management restrictions

- (NGF) Plans that cover dependent children must provide for coverage of a dependent “child” to age 26
  - There is no requirement to cover children of covered dependent children (i.e., grandchildren)
  - Applies to “married” children
  - Consider impact on disabled coverage extensions and Michelle’s Law
  - Agencies appear to define “child” as set forth in plan
  - For grandfathered plans only, no requirement to cover if eligible for other coverage as employee (until 1/1/2014)
  - Tax exclusion under 105(b) (and 501(c)(9) and 401(h)) expanded to include a “child” (as defined by IRC 152(f)(1) through age 26.
    - Potential immediate impact for FSAs/HRAs that define eligibility based on 105(b)
Immediate Health Reform-effective first plan year six months after enactment:

- (NGF) Prepare and distribute a new “Summary of Coverage”
  - Distributed at enrollment, no more than 4 pages, and 12pt font
  - Notice of material changes in Summary required 60 days prior to effective date
  - Agencies will identify additional requirements within 12 months
  - Plans will have an additional 12 months to distribute
- Fully insured plans sponsored by employers will generally be required to satisfy the same Section 105(h) discrimination requirements that apply to self-funded plans
  - Applicable to premium reimbursement plans (not subject to 105(h))?
  - Penalty is $100 per day excise tax (self reported) for affected participant

Immediate Health Reform-effective first plan year six months after enactment:

- Appeals process changes including allowing claimants to continue receiving coverage during the appeals process and providing for an external review process established by the Secretary of HHS and/or DOI for insured plans
- Special rules regarding health care providers:
  - Plan enrollees are allowed to select their primary care provider, or pediatrician, from any available participating providers;
  - Precludes prior authorization or increased cost-sharing for emergency services, whether in-network or out-of-network
    - Interim final regulations require payment at greater of network rate, out of network rate, or Medicare rate; and
  - Precludes plans from requiring authorization or referral by the plan for obstetrical or gynecological care
  - Interim final regulations impose notice requirements
Effective in 2011

- Employers must report aggregate value of employer-sponsored coverage on Form W-2 (first report due in 2012)
  - Includes COBRA rate of all health coverage subject to Cadillac tax
- No reimbursement of OTC medicines or drugs (except insulin) by health FSA, HRA, or HSA without prescription
  - Related to expenses incurred in calendar year 2011; not based on “plan year”
- “Simple” cafeteria plans (years beginning after 12/31/10)
  - Safe harbor available to eligible small employers (100 or fewer employees during either of two preceding years)
  - Treated as meeting nondiscrimination rules for cafeteria plans and certain components (e.g., group term life, health FSAs, DCAPs)
  - Must meet contribution, eligibility, and participation requirements
- Tax on HSA distributions not for qualifying medical expenses increases to 20% (from current 10%)

Effective in 2013

- Health FSA salary reductions limited to $2,500 each year
  - The cap is indexed to the CPI starting in 2014
- Deduction previously permitted for amounts allocable to the Medicare Part D subsidy for prescription drug plans is eliminated
- Effective 3/1/2013, employers must notify employees at time of hiring of—
  - Existence of the exchange
  - That employee may be eligible for subsidy under the exchange if the employer’s share of total costs is less than 60%
  - That if employee purchases a policy through the exchange without employer providing a voucher, he or she may lose the employer contribution to health benefits offered by employer
Reforms Effective Plan Years On/After 2014

• (NGF) No preexisting condition exclusions or limitations are permitted

• (NGF) Prohibition on excessive waiting periods—i.e. no waiting period in excess of 90 days

• Fair Health Insurance Premiums (applicable only to health insurers)
  – Limitations on premium setting (e.g. limitations on premium setting based on age, tobacco use)
  – Indirect impact on self insured plans?

Reforms Effective Plan Years On/After 2014

• No discrimination based on health status is permitted
  – Essentially, the same rules that currently exist under HIPAA
  – The bill raises maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage
    • Also gives the Secretaries of Labor, HHS, and the Treasury leeway to increase the percentage to 50 percent

• Cost limitations
  – Out-of-pocket expenses do not exceed the amount applicable to coverage related to health savings accounts (HSAs)
  – Deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage (as indexed)
    • Deductible requirement may only apply to fully insured plans in small group market
Reforms Effective Plan Years
On/After 2014

• Fully insured plans in small group market must provide essential benefits
  – Not applicable to fully insured plans in large group market and self insured plans
  – Self insured plans NOT required to provide essential benefits

• Group and individual plans are required to cover routine costs of participation in certain clinical trials by qualified individuals

• No nondiscrimination against providers who act within the scope of their license
  – Not an any willing provider statute

Individual Responsibility

• Effective January 1, 2014
• Individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax of the greater of
  – $95 in 2014, $325 in 2015 and to $695 in 2016 and thereafter
  – A percentage of income equal to 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and thereafter
• Families will pay half the amount for children up to a cap of $2,250 for the entire family or percentage of household income (if greater)
• After 2016, dollar amounts will increase by the annual cost of living adjustment
Individual Responsibility

- Individual enrolled in “minimum essential coverage” meets the requirements
- What is “minimum essential coverage”?
  - Gov’t sponsored programs (e.g. Medicare, Medicaid, Tricare)
  - Plans in the individual market
  - “Eligible Employer Sponsored Plan”
    - Group health plan
    - Fully insured plan in large/small group market
  - Grandfathered Plan
- “Excepted Benefits” do not qualify as “minimum essential coverage”

Health Insurance Exchange

- PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014
- Exchange-related provisions in PPACA impact employers in the following ways:
  - Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange
    - Prior to 2017, only small employers - employers with 100 employees or less (except in states that limit small employers to employers with 50 or fewer employees)— may participate
  - Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer’s cafeteria plan
Vouchers

- Employers that offer coverage and make a contribution must offer “free choice vouchers” to qualified employees for the purchase of qualified health plans through exchanges
  - The free choice voucher must be equal to the contribution that the employer would have made to its own plan
  - Employees qualify if household income does not exceed 400% of the federal poverty level and required contribution under the employer’s plan would be between 8 and 9.8 percent of income
  - Free choice vouchers are excludable from employees’ incomes (to the extent used for health care) and deductible by employer
    - Excess employer contribution must be paid to employee as taxable compensation
    - Voucher recipients eligible for tax credits through exchange

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1:
  - Employers with 50 or more full-time “applicable” employees are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees:
    - Applicable employers who fail to offer full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any full-time employee receives a federal subsidy for the exchange
      - The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer (over 30) for that month and 1/12 of $2000 (up from $750)
        » For example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount
Employer Responsibility

• Effective January 1, 2014 - play or pay mandate #1 (cont’d):
  • Part-time employees are taken into account solely for the purpose of determining if an employer has at least 50 employees
    – The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time employees by 120
  • Employers who are “applicable large employers” solely because of seasonal employees who are otherwise full-time employees and that work less than 120 days during the year are NOT considered “applicable large employers”

Employer Responsibility

• Effective January 1, 2014 - play or pay mandate #2:
  • Even when coverage is extended, applicable employers who offer coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such employees who have received a tax subsidy and 1/12 of $3000 (capped at 1/12 of $2000 times the total number of full-time employees during such month)
    – Note: employees offered employer coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan’s share of allowed costs is less than 60%.
Cadillac Plan Tax

- Beginning in 2018, PPACA (as modified by the Reconciliation Bill) imposes a 40 percent excise tax on:
  - “Coverage providers:” for the sum of months in which the aggregate value of employer-sponsored health coverage for the employee exceeds:
    - 1/12 of $10,200 for single coverage and $27,500 for family coverage
    - The higher family threshold applies to both single and family coverage offered under a multiemployer plan
    - These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
    - The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter
    - An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer’s age and gender demographics are not representative of a national average
    - The PPACA transition rule for high cost states does not apply
  - The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, longshoremen, construction workers, and miners), and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage

Cadillac Plan Tax

- Determined by the employer and assessed against “coverage providers”
- “Coverage providers” are defined to include the following:
  - In the case of fully insured plans, the health insurer
  - In the case of HSA or medical savings account (MSA) contributions, the employer making the contributions
  - In the case of a self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g., the TPA)
- In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (also includes HSA contributions)
  - The coverage provider’s applicable share of the tax will bear the same ratio to the total excess benefit as the cost of provider’s coverage to the total value of employer-sponsored coverage
Cadillac Plan Tax

- The coverage subject to the excise tax rule includes:
  - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee (except vision only insurance, dental insurance, accident and disability insurance, long-term care insurance, and after-tax funded hospital indemnity and/or specified disease coverage)
  - Both non-elective and salary reduction contributions to a health FSA
  - Employer contributions (presumably including salary reductions) to an HSA

Other New Taxes

- Several new taxes are imposed, including:
  - Indoor tanning procedures effective for services performed on or after July 1, 2010
  - New sector tax on health insurers (but not self-insured plans or TPAs) beginning in 2014
  - 0.9 percent increase in Medicare taxes for those earning more than $200,000 for single individuals and $250,000 for joint filers (effective beginning in 2013)
    - Such individuals would also be subject to a 3.8% tax on their net investment income (to the extent total income exceeds the thresholds)
    - This new tax would be effective starting in 2013
  - CER fee: A fee equal to $2 ($1 in 2013) multiplied by average number of covered lives. Applies to both fully insured and self insured plans.
Grandfathered Status – Is it Worth Keeping?

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Issues to be discussed
- Decision making factors relative to maintaining grandfather status
- Overview of mandates as applied to grandfathered group health plans
- Grandfather plan rules as described in interim final regulations published in Fed Reg on June 17, 2010
Decision-Making Process

- The agencies' intent in adopting the grandfather rules was to make sure that most plans would lose grandfather status over time.
- The limited changes that are permitted under the rules means that the agencies will have achieved their goal.
- The question is then not so much “if” a plan will lose grandfather status, but “when”.

Decision-Making Process

- Use a cost benefit analysis to determine whether the benefits of the plan changes will be worth the costs associated with additional reforms.
- Grandfathered plans are exempt from many reforms:
  - Caveat: Guidance has not yet been issued on all requirements that will apply, so the costs of compliance is not yet known.
  - Separate advisory contains full list of which requirements do and do not apply to grandfathered plans.
Decision-Making Process

• Grandfathered plans are subject to key reforms:
  – Coverage of dependent children up to age 26
    • A special transition rule applies to grandfathered plans up to 2014
    • Coverage does not have to be extended if the adult child is eligible for
      other employer-sponsored coverage (not through a parent)
  – Prohibition on rescissions
  – Prohibition on imposing preexisting condition limitations
    • Effective for plan years beginning on/after Sept. 23 for individuals
      under age 19

• Prohibition on lifetime limits
• Restrictions on annual limits
• MLR requirements (insured plans only)
• Uniform description of benefits
  • Effective date depends on issuance of guidance; statute indicates first
    notice not required before March 23, 2012
  • Prohibition on waiting periods in excess of 90 days
    • Effective for plan years beginning on/after January 1, 2014
Decision-Making Process

• Grandfathered plans are permanently exempt from the following reforms:
  – Preventive services
  – Limits on cost sharing
  – Reporting requirements
  – Appeals process
  – Selection of doctors and referral requirements
  – Coverage of clinical trials
  – No discrimination against providers
  – (See advisory in materials for list)

Definition of Grandfathered Plan

• A group health plan is grandfathered if:
  – At least one individual was enrolled in the plan on March 23, 2010,
  – At least one individual is enrolled at all times after March 23, 2010 (does not have to be the same individual), and
  – No changes are made to the plan that result in loss of grandfather status
### Adding New Individuals To a Grandfathered Plan

- Grandfathered status is not limited to individuals who were enrolled in the plan on March 23
  - New employees (and their families) may be covered under an employer’s grandfathered plan
    - Allows coverage of both newly hired employees and newly enrolled employees
  - Family members of current employees who are covered by the grandfathered plan may also be added

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### Adding New Individuals To a Grandfathered Plan

- If a principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan, the plan ceases to be a grandfathered plan
- Transferring employees from one grandfathered plan to another grandfathered plan may result in loss of GF status
  - Must be a bona fide business reason for the transfer
  - GF status of the transferee plan is lost if the transfer, treated as a plan amendment, would have resulted in loss of GF status
    - Example: More generous plan is terminated and employees are transferred to another GF plan with less generous benefits, e.g., higher cost sharing requirements

| 10 |
Maintaining Grandfathered Status

• Regulations contain a list of changes that will result in loss of grandfather status
• ONLY those changes specifically listed in the IFR will result in loss of grandfather
• However, the agencies may add additional changes that will result in loss of grandfather on a "prospective" basis
• Until further notice, changes that do NOT result in loss of grandfather status include
  – Changes to a drug formulary, changing from insured to self insured, changing TPAs, certain eligibility changes (e.g., eliminating classes of employees from coverage)
  – Splitting off retirees into a separate plan?

Maintaining Grandfathered Status

• The regulations lists 6 types of changes that result in lost of grandfather status
  – When does loss of GF status occur if changes not effective on first day of plan year?
• Whether GF status is lost is determined separately for each “benefit package”
  – No precise definition of a “benefit package”
  – Example: Two insured options under a plan, A and B. If only option A is changed in a manner that triggers loss of GF status, option B still retains GF status
Maintaining Grandfathered Status

• Changes are measured from the plan terms in effect on March 23, 2010
  – Changes are generally not cumulative. For example, IFR permits increase in employee contribution rate of no more than 5%, measured from March 23, not 5% per year

Maintaining Grandfathered Status – Prohibited Changes

1. Entering into a new policy, certificate or contract of insurance after March 23, 2010 (as compared to renewing a policy) creates a new plan.
   • Example: If a benefit package under a grandfathered self-insured plan becomes fully insured, grandfathered status would be lost, because the new policy would be considered a new plan.
   • An exception exists for certain collectively bargained plans.
   • Not limited to changes in carriers.
     • What constitutes a “new” policy?
Maintaining Grandfathered Status – Prohibited Changes

2. Changes in the scope of benefits
   – The elimination of all or substantially all benefits to diagnose or treat a particular condition results in loss of grandfather status, even if no plan participants have ever had the condition
   – The elimination of benefits for any necessary element to diagnose or treat a particular condition also results in loss of grandfather status
     • What if only certain treatments are eliminated?

3. Increases in percentage cost sharing
   – Any increase in any percentage cost-sharing amount (such as increasing a 20 percent coinsurance requirement for in-patient surgery to 30 percent) results in loss of grandfather status.

Maintaining Grandfathered Status – Prohibited Changes

4. Increases in fixed amount cost sharing
   – For fixed amount cost sharing other than co-payments (e.g., deductibles) the maximum permitted increase in the fixed amount is medical inflation plus 15 percentage points.
   – For co-payments, the maximum permitted increase is the greater of (a) the maximum percentage increase for other cost sharing, and (b) $5 increased by medical inflation.
   – These restrictions apply to changes in any cost sharing requirement.
   – Note: IFR has a (confusing) example for illustration; plans must use actual inflation as provided in the IFR
Maintaining Grandfathered Status – Prohibited Changes

5. Increase in employee contribution *rate* by more than 5%
   • Applies to rate, not dollar amount of employee contribution
   • Applies to any tier of coverage
   • New tiers (e.g., change from employee/family to employee, employee plus one, etc) must be measured against this rule

Maintaining Grandfathered Status – Prohibited Changes

6. Addition of annual dollar limits on benefits or changes to annual dollar limits
   • If a benefit option did not have either an annual limit or a lifetime limit, no annual limit may be added
   • If a benefit option had an annual limit, the annual limit cannot be reduced
   • If the benefit option had a lifetime limit, but no annual limit, an annual limit may be added only if it is not less than the lifetime limit
   • Application to new treatment limits?
Maintaining Grandfathered Status – Prohibited Changes

6. Addition of annual dollar limits on benefits or changes to annual dollar limits
   • If a benefit package did not have either an annual limit or a lifetime limit, no annual limit may be added
   • If a benefit package had an annual limit, the annual limit cannot be reduced
   • If the benefit package had a lifetime limit, but no annual limit, an annual limit may be added only if it is not less than the lifetime limit
   • Application to new treatment limits?

Maintaining Grandfathered Status – Transition Rules

• Changes adopted before March 23 that take effect later
  – Treated as in effect on March 23 if made pursuant to a legally binding contract entered into on or before March 23 or a written plan amendment adopted on or before March 23. For insured plans, rule applies if change pursuant to a state insurance filing made on or before March 23.
  – Revocation of changes adopted after March 23 and before June 14, 2010 (date the GF IFR was publicly released)
    – Revocation must be effective for first plan year beginning on/after September 23, 2010
    – Similar binding contract, plan amendment rules apply
  • Enforcement position for changes adopted before June 14 and that “only modestly” exceed permitted changes
Notice and Recordkeeping Requirements

• Disclosure of GF status required
  – In order to maintain GF status, a notice that the plan is intended to be grandfathered must be included in “any” plan materials describing benefits
  – The notice must include a contact number for questions (or complaints)
  – A model notice is provided

• Records must be maintained and open for inspection
  – For as long as plan intends to retain GF status, records must be maintained to document grandfather status (including plan provisions in effect on March 23)
  – Records must be available upon request to participants, beneficiaries and agency officials
  – Note: Enforcement of grandfather rules may come through actions by groups of participants and beneficiaries
## Special Rules for Collectively Bargained Plans

- No effective date delay 😊
- No special treatment for self insured collectively bargained plans
- **Insured** plans maintain grandfather status until the last of the collective bargaining agreements in effect on March 23 expires
  - What is plan maintained pursuant to a CBA?
  - Literally, compliance date is the date that the last applicable CBA related to such coverage terminates---NOT the next plan year.
Waiver Process for “Mini Med” Plans

- Process to obtain a waiver from restricted annual limits was announced in a memo released by HHS on September 3
  - Do not confuse “limited benefit plans” with HIPAA “excepted benefits” such as limited vision and dental plans. The latter are exempt from the reforms
- Available for plans offered before September 23, 2010
- No form is provided, but application must include the information set forth in the HHS memo

Waiver Process for “Mini Med” Plans

- Waivers will be granted at this time only for the first plan year beginning on/after September 23, 2010
- Separate applications for later years must be submitted
  - HHS may change requirements for later years
- No waivers for years beginning on/after January 1, 2014 (i.e., when exchanges are to be effective)
Waiver Process for “Mini Med” Plans

• Timing
  – If plan year starts before November 2, 2010, application must be submitted at least 10 days in advance of plan year
    • HHS will act on such applications no later than 5 days in advance of the start of the plan year
  – In other cases, application must be submitted at least 30 days in advance of plan year
    • HHS will process within 30 days of receipt

• Information to be included in application
  – Terms of the plan (does not appear to require submission of actual plan document)
  – Number of individuals covered
  – Annual limits and rates that apply
  – Attestation by plan administrator or CEO of insurer
Waiver Process for “Mini Med” Plans

• Information to be included in application
  – A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation
    • This not necessarily “one size fits all”; consider this as an advocacy piece
    • No indication as to what is considered “significant”
  – Supporting documentation should be retained
PPACA Implementation Issues for Group Health Plans

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PPACA Implementation Steps for Group Health Plans

What!!!

When!!!

How!!!
Surveying the Landscape

- Health Insurance Reforms
  - 2 waves of reforms for Group Health Plans
- Health Care Exchange
- Employer Responsibility Requirements
- Miscellaneous Tax Provisions

Health Insurance Reforms

- What are the specific Health Insurance Reforms?
- To which plans do the Health Insurance Reforms apply?
- When are they effective?
- What is a grandfathered plan (and why do I care)?
Health Insurance Reforms

• PPACA added the Reforms to the HIPAA portability subparts of PHSA, ERISA and the IRC
  – The reforms do not appear to apply to:
    • Excepted Benefits (such as dental, vision, Health FSA)
    • Stand alone retiree plans likely exempt as well
      – BEWARE: Issues for fully insured stand alone retiree plans

• Three step application analysis (“Grid” Analysis):
  – Step #1: Is this plan a “group health plan”?
    • If NO, STOP!!! It is NOT subject to the Health Insurance Reforms.
    • If YES, Continue to Step #2.
  – Step #2: Do the benefits qualify as excepted benefits? (Use “Cubby Hole” Approach)
    • If YES, STOP!!! The Health Insurance Reforms do not apply.
    • If NO, Continue to Step #3.
  – Step #3: Is the plan a stand alone retiree health plan?
    • If YES, STOP!!!! The Health Insurance Reforms do not apply.
    • If NO, THE HEALTH INSURANCE REFORMS APPLY!!!!!!!!!

Health Insurance Reforms

• 2 waves of reforms
  – Immediate—generally effective first plan year on or after September 23, 2010
  – Other—effective for plan years beginning on or after January 1, 2014
  – What is “Plan Year”? (see 29 C.F.R. 2590.701-2)
    • Plan year identified in document
    • If no plan document, then deductible year
    • If no deductible, then policy year
    • If no policy year, then employer’s tax year
    • In all other cases, the calendar year
Health Insurance Reforms

- Liability for failing to comply with reforms is same as violating HIPAA portability under PHSA/ERISA/Code
  - Specific performance under ERISA
  - $100/day penalty under IRC/PHSA
  - Mandatory Self-Reporting and excise tax for violations (Form 8928)?

Grandfathered Plans

- What is the all the buzz about Grandfathered Plans?
  - Grandfathered Plans are subject to SOME but NOT ALL of the Health Insurance Reforms
- Interim Final Regulations issued 6/14
- A plan is a grandfathered plan with respect to individuals who were enrolled on March 23, 2010.
  - The plan does not stop being a grandfathered plan because individuals enrolled on that date cease to be covered, provided that the plan has continuously covered someone since March 23, 2010.
  - Family members may be added
  - “New employees” (newly eligible and newly hired) may be added
  - Two anti abuse rules
    - Merger and acquisition
    - Employer initiated transfer to another option/plan
- Regulations apply separately to each benefit package option offered under a plan
Grandfathered Plans

• The myth about union plans—“Grandfathered plans subject to a collectively bargained agreement do not have to comply with ANY of the health insurance reforms until after the last collectively bargained agreement expires”
  - FALSE!!!!!!!

• The truth about union plans—“Grandfathered plans subject to a collectively bargained agreement are subject to the same health insurance reforms, at the same time, as a plan that is not subject to a collectively bargained agreement”
  - Fully insured collectively bargained plans subject to a special maintenance rule.

Grandfathered Plans

• Disqualifying Changes
  - Change in insurance contract or carriers (except as provided for plans subject to a CBA)
    • Change in administrators does NOT impact grandfather plan status
  - Elimination of benefits to treat or diagnose a condition
  - ANY increase in percentage cost sharing (e.g., coinsurance)
  - Certain increases in fixed amount cost sharing
    • [Other than co-payments] medical inflation (from March 23, 2010) reflected as a percentage, plus 15 percentage points
    • [Copayments] greater of (a) medical inflation (from March 23, 2010), reflected as a percentage, plus 15 percentage points and (b) $5 increased by medical inflation
  - Change in contribution structure
    • A decrease in the employer contribution rate of more than 5 percentage points below the rate on March 23, 2010 for any tier of coverage for similarly situated individuals
  - Certain changes in lifetime/annual limits
• Special rule for fully insured plans subject to a collectively bargained agreement
  - An otherwise grandfathered, fully insured plan subject to a collectively bargained plan ratified on or before March 23, 2010 will not lose grandfather plan status prior to the date the last collectively bargained agreement expires, even if the above mentioned changes are made during that period.
  - Continued grandfather plan status determined as of date last collectively bargained agreement expires
Grandfather Plans

- Cubby Hole Approach:
  - Does the change fit into any one of the cubby holes?
    - If YES, the benefit option loses grandfather plan status
    - If NO, the benefit option does not lose grandfather plan status.

- What about . . .
  - Change from fully insured to self-funded
  - Changes to network or formulary
  - What is a separate coverage option
  - Dropping one of many coverage options
  - Implementing new coverage categories (spouse, children)
  - Moving retirees into free-standing plan

Health Insurance Reforms

First Plan Year on or After September 23, 2010

Key:

“All”=applies to both grandfathered and non-grandfathered plans
“NGF”=applies only to non-grandfathered plans
Prohibition on Lifetime and Annual Limits
PHSA 2711(ALL)

• General Rule: No lifetime limits and only restricted annual limits on the dollar value of essential benefits offered under the plan

• Interim Final Regulations issued on 6/28/2010
  – Defines restricted annual limit
  – Requires special enrollment for those who would otherwise be eligible for coverage but for reaching a lifetime maximum
    • 30 day enrollment period beginning no later than effective date of rule
    • Coverage effective no later than effective date of rule

Prohibition on Lifetime and Annual Limits
PHSA 2711(ALL)

• What are essential benefits?
  – Benefit “categories” generally defined in PPACA Section 1302
    • 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
  – No guidance yet as to which benefits fit into the specific categories
    • Chiropractic?
    • Infertility?
    • Dental/vision benefits?
  – IFR indicate that we must make a good faith reasonable determination until specific guidance is issued.
Prohibition on Lifetime and Annual Limits
PHSA 2711(ALL)

• What are restricted annual limits?
  
  – $750k PY before 9/23/2011
  – $1.25M PY before 9/23/2012
  – $2M PY before 9/23/2014

Prohibition on Lifetime and Annual Limits
PHSA 2711(ALL)

• Implementation Issues related to Scope of prohibition
  
  – Are visit or treatment limits permitted?
  – Does the prohibition apply both to aggregate benefits AND specific benefits or just aggregate?
  – Scope of special enrollment rights
    • E.g. How does it impact a qualified beneficiary under COBRA?
  – What is the impact on HRAs?
    • Integrated HRA o.k. as long as “plan” complies with requirements
    • Stand alone plans may have issues
      – Exemption if HRA is a “health flexible spending arrangement” under IRC 106(c)
Prohibition on Lifetime and Annual Limits  
PHSA 2711 (ALL)

- **Required actions:**
  - Review and revise plan to eliminate all lifetime dollar maximums that apply generally to all benefits
  - Review and revise enrollment materials/process to ensure 30 day enrollment
  - Identify any annual limits in plan
    - With regard to any remaining annual limits:
      - Ensure not an essential benefit or
      - If an essential benefit, ensure that it is within IFR’s “restricted” limits

Prohibition on Rescissions  
PHSA 2712 (ALL)

- **General Rule:** No rescission of coverage is permitted except in cases of fraud or intentional misrepresentation

- **Interim final regulations issued on 6/28/2010**
  - Defines “rescission”
  - Provides examples
Prohibition on Rescissions
PHSA 2712 (ALL)

• What is a rescission?
  – **ANY** termination/cancellation of coverage that has a retroactive effect
    • Does not apply in cases of failure to pay premiums
    • IFR clarifies that it applies in cases in coverage provided by the employer erroneously
• Rescission NOT Permitted except in cases of fraud or intentional misrepresentation
  – What is fraud?
  – What is intentional misrepresentation?
• If rescission is permitted, must provide 30 days advance notice
• See also special appeal rights

Prohibition on Rescissions
PHSA 2712 (ALL)

• Implementation issues
  – What is **fraud** in this context?
    • E.g. Failure to provide notice of a terminating event
  – **Innocent Parties Conundrum**
    • What do you do if both employer and employee are innocent?
      • E.g. Employer must rely on notice of terminating event from covered individual (e.g. Divorce, dependent ceasing to be a dependent)
        » Intersection between rescission rules and COBRA
  – Appeals (see appeal slides)
  – Impact on dependent audits
Prohibition on Rescissions
PHSA 2712 (ALL)

- **Required action:**
  - Determine approach to Innocent Party Conundrum
    - Assume COBRA trumps (where COBRA applies)?
    - Assume not applicable to employee initiated events?
  - Ensure plans have adequate “enrollment” language
    - Employees obligated to enroll only those that are eligible (based on terms of plan)
    - Employees/dependents required to provide supporting documentation upon request
  - If rescission due to fraud or intentional misrepresentation is enforced, provide 30 days advanced notice to affected individuals.
  - Adhere to claims procedures, as rescission is an adverse benefit determination

Age 26 Coverage Mandate
PHSA 2714 (ALL)

- **General Rules:** Plans that cover dependent children must provide for coverage of a dependent “child” to age 26

- **Interim Final Regulations issued on 5/13/2010**
  - Applies only if you make dependent coverage of children available
  - Plan may not define dependent under the plan other than in terms of the relationship between the child and the employee
    - NO DEFINITION OF CHILD IS PROVIDED
    - May not be based on tax dependency
  - Terms of the plan may NOT vary based on age
  - There is no requirement to cover children of covered dependent children (i.e., grandchildren)
  - Applies to “married” children
  - For grandfathered plans only, no requirement to cover if eligible for other coverage as employee (until 1/1/2014)
  - Special enrollment for children of otherwise eligible employees who satisfy new eligibility requirements and were dropped due to age or not previously enrolled
    - 30 day enrollment period beginning no later than effective date of rule
    - Coverage effective on effective date of rule
    - Subject to special enrollment coverage rights (i.e. can elect other options made available to similarly situated)
Age 26 Coverage Mandate  
PHSA 2714 (ALL)

**Implementation Issues:**
- Who is a child?
  - No bridge between new definition in 105(b) and the definition of “child” for purposes of the age 26 mandate
    - Read literally, it applies any “child” whom the plan indicates is eligible based on the child’s relationship to the employee
      » Stepchild?
      » Grandchild?
      » Domestic partner’s child?
  - Policing “other employment coverage” exception for certain GF plans

**Required action:**
- Review and assess definition of “child” under plan
  - Must be covered at least until day before turning age 26
  - May not impose student/status, financial dependency, or residency requirements
  - Consider imposing “legal obligation” or “parent/child” relationship
- Identify benefits previously provided to children up to age under 26
  - E.g. Orthodontia up to age 18
- Review and revise enrollment materials/process to ensure 30 day enrollment period
No Pre-existing Condition Exclusions for Enrollees under Age 19 (ALL)

- General Rule: No pre-existing condition exclusions on enrollees under age 19
- Interim final regulations issued on 6/28/2010
- What is an “enrollee”?
  - Any individual enrolled for coverage under the plan (i.e. employees, spouses, dependents)
- Implementation issues
  - Determine if any pre-ex in plan may apply to children
  - Revise certificate of creditable coverage process accordingly

Summary of Coverage (ALL)

- General Rule: Plans must prepare and distribute a new “Summary of Coverage” that
  - generally describes benefits under the plan
  - no more than 4 pages long and no less than 12 pt font
  - Summary is distributed at enrollment
  - Notice of material modifications to summary required 60 days prior to effective date
  - NOTE: This does not affect the SPD requirements
- No regulations to date
- Implementation issues:
  - Coordinating current enrollment material with new summary of coverage
  - Coordinating enrollment with 60 day notice requirement
- Required Action:
  - Nothing at this time!!!!!!
  - Agencies will identify additional requirements within 12 months
  - Plans will have an additional 12 months to distribute
Mandatory Coverage of Preventive Care
PHSA 2713 (NGF)

• General Rule: First dollar coverage (i.e., no cost-sharing) must be provided for certain evidence-based preventive care (including well-child care) and certain immunizations
• Interim final regulations issued on 6/28/2010
  – Identify recommended preventive services
  – Address billing issues associated with recommended preventive services provided during office visit
  – Allow for network and medical management restrictions

Required action:
– Ensure that all preventive care requirements listed in the regulation are covered 100% for the first plan year
  • Establish process to monitor website for updates
  • Note that aspirin, folic acid, and iron supplements are covered as preventive care, so review these requirements with your prescription drug plan to determine whether these drugs and supplements will be covered under the prescription drug plan or medical plan
New Claim Appeals Process
PHSA 2719 (NGF)

• General Rule: Plans must establish an effective internal claims appeal process, provide notice in a culturally and linguistic manner, and establish an external review.

  – Definition of “adverse benefit determination”
    • Now includes rescission determinations
  – Urgent Care Timeframe
    • No more than 24 hours
  – Appeals Procedure
    • Access to documents
  – Conflicts of Interest
  – Denial Notice Content
  – Strict Adherence
  – External review safe harbor

New Claim Appeals Process
PHSA 2719 (NGF)

• Implementation Issues:
  – Establishing an “external review” process
    • Self insured plans must contract with at least 3 qualified independent review organizations
    • Plan must pay for external review
  – Implementing culturally linguistically appropriate notice procedure
    • Identifying applicable population
    • Ensuring all subsequent notices for an “electing” individual is in primary language
  – Reduced time frame for urgent care (72 to 24)
  – Additional evidence rule
### New Claim Appeals Process

**PHSA 2719 (NGF)**

- **Required Action:**
  - Review and revise current internal claims review process
    - Revise urgent care
    - Culturally and linguistically appropriate notices
    - Additional evidence
    - Revise notices regarding external review
  - Establish an external review process
  - Review and revise SPDs accordingly

### Network Providers

**PHSA 2719A (NGF)**

- **General Rule:**
  - Plan enrollees are allowed to select their primary care provider, or pediatrician, from any available participating providers;
  - Precludes prior authorization or increased cost-sharing for emergency services, whether in-network or out-of-network
  - Precludes plans from requiring authorization or referral by the plan for obstetrical or gynecological care

- **Interim Final Regulations Issued 6/28/2010**
  - Clarify treatment of out of network emergency services
  - Provide model notice

- **Required action:**
  - Incorporate the model language into the SPD if designation of PCP.
  - Remove contrary provisions in the plan (e.g., referral requirements for OB/GYN)
  - Eliminate all disparate financial requirements/cost-sharing between in-network and out-of-network emergency services.
  - Eliminate all precertification-type requirements from emergency services, including for mental health/substance abuse.
  - Ensure that any administrative requirement for out-of-network emergency services is the same as those for in-network (e.g., post-emergency services “notice” requirement for out-of-network should not be 24 hours if in-network emergency services notice requirement is 48 hours).
Nondiscrimination Rules for Fully Insured Plans (NGF)

- **General Rule:** Fully insured group health plans must generally satisfy the same Section 105(h) discrimination requirements that apply to self-funded plans.
- No regulations issued to date.
- Implementation issues:
  - Applicable to premium reimbursement plans (not subject to 105(h))?  
  - Who are affected individuals for purposes of IRS excise tax?  
  - Executive medical plans
- Required action:
  - Conduct discrimination testing

Other NGF Provisions

- Ensuring quality of health care
  - Implementing and reporting on certain reimbursement structures under the plan, including implementation of wellness programs
  - Criteria developed within 2 years of date of enactment
- Transparency Reporting
  - Report to HHS, applicable state insurance commissioner, and the public:
    - Claims payment policies and practices
    - Periodic financial disclosures
    - Enrollment data
    - Number of claims denied
    - Rating practices
    - Out of network cost sharing
Health Insurance Reforms

First plan year on or after January 1, 2014

Reforms Effective Plan Years On/After 2014

• (ALL) No preexisting condition exclusions or limitations are permitted

• (ALL) Prohibition on excessive waiting periods—i.e. no waiting period in excess of 90 days

• (ALL) Fair Health Insurance Premiums (applicable only to health insurers)
  – Limitations on premium setting (e.g. limitations on premium setting based on age, tobacco use)
Reforms Effective Plan Years On/After 2014

- (NGF) No discrimination based on health status is permitted
  - Essentially, the same rules that currently exist under HIPAA
  - The bill raises maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage
    - Also gives the Secretaries of Labor, HHS, and the Treasury leeway to increase the percentage to 50 percent
- (NGF) Cost limitations
  - Out-of-pocket expenses do not exceed the amount applicable to coverage related to health savings accounts (HSAs)
  - Deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage (as indexed)
    - Deductible requirement may only apply to fully insured plans in small group market

Reforms Effective Plan Years On/After 2014

- (NGF) Fully insured plans in small group market must provide essential benefits
  - Not applicable to fully insured plans in large group market and self insured plans
  - Self insured plans NOT required to provide essential benefits
- (NGF) Group and individual plans are required to cover routine costs of participation in certain clinical trials by qualified individuals
- (NGF) No nondiscrimination against providers who act within the scope of their license
  - Not an any willing provider statute
Health Insurance Exchange

• What is it?

• How might it affect you as a plan sponsor?

PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014.

Exchange-related provisions in PPACA impact employers/plan sponsors in the following ways:

– Group Market
  • Until 2017: only small employers - employers with 100 employees or less (except in states that limit small employers to employers with 50 or fewer employees)—may participate. 
  • Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange.
  • Only employers who offer group coverage through the exchange may allow exchange coverage to be offered through the cafeteria plan.

– Individual Market
  • Beginning no later than March 1, 2013, employers must notify employees of the existence of the exchange, how to receive a tax subsidy for the exchange, and the fact that the employee will forfeit employer contributions if they enroll in the exchange (other than as required by a free choice voucher).
  • Your employees participation in exchange interacts with the following Employer Responsibility Requirements:
    – Free Choice Voucher
    – Pay or Play (if they are eligible for a tax subsidy).
Employer Responsibility Requirements

- What are they?
- When do they apply?
- How will they impact our current coverage decisions?

Auto Enrollment

- Effective when regulations are issued
- Employers with 200+ full-time employees who offer coverage to full-time employees must
  - Enroll all new full-time employees in “one of the plans offered”
  - Continue the enrollment of existing full-time employees
    - What about existing full-time employees who are not enrolled?
  - Must provide notice of right to opt out
  - Details, including effective date, subject to regulations.
Free Choice Vouchers

- Effective January 1, 2014
- Employers that offer minimum essential coverage and make a contribution must offer “free choice vouchers” to qualified employees for the purchase of qualified health plans through exchanges
- The free choice voucher must be equal to the contribution that the employer would have made with respect to the option for which the employer pays the largest portion
  - Based on level of coverage elected by the employee
- Employees qualify if their household income does not exceed 400% of the federal poverty level and required contribution under the employer’s plan would be between eight and 9.8 percent of their household income
  - Free choice vouchers are excludable from employees’ incomes (to the extent used for health care) and deductible by the employer
  - Excess employer contribution must be paid to employee as taxable compensation
  - Voucher recipients are not eligible for tax credits through the exchange

Pay or Play

- Effective January 1, 2014 - play or pay mandate #1
  - Applicable employers who fail to offer full-time employees minimum essential coverage must pay a penalty with respect to each full-time employee in any month in which any full-time employee receives a federal subsidy for the exchange
  - The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer (over 30) for that month and 1/12 of $2000
    - For example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount
Pay or Play

- Effective January 1, 2014 - play or pay mandate #2:
  - Even when coverage is extended, applicable employers who offer minimum essential coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such full-time employees who have received a tax subsidy and 1/12 of $3000 (capped at 1/12 of $2000 times the total number of full-time employees over 30 during such month)
    - Note: employees offered employer coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan’s share of allowed costs is less than 60%.

Miscellaneous Tax Issues

*And other fun stuff!!!!!!*
Small Employer Tax Credit

- Effective beginning 2010
- Notice 2010-44; Rev. Rul. 2010-13
- Small employers with less than 25 “full-time equivalent” employees (based on control group rules) and annual average wages below $50,000 are eligible for a tax credit equal to lesser of actual non-elective employer contributions or amount under plan with average premium in small group market (see Rev. Rul. 2010-13)
- Employers must contribute at least 50% of the cost (special rule for 2010)
- Credit amount is 35% through 2013; 50% thereafter
  - The credit amount begins to phase out for employers with more than 10 employees and/or more than 25,000 in average wages.
- Applies to most “health insurance” prior to 2014
  - Most excepted benefits qualify (other than those in 9832(c )(1))
- Applies only to small group market “exchange” coverage in 2014

Expanded Definition of Health Care Tax Dependent

- Effective March 30, 2010
- Amends definition of dependent in Code Section 105(b) (and 401(h), 501(c )(9))
  - Any “child” (as defined in IRC Sec. 151(f)) of participant who will not reach age 27 before the end of the year (through age 26) is considered a tax dependent for purposes of tax free health coverage
    - Child includes natural children of employee/spouse, step children, adopted children and foster children
  - No requirement that individual be a “tax dependent” for exemption purposes
    - “Basement dwelling”-children
    - Married children who reside with their spouses and receive no support from employee
- Plans affected
  - All 105(b) health plans (medical, vision, dental)
  - No impact on HSAs – just like GOZONE, further legislation required
  - Biggest impact on Health FSA/HRA coverage that defines dependent by reference to 105(b)
OTC Limitation

- Effective January 1, 2011
  - Applies to expenses incurred on or after January 1, 2011
- No reimbursement of OTC medicines or drugs (except insulin) by health FSA, HRA, or HSA that are not “prescribed”.
- See Notice 2010-59
- Applies only to “medicine or drugs” other than insulin
  - “generally accepted as falling within the category a medicine or drugs”
  - Clearly applies to aspirin, cold remedies, allergy medicine, etc
  - Does not apply to non-medical items (e.g., saline solution, bandages, etc)
  - Does not apply to insulin
- Prescription must meet applicable state law requirements
  - Imposes difficulty on substantiation
- Significantly impedes ability to purchase medicines or drugs with debit card
  - NO IIAS
  - May still be purchased at pharmacy that meets 90% requirement

W-2 Reporting

- Value of coverage reporting
  - Generally effective for coverage offered beginning January 1, 2011
  - Reported on W-2
  - Employers must calculate and report value of applicable employer sponsored coverage
    - Generally the COBRA amount of
      - Major medical
      - HSA contributions
      - On-site medical clinics
      - Medicare Supplemental Policies
    - Health FSA salary reductions not included!!!!!! (unclear as to why this is since they are included in Cadillac tax calculation).
Cadillac Plan Tax

- Beginning in 2018, PPACA (as modified by the Reconciliation Bill) imposes a 40 percent excise tax on:
  - "Coverage providers:" for the sum of months in which the aggregate value of employer-sponsored health coverage for the employee exceeds:
    - $1/12 of $10,200 for single coverage and $27,500 for family coverage
    - The higher family threshold applies to both single and family coverage offered under a multiemployer plan
    - These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
    - The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter
    - An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer’s age and gender demographics are not representative of a national average
    - The PPACA transition rule for high cost states does not apply
  - The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, longshoremen, construction workers, and miners), and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage

- Determined by the employer and assessed against “coverage providers”
- “Coverage providers” are defined to include the following:
  - In the case of fully insured plans, the health insurer
  - In the case of HSA or medical savings account (MSA) contributions, the employer making the contributions
  - In the case of a self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g., the TPA)
- In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (also includes HSA contributions)
  - The coverage provider’s applicable share of the tax will bear the same ratio to the total excess benefit as the cost of provider’s coverage to the total value of employer-sponsored coverage
Cadillac Plan Tax

- The coverage subject to the excise tax rule includes:
  - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee (except vision only insurance, dental insurance, accident and disability insurance, long-term care insurance, and after-tax funded hospital indemnity and/or specified disease coverage)
  - Both non-elective and salary reduction contributions to a health FSA
  - Employer contributions (presumably including salary reductions) to an HSA
Appendix 4
Health Plan Design for Optimal Financial Results in the Age of Health Care Reform (PPACA)

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PPACA Timeline

– 2010
  • Small employer tax credit
  • Early retiree reinsurance
  • Grandfather decision (will have to be made each year, as long as plan is grandfathered)
PPACA Timeline

- Grandfather decision
  - Maintain records on plan document and all amendments
  - Maintain records on employee premiums, co-pays, co-insurance, limits, etc.
  - Employee premiums, co-pays, co-insurance, limits etc. cannot rise faster than inflation plus nominal amounts. (This separately applied to each item, not aggregate.)
  - Limits on expansion of grandfathered plans to prevent “abuse.”

PPACA Timeline

- 2011 (First PY beginning on or after 9/23/10)
  - Cover children through age 26 (adult children with other available coverage*)
  - Limits on OTC benefits in FSA
  - W-2 reporting for cost of coverage (first report in 2012)
  - No lifetime limits / restricted annual limits on essential benefits
  - First $ coverage of preventive care *
  - No pre-existing condition exclusion below age 19
  - Limitations on rescission (note interesting definition of fraud)
  - Fully insured plans subject to non-discrimination rules (highly compensated) *
  - Claim procedure rules (independent medical review)*
  - Mental health parity (can eliminate – all in or all out)
  - Wellness program incentive can increase to 20% from 10%

* Does not apply to Grandfathered Plans
PPACA Timeline

– 2011 (First PY beginning on or after 9/23/10)
  • Minimum loss ratios for insured arrangements

– 2012
  • CER Fee ($1 / $2 per covered life)

* Does not apply to Grandfathered Plans

PPACA Timeline

• 2013
  • Loss of Medicare Part D retiree subsidy deduction
  • $2500 cap on FSA salary reductions (indexed)
  • Increase in employee portion of Medicare Tax (.9% over $200,000 / $250,000 for joint filers)
  • 3.8% tax on net investment income on high income individuals
PPACA Timeline

• 2014
  – “Individual mandate”
  – Employer pay or play requirement
  – Auto-enrollment
  – Employer Coverage Reporting (first report in 2015 for 2014)
  – Free Choice Vouchers
  – Exchange (State responsibility / Federal if not State)

PPACA Timeline

• 2014
  – No pre-existing coverage exclusion at any age
  – Waiting period no more than 90 days
  – No annual limits on essential benefits
  – Deductible not to exceed $2,000 ($4,000 family) indexed / Max out of pocket
  – Wellness increases to 30% (possibly 50%)
  – Premium limitations (age, tobacco use, etc.)
PPACA Timeline

• 2014
  – Guaranteed availability / renewability (applies to insurers)
  – Small group fully insured plans must provide essential benefits*
  – Coverage of clinical trials*
  – No discrimination against health care providers (e.g., Chiropractors) *
    – Sector tax on health insurers

• 2018
  – “Cadillac Plan” excise tax
    – (Will never happen – see “doc fix”)
Individual “Mandate” - 2014

- Individuals to have “minimum essential coverage” for themselves and their dependents
- Tax of $695 per year or less (note restrictions on collection by IRS – possibly not collectible if individual owes no income tax).
- Not applicable if household income < 12.5 times cost (to individual) of coverage

Vouchers

- Employers must offer “free choice vouchers” to employees for the purchase of health plans through exchanges
- Equal to the employer contribution (or subsidy)
- Exception: household income does exceed 400% of the federal poverty level
- Only if: employee contribution under employer’s plan is between 8% and 9.8% of household income
Employer Mandate – 2014

Applies to:

- Employers with 50 or more FTEs
- PT employees count based on hours / 120 per month (only for whether penalty applies, not for calculation of the amount of penalty)
- Certain exceptions for seasonal employees who work < 120 days per year
- Controlled group rules apply (combine related employers)

Sledgehammer Penalty

- If one FT employee does not have offer of minimum essential coverage
- If one FT employee who is not eligible for coverage purchases insurance on an exchange and receives a tax credit
- Penalty = $2,000 times # of FT Employees minus 30

Example

- Galactic Business Machines (GBM) has 300,000 employees
- GBM offers insurance to 299,999 employees
- The last employee (Sam) purchases insurance on exchange and receives a tax credit
- Penalty = 299,970 times $2,000 = (approx) $600 million
- GBM wishes it had offered coverage to Sam!
Tackhammer Penalty

- Where coverage is offered to all FT employees
- Cost to employee of coverage exceeds 9.5% of household income or employer subsidy is less than 60% of cost of coverage.
- FT Employee enrolls in exchange and receives tax subsidy.
- Penalty to Employer is $3,000 per year for that employee
- Capped at Sledgehammer penalty.
- Employer pays no penalty for employee if:
  - Household income > 4 x poverty (about $40,000 for individual, $88,000 for family of 4)
  - Employee chooses not to purchase coverage on the exchange
  - Employee is covered by Medicare, Medicaid, spouse’s plan, parents’ plan, other employer’s plan, etc.

Example

- Galactic Business Machines offers coverage to Sam at high price; he goes to the exchange and obtains coverage with a subsidy.
- Tackhammer penalty = $3,000, not $600 million.
PPACA Economics

• Reasons for insurance
  – Spreading risk (not really)
  – Negotiated discounts (overcharging the uninsured)
• Reasons for employer sponsored insurance
  – Many employers have business reasons for wanting their employees to be insured
    • Avoid unionization
    • Company cultural imperatives
    • High value workforce
    • Impact on productivity
    • Public relations / government relations
  – Complex purchasing decision / most individuals incapable of evaluating
  – Anti-selection makes individual insurance excessively expensive
  – Tax advantages (FICA / income tax exclusion)
  – Sledgehammer penalty / tackhammer penalty reduce money available for wages

PPACA Economics

• Employees will trade wages for insurance
  – Some employees will trade more than dollar for dollar
  – Some employees place little or no value on insurance and will not accept lower wages in exchange for insurance
  – Net effect: somewhere in-between. Probably less than $1; much more than zero.
PPACA Economics

- Many employees will choose not to purchase employer insurance if the price is high enough, and will not purchase subsidized exchange insurance either
  - Cultural factors: some groups simply do not purchase health insurance
  - Coverage is available elsewhere (spouse, parent)
  - Covered by Medicare / Medicaid
  - Can’t afford it, even with subsidy

Single Employee (Poverty Line $10,830)

<table>
<thead>
<tr>
<th>Salary</th>
<th>25,000</th>
<th>40,000</th>
<th>60,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium (annual)</td>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Credit toward purchase on exchange</td>
<td>(3,155)</td>
<td>(109)</td>
<td>0</td>
</tr>
<tr>
<td>Cost to Employee</td>
<td>1,845</td>
<td>4,891</td>
<td>5,000</td>
</tr>
<tr>
<td>Penalty for not buying insurance</td>
<td>534</td>
<td>695</td>
<td>695</td>
</tr>
<tr>
<td>Penalty to Employer *</td>
<td>3,000</td>
<td>3,000</td>
<td>0</td>
</tr>
</tbody>
</table>

* if employee buys on exchange
### Employee + 3 (Poverty Line $22,050)

<table>
<thead>
<tr>
<th></th>
<th>40,000</th>
<th>60,000</th>
<th>90,000</th>
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</thead>
<tbody>
<tr>
<td>Salary</td>
<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Premium (annual)</td>
<td>(9,740)</td>
<td>(6,706)</td>
<td>0</td>
</tr>
<tr>
<td>Cost to Employee</td>
<td>2,260</td>
<td>5,294</td>
<td>12,000</td>
</tr>
<tr>
<td>Penalty for not buying insurance</td>
<td>635</td>
<td>1,135</td>
<td>1,885</td>
</tr>
<tr>
<td>Penalty to Employer *</td>
<td>3,000</td>
<td>3,000</td>
<td>0</td>
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</tbody>
</table>

* if employee buys on exchange

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### Tactical Issues

- No family coverage – charge for employee, ee+1, ee+2, etc. There should be an incremental charge for each dependent.
- Cover *ALL* full time employees / no worker misclassification.
PPACA Strategy

• The optimal strategy will vary from employer to employer depending on business goals and employee demographics.
• No coverage will rarely if ever be the optimal strategy because of the $2,000 penalty.
• Collection of data is critical.

Sample Strategy 1 – High Employee Premium

• Convert a portion of premium increase to wage increase.
• Will be more competitive compensation package for healthy employees, less competitive for unhealthy.
• Employees with large subsidies move to exchange.
• Anti-selection against exchange works for employer.
• Will leave many employees uninsured.
Sample Strategy 1 – High Employee Premium

Example – Consolidated Refined Amalgamated Products (“Consolidated”)

- Consolidated has 10,000 hourly employees, with typical wage of $25,000 to $40,000.
- Before PPACA Consolidated did not offer insurance to hourly employees.
- After PPACA, Consolidated charges $5,000 per year to hourly employees for health insurance.

Sample Strategy 1 – High Employee Premium

Example – Consolidated Refined Amalgamated Products (“Consolidated”)

- 3,000 Employees elect employer coverage at $5,000
  - Cost to Consolidated: $6 million
- 3,500 choose to be uninsured
- 1,500 add coverage through spouse or parent
- 1,000 are on Medicare or Medicaid
- 1,000 purchase subsidized insurance on an exchange
  - Cost to Consolidated (tack hammer penalty): $3 million
- Total cost to Consolidated: $9 million
- Compare to sledgehammer penalty: $20 million
Sample Strategy 2 – Good Coverage / Low Employee Premium

- Take advantage of reduction in anti-selection / tax advantages to deliver value to employees.
- No tax or penalty “wedge” between employer cost and employee receipt of wages / benefits.
- Probably good strategy for highly paid workforce with low turnover and cohesive culture.

For Additional Information

http://www.alston.com/tax_employee/

Click on “Highlight” or “Publications”
TAB D
By now, employer/plan sponsors should be well underway in examining their current group health plan documents to ensure compliance with the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). This article will refer to the two bills collectively as “PPACA” or just “health care reform.”

Health care reform includes a number of provisions that will have a significant impact on employer sponsored group health plans. Some of these provisions are effective immediately, while others become effective later (in some cases, as late as 2014 for the “pay or play” tax or 2018 for the “Cadillac tax”). The key to complying with the health care reform requirements is understanding what applies to your plan and when.

To help you understand your obligations as an employer/plan sponsor, we have provided a suggested “Implementation Chart” which includes a discussion of the soon to apply health coverage “mandates” as they relate to covered group health plans, and suggested required and recommended implementation steps. This chart does not purport to be an exhaustive list, and there are other aspects of health care reform not addressed herein – e.g. “Cadillac tax or “pay or play” mandates.
<table>
<thead>
<tr>
<th>Insurance Reform (PHSA §)</th>
<th>Rule</th>
<th>Notes and Actions</th>
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</thead>
</table>
| **Prohibition on lifetime/annual limits** § 2711(a) | Prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from establishing lifetime limits and annual limits on the dollar value of benefits. Caps on annual benefits for essential health benefits are allowed until 2014 as follows:  
  - $750,000 for plan years beginning on or after 09/23/2010, but before 09/23/2011  
  - $1.25 million for plan years beginning on or after 09/23/2011, but before 09/23/2012  
  - $2 million for plan years beginning on or after 09/23/2012, but before 09/23/2013 | **Required action:**  
  - Eliminate all lifetime dollar maximums that apply generally to all benefits.  
  - Ensure that generally applicable annual dollar maximums are within the phase-out allowance.  
  - Eliminate combinations of dollar/treatment maximums (e.g., “up to 10 visits per year capped at $50 per visit” is akin to a $500 annual limit)  
  **Recommended action:**  
  - Consider removing lifetime and annual limits for any individual benefit until further guidance on “essential” benefits is released; and/or  
  - Convert dollar limits on specific benefits to treatment visit limits. |
<p>| <strong>Prohibition on preexisting condition exclusion of enrollees under age 19</strong> § 2704 | Group health plans and health insurance issuers offering group or individual coverage may not impose a preexisting condition exclusion or discriminate based on health status | <strong>Required action:</strong> Remove all pre-existing condition exclusions for enrollees (employees and their dependents) under age 19. |</p>
<table>
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<tr>
<th>Insurance Reform (PHSA §)</th>
<th>Rule</th>
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</table>
| Prohibition on rescissions § 2712 NGF | • Group health plans and health insurance issuers may not rescind health coverage (i.e., retroactively cancel) after coverage begins except in the case of fraud or intentional misrepresentation.  
• Thirty (30) day advanced notice required for all rescissions to all individuals whose coverage is affected by the rescission.  
• Rescission is now an “adverse benefit determination” subject to claims procedures.  
• Coverage for concurrent care must continue during any appeals process.  
• Prospective cancellation of coverage or retroactive cancellation for failure to promptly pay premiums are not rescissions (i.e., no notice required and not subject to claims procedures) | Notes  
• Prospective cancellation of coverage is not a rescission.  
• In the event of failure to elect or pay for COBRA coverage position can be taken that coverage is terminated for non-payment of premium; thus rescission rules would not apply. |
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<th>Insurance Reform (PHSA §)</th>
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<td>Required action:</td>
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<td>Absent fraud or intentional misrepresentation as prohibited by the plan, remove all rescissions, including those for:</td>
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<td>- Discovery of an ineligible dependent or former spouse upon a dependent audit.</td>
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<td>- Mistaken enrollment (e.g., enrolled employee’s regularly scheduled work hours fall below plan eligibility level).</td>
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<td>- Any eligibility failure based on retroactive eligibility determinations (e.g., union employees covered if they worked at least one hour during the month, but eligibility determination is not made until the close of the month).</td>
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<td>- Any other rescission not involving fraud or intentional misrepresentation.</td>
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<td>If rescission due to fraud or intentional misrepresentation is enforced, provide 30 days advanced notice to affected individuals.</td>
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<td>Adhere to claims procedures, as rescission is an adverse benefit determination (including the requirement to continue with concurrent care).</td>
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<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
<td>Notes and Actions</td>
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<td>Recommended action:</td>
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<td>Establish a mechanism whereby the plan can show fraud or intentional misrepresentation for coverage of an ineligible spouse/dependent. For example, require re-designation of all spouses and dependents at open enrollment each year and prior to dependent audits. Allow “amnesty” period prior to dependent audit to allow violators to voluntarily come forward in exchange for prospective termination of coverage.</td>
</tr>
</tbody>
</table>
| Coverage of adult children§ 2714 NGF | • Dependent coverage of adult children must continue until age 26.  
• “Child” who has not attained age 26 cannot be defined other than in terms of a relationship between a child and the participant (e.g., no limitations based on marital, employment, student, residency or tax dependent status).  
• Rule applies to ANY “child” regardless of whether they are a 152(f) child (i.e., son, daughter stepchild, adopted child, or eligible foster child) (pending further guidance) | Notes:  
This requirement is not tied to the new 105(b) rule that incorporates 152(f) children until the end of the year in which they attain age 26. Consequently, coverage of ANY child (e.g., grandchild, any child living with you for whom you support) must apparently be extended free from most limitations like student or marital status, etc. Many have commented on this issue and future guidance is expected.  
The rule does not apply to excepted benefits like health FSA, dental, and vision (i.e., covered under a separate policy of insurance or not an integral part of the medical plan). |
<table>
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<tr>
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<td><strong>Required action:</strong></td>
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<td>• Raise limiting age for children to 26.</td>
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<td>• Check plan definition for “dependent” to ensure it is not tied to a section of the code that may violate the rules (e.g., 152).</td>
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<td>• Remove all eligibility limitations for any child under age 26 except to define the relationship between the child and participant, including references to such child as a “tax dependent”, or to such child’s marital, student, employment, or residency status.</td>
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<td>• Check all plan/SPD provisions that may be affected (e.g., dependent eligibility is often repeated in sections regarding termination of coverage and COBRA).</td>
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<td><strong>Recommended action:</strong></td>
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<td>Check health FSA definition for dependent and amend to correspond with new 105(b) rules (i.e., 152(f) children until the end of the year in which they attain age 26). Health FSAs technically are not subject to PPACA, but health plan participants will expect their covered dependents to be eligible for health FSA coverage.</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
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</table>
| Coverage of preventive care (without cost sharing) § 2713 | • Group health plans and health insurance issuers offering group or individual health insurance coverage must cover certain preventive services, immunizations, and screenings, without any cost sharing  
• If required preventive care is covered 100% in-network, cost sharing is permitted for preventive care sought out-of-network.  
• Recommendations and guidelines for preventive care services that must be covered are described in the regulations (and in the July 27 A&B Advisory on Preventive Care) and will be updated at [http://www.HealthCare.gov:center/regulations/prevention.html](http://www.HealthCare.gov:center/regulations/prevention.html).  
• Plans and issuers need not make changes to coverage and cost-sharing requirements based on a new recommendation or guideline until the first plan year (in the individual market, policy year) beginning on or after the date that is one year after the new recommendation or guideline went into effect. Plans or issuers need to visit the site just once annually to have access to all the information necessary to determine any changes to the preventive care coverage requirements. | **Required action:**  
Ensure that all preventive care requirements listed in the regulation are covered 100% for the January 1, 2011 plan year. |
| | **Recommended action:**  
Have administrator or insurer confirm that all preventive care requirements posted on HHS website are covered. Note that aspirin, folic acid, and iron supplements are likely covered as preventive care, so review these requirements with your prescription drug plan to determine whether these drugs and supplements will be covered under the prescription drug plan or medical plan. |
<table>
<thead>
<tr>
<th>Insurance Reform (PHSA §)</th>
<th>Rule</th>
<th>Notes and Actions</th>
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</thead>
<tbody>
<tr>
<td>Claims appeal procedures § 2719</td>
<td>• GHPs (and insurers offering group or individual health coverage) must comply with existing DOL claims procedures, as modified by PPACA regulations, and comply with any applicable State external review process meeting minimum federal standards. &lt;br&gt; • Fully-insured plans can have only one level of appeals review; self-insured plans can still have two levels. &lt;br&gt; • Claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. (E.g., no compensation or promotion decisions based upon the likelihood that the individual will support a denial of benefits.) &lt;br&gt; • Plans/issuers must “strictly adhere” to new claims procedures; failure to do so triggers deemed exhaustion of procedures, allowing claimant to pursue external review and/or judicial review. &lt;br&gt; • Interim External Review Safe Harbor for self-insured plans: Establish external review procedures that comply with Technical Release 2010-01 or, if access is permitted by the state, comply with state external review. &lt;br&gt; • Interim External Review Safe Harbor for insured plans: HHS will not take any enforcement action against an issuer that complies with the interim compliance method that will be detailed by HHS at <a href="http://www.hhs.gov/ociio/">http://www.hhs.gov/ociio/</a>. This method will either involve use of a State external appeals process or a temporary process established by HHS. &lt;br&gt; • Disclosure/SPD requirements expected in future guidance.</td>
<td>Required Action: &lt;br&gt; For covered plans, apply PPACA regulatory changes to existing DOL claims procedures: &lt;br&gt; • Include rescissions in definition of “adverse benefit determination”. &lt;br&gt; • Review of urgent care must be changed from 72 hours to 24 hours. &lt;br&gt; • Remove second level appeals for fully-insured options/plans. &lt;br&gt; • Allow claimant to provide “testimony” and provide claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim. &lt;br&gt; • Provide claimant with rationale for the decision. &lt;br&gt; • Update communications based on new model notices for adverse benefit determinations and appeals decisions available at <a href="http://www.hhs.gov/ociio/">http://www.hhs.gov/ociio/</a>. &lt;br&gt; • Do not provide any incentives to adjudicators to deny claims. &lt;br&gt; • For self-insured plans and insurers without access to an existing state review process, arrange for external review in accordance with requirements.</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
<td>Notes and Actions</td>
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<td><strong>Recommended Action:</strong> Consider whether to conform review process for non-covered plans (vision, dental, FSA, etc). Watch for further guidance related to SPDs and until further guidance is available, reference the availability of external procedures in SPDs. Include notice that external review may be pursued concurrently with internal review of urgent claims and concurrent care claims in the SPD.</td>
</tr>
<tr>
<td>Patient protections: choice of primary care provider §2719A GF</td>
<td>• Group health plans and insurers offering group or individual health coverage that require or provide for designation by a participant, beneficiary, or enrollee of a participating primary care provider, must permit the designation of any participating primary care provider (or pediatrician in the case of a child) who is available to accept the participant, beneficiary, or enrollee. • Must provide direct access to obstetrical or gynecological care without a referral. • Model language is set forth in the regulation for such notices (and in the June 29 A&amp;B Advisory on Core Interim Requirements).</td>
<td><strong>Required action:</strong> • If designation of a PCP is required or provided, then incorporate the model language into the SPD. • Remove contrary provisions in the plan (e.g., any referral requirements for OB/GYN)</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
<td>Notes and Actions</td>
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</tr>
<tr>
<td>Patient protections:</td>
<td>Emergency services (defined by regulation) must be provided:</td>
<td></td>
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<tr>
<td>emergency services</td>
<td>• without the need for any prior authorization</td>
<td></td>
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<tr>
<td>without prior</td>
<td>determination, even for out-of-network emergency care</td>
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<tr>
<td>authorization and out-</td>
<td>(although “notice” is permitted).</td>
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<tr>
<td>of-network charges</td>
<td>• without regard to whether the emergency care provider</td>
<td></td>
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<tr>
<td>§2719A</td>
<td>in- or out-of-network.</td>
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<tr>
<td>GF</td>
<td>• without imposing any administrative requirement or</td>
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<td></td>
<td>limitation on out-of-network coverage that is more</td>
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<td>restrictive than those applied to in-network emergency</td>
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<td>coverage.</td>
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<td>“Notice” can be required, even at the time of or prior</td>
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<td>to receipt of emergency services, in exchange for a</td>
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<td>lower coinsurance rate or waiving a copay.</td>
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<td>Cost sharing for emergency services provided out-of-</td>
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<td>network cannot exceed those charged for in-network</td>
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<td>emergency services, although participant can be</td>
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<td>balance-billed if the emergency services exceed a</td>
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<td>reasonable amount.</td>
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<td></td>
<td>Plans/insurers must pay “reasonable” amount for out-of-</td>
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<td></td>
<td>Required Action:</td>
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<tr>
<td></td>
<td>• Eliminate all disparate financial requirements/cost-</td>
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<tr>
<td></td>
<td>sharing between in-network and out-of-network emergency</td>
<td></td>
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<tr>
<td></td>
<td>services.</td>
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<tr>
<td></td>
<td>• Eliminate all precertification-type requirements</td>
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<td>from emergency services, including for mental health/</td>
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<td>substance abuse.</td>
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<td>• Ensure that any administrative requirement for</td>
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<td>out-of-network emergency services is the same as those</td>
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<td>for in-network (e.g., post-emergency services “notice”</td>
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<td></td>
<td>requirement for out-of-network should not be 24 hours</td>
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<td></td>
<td>if in-network emergency services notice requirement is</td>
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<td></td>
<td>48 hours).</td>
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<td>• For actual payment of emergency services, plan</td>
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<td>must pay the “reasonable” amount.</td>
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<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
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| network emergency care, which means the greatest of (excluding any in-network cost sharing):  
  - The negotiated rate for in-network;  
  - The amount for emergency services using the same method the plan uses for determining other out-of-network amounts (e.g., usual and customary; reasonable amount); or  
  - The amount Medicare would pay. | **Recommended action:**  
  - Define emergency services in the plan to correspond to regulatory definition. Ambulance services for non-emergency purposes would not be required to be included.  
  - Eliminate terminology such as “precertification” or “prior authorization” from emergency service benefit requirements (even if functionally these are post-service notice requirements) and replace with post-emergency services “notice” requirement.  
  Explain in SPD what “reasonable amount” is based on for purposes of “balance billing”. |
<table>
<thead>
<tr>
<th>Insurance Reform (PHSA §)</th>
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</thead>
<tbody>
<tr>
<td>Limitation on waiting periods §2708 NGF</td>
<td>Prohibits any waiting periods that exceed 90 days for group health plans and group health insurance coverage</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Guaranteed renewability of coverage (applicable to health insurance issuers) §2703 GF</td>
<td>Requires guaranteed renewability of coverage regardless of health status, utilization of health services, or any other related factor. Coverage can only be cancelled under specific, enumerated circumstances.</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
<td>Notes and Actions</td>
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</tr>
<tr>
<td>Fair health insurance premiums (limits factors that can be used to determine premiums) §2701</td>
<td>Health insurance issuers may not charge discriminatory premium rates. The rate may vary only by whether such plan or coverage covers an individual or family, rating area, actuarial value, age, and tobacco use.</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Guaranteed availability of coverage (applicable to health insurance issuers) §2702</td>
<td>Health insurance issuers in both the individual and group markets must accept every employer and individual in the State that applies for coverage, but are permitted to limit enrollment to annual open and special enrollment periods for those with qualifying lifetime events.</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
<td>Notes and Actions</td>
</tr>
<tr>
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</tr>
<tr>
<td>Nondiscrimination based on health status&lt;br&gt;§2705&lt;br&gt;GF</td>
<td>Retains the HIPAA nondiscrimination provisions for group health plans and group health insurance issuers. Specifically, plans and group health insurance issuers may not set eligibility rules based on factors such as health status and evidence of insurability – including acts of domestic violence or disability. Provides limits on the ability of plans and issuers to vary premiums and contributions based on health status. The Affordable Care Act adds new provisions regarding wellness programs.</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Prohibition on discrimination against providers&lt;br&gt;§2706&lt;br&gt;GF</td>
<td>Prohibits discrimination by group health plans and health insurance issuers against health care providers acting within the scope of their professional license and applicable State laws.</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Comprehensive health insurance coverage (requirement to provide essential benefits and OOP and deductible cost sharing provisions)&lt;br&gt;§2707&lt;br&gt;GF</td>
<td>Requires health insurance issuers in the small group and individual markets (and large group markets in State exchanges) to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all group health plans to comply with limitations on allowable cost sharing. <strong>NOTE</strong>: Self-insured plans and large insured plans will not have to provide essential benefits, even if it loses grandfather plan status.</td>
<td>Awaiting future guidance.</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Rule</td>
<td>Notes and Actions</td>
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<tr>
<td>Participation in clinical trials §2709*</td>
<td>Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.</td>
<td>Awaiting future guidance.</td>
</tr>
</tbody>
</table>

* Due to drafting errors, there are two sections 2709 of the PHSA after PPACA. The section referred to in the table is a new section. The other section 2709 (relating to disclosure of information) is renumbered from prior law PHSA section 2713. Grandfathered plans remain subject to the pre-PPACA requirements that are still in effect.
TAB E
<table>
<thead>
<tr>
<th>Insurance Reform (PHSA §)</th>
<th>Effective Date (in individual market, policy year is used instead of plan year)</th>
<th>Notice Description</th>
<th>Applicable to Grandfathered Plans</th>
</tr>
</thead>
</table>
| Early Retiree Reinsurance Program (ERRP)  
§ 1102 of PPACA | Effective for plans participating in ERRP for expenses incurred and reimbursed on or after June 1, 2010  
The Department of Health and Human Services (HHS) expects to provide the form notice to plan sponsors in September 2010.  
HHS will also provide instructions on the manner and timing of sending the notices. | The plan sponsor must provide a form notice to plan participants notifying them that, because the plan is participating in the PPACA Early Retiree Reinsurance Program, the plan may use payments to reduce premium contributions, co-payments, deductibles, co-insurance or other out-of-pocket costs and therefore that plan participants may experience such changes in the terms and conditions of their plan participation. | Yes |
| Grandfather plan status  
§1251 of PPACA  
Note: Notice required to maintain status as a grandfathered plan | Effective for plan years beginning on or after September 23, 2010 | To maintain status as a grandfathered health plan, a plan must include a statement in any plan materials describing the benefits provided under the plan and provided to a participant or beneficiary, that the plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Care Act and the notice must provide contact information for questions and complaints*  
* Applicable regulations contain model language for this disclosure | Yes |
| Prohibition on preexisting condition exclusion  
§ 2704 of PHSA | First plan year beginning on or after September 23, 2010 for individuals under age 19; first plan year beginning on or after January 1, 2014 for other individuals | No separate notice required. Plan amendment/SMM may be required. | Group—Yes  
Individual-- No |
<table>
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<tr>
<th>Insurance Reform (PHSA §)</th>
<th>Effective Date (in individual market, policy year is used instead of plan year)</th>
<th>Notice Description</th>
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<tbody>
<tr>
<td>Prohibition on lifetime limits</td>
<td>§ 2711(a) of PHSA</td>
<td>This notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010 for any individual whose coverage or benefits ended due to reaching a lifetime limit and who becomes eligible for benefits not subject to the lifetime limits by reason of PPACA.</td>
<td>Eligible individuals who lost coverage on reaching a plan’s lifetime dollar limit must receive a written notice stating that the limit no longer applies and the plan must give such individual a one-time, 30-day special enrollment opportunity.</td>
</tr>
<tr>
<td>Restricted/prohibited annual limits</td>
<td>§ 2711(b) of PHSA</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>“Restricted” annual limits are permitted until 2014; for plan years beginning on or after January 1, 2014, no annual limits are permitted.</td>
</tr>
<tr>
<td>Prohibition on rescissions</td>
<td>§ 2712 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Plans cannot retroactively terminate coverage except in cases of fraud or intentional misrepresentation. A plan that rescinds coverage must give affected individuals at least 30 days’ advance written notice.</td>
</tr>
<tr>
<td>Coverage of preventive care (without cost sharing)</td>
<td>§ 2713 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>No separate notice required. Plan amendment/SMM may be required.</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Effective Date (in individual market, policy year is used instead of plan year)</td>
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<tr>
<td>Coverage of adult children § 2714 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010;</td>
<td>A plan must give an adult dependent child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent.</td>
<td>Yes; for grandfathered plans, coverage is required before 2014 only if the child is not eligible for other employer coverage (other than through parents)</td>
</tr>
<tr>
<td>Uniform Explanation of Coverage § 2715 of PHSA</td>
<td>Summary must be provided beginning no later than March 23, 2012</td>
<td>Still awaiting regulatory guidance</td>
<td>Yes</td>
</tr>
<tr>
<td>Notice of Material Modification § 2715 of PPACA</td>
<td>Unclear</td>
<td>The plan must give enrollees at least 60 days’ advance notice if a plan makes any material modifications in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage.</td>
<td>Yes</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
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<tr>
<td>Provision of additional information (transparency requirements) § 2715A of PHSA</td>
<td>First plan year beginning on or after September 23, 2010 (under the statute, the additional information is first required in connection with the Exchanges that must be operational by January 1, 2014)</td>
<td>Still awaiting regulatory guidance Plans must provide certain government agencies and the public with information related to enrollment and disenrollment, claims payments, denials, processing and appeals. Information must be available to the public and provided in “plain language” which means language that the intended audience, including individuals with limited English proficiency, can readily understand.</td>
<td>No</td>
</tr>
<tr>
<td>Nondiscrimination rules for insured plans §2716 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Still awaiting regulatory guidance</td>
<td>No</td>
</tr>
<tr>
<td>Certain reporting requirements (“Ensuring Quality of Care”) § 2717 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010 Agencies must develop reporting requirements by March 23, 2012</td>
<td>Still awaiting regulatory guidance Plans must annually file a report and provide enrollees a notice describing quality-of-care initiatives, including wellness programs, and health-improvement activities</td>
<td>No</td>
</tr>
<tr>
<td>Bringing down the cost of health coverage (minimum medical loss ratio) §2718 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Still awaiting regulatory guidance</td>
<td>Yes (provision applies to insured plans only)</td>
</tr>
<tr>
<td>Insurance Reform (PHSA §)</td>
<td>Effective Date (in individual market, policy year is used instead of plan year)</td>
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</tr>
<tr>
<td>Claims appeal procedures § 2719 of PHSA</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Enrollees whose claims are denied must receive notices about the plan’s procedures for internal appeals and external reviews of such decisions.*</td>
<td>No</td>
</tr>
<tr>
<td>Patient protections (choice of primary care provider and emergency services without prior authorization) §2719A of PHSA</td>
<td>First plan year beginning on or after September 23, 2010 whenever the plan provides a participant an SPD or other similar benefit description</td>
<td>Plans must provide notice to participants to (i) choose a primary care provider or pediatrician when a plan or issuer requires designation of a primary care physician, or (ii) obtain obstetrical or gynecological care without prior authorization. The notice must be provided whenever the plan or insurer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.*</td>
<td>No</td>
</tr>
<tr>
<td>Over-the-counter medications § 9003 of PPACA</td>
<td>Applies after December 31, 2010 Design enrollment materials and SPD and other communications to reflect this change</td>
<td>Recommend separate communication in 4th Quarter to allow participants to purchase over the counter medicines or drugs before the 1/1/2011 deadline</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Insurance Reform  
(PHSA §) | Effective Date  
(in individual market, policy year is used instead of plan year) | Notice Description | Applicable to Grandfathered Plans |
|-----------------|-------------------------------------------------|-------------------|-----------------------------------|
| W-2 health coverage reporting  
§ 9002 of PPACA | For tax years beginning on or after January 1, 2011 | Employers must report the value of each employee’s health coverage on Form W-2, the annual wage and tax statement | Yes |
| Auto-Enrollment Notice  
§ 1511 of PPACA | Notice required beginning March 1, 2013 for newly hired employees (no later than March 1, 2013 for existing employees) | Still awaiting regulatory guidance  
Employers covered under the Fair Labor Standards Act (FLSA) that have more than 200 full-time employees and sponsor group health plans must automatically enroll employees and provide them auto-enrollment notices with an opportunity to opt-out of health coverage. | Yes |
| Exchange Related Reporting  
§ 1512 of PPACA | Reporting required beginning March 1, 2013 for newly hired employees (no later than March 1, 2013 for existing employees) | Still awaiting regulatory guidance  
Notice must inform employees about i) the new health insurance Exchange, ii) how to qualify for a premium subsidy through the Exchange, and loss of employer’s contribution for health coverage if an employee enrolls in a plan through the Exchange. | Yes |
| Employer “Pay or Play” Reporting  
§ 1514 of PPACA | Beginning in calendar year 2014, “applicable large employers” (employers who employ on average of at least 50 employees or employers that require employees to pay more than 8% of wages for coverage) must file an annual report with the IRS describing health coverage. | Still awaiting regulatory guidance  
No later than January 31 of the year after the annual report is filed, employees covered under the report must receive a notice with details reported on their coverage. | Yes |
<table>
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</thead>
<tbody>
<tr>
<td><strong>Notice of High-Cost Coverage</strong>&lt;br&gt;§ 9001 of PPACA</td>
<td>Beginning in calendar year 2018</td>
<td>Still awaiting regulatory guidance&lt;br&gt;Any employer sponsoring “high-cost coverage” triggering PPACA’s 40% excise tax must notify the IRS and the health insurer (for insured coverage) or plan administrator (for self-insured coverage) and provide information on each party’s associated tax liabilities.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
TAB F
New Group Health Plan Internal Claims and Appeals and External Review Procedures Created By PPACA

On July 23, 2010, the U.S. Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) (collectively, the “Agencies”) jointly issued interim final regulations (“Interim Regulations”) regarding internal appeals and external claim review procedures (“Claims Review Rules”) for fully insured and self-funded group health plans and insurance policies issued in the individual market. These new requirements were included in new Section 2719 of the Public Health Service Act (PHSA), as added by the Patient Protection and Affordable Care Act (PPACA), and were incorporated into ERISA and the Internal Revenue Code. In this advisory, we address the new Claims Review Rules as applied to group health plans.

The new Claims Review Rules are generally effective for plan years beginning on or after September 23, 2010. However, as discussed below, on September 20, 2010, the Department of Labor issued Technical Release 2010-2, which announced an enforcement grace period until July 1, 2011, for certain of the new Claims Review Rules.

The new Claims Review Rules apply only to non-grandfathered group health plans otherwise subject to the health insurance reforms added by PPACA. Thus, the Claims Review Rules do not apply to the following plans:

- health plans that are grandfathered plans;
- health plans that constitute “excepted benefits” as defined by HIPAA’s portability rules (e.g., most health flexible spending arrangements (FSAs), vision and dental plans);
- plans with less than two current employees participating in the plan on the first day of the plan year (e.g., stand-alone retiree-only plans); or
- non-health plans, such as disability and retirement plans.

The new Claims Review Rules establish both internal and external claims review procedures. We address each in turn.

A. Internal Review Procedures

The Interim Regulations clarify that group health plans must establish an “effective” internal claims review process. As a threshold matter, group health plans must comply with all of the requirements currently applicable to ERISA-covered group health plans as set forth in 29 C.F.R. 2560.503-1 (the “ERISA Claims Rules”), without regard to whether ERISA applies or not (e.g., nonfederal governmental plans). In addition, the Interim Regulations augment existing ERISA requirements by requiring the new internal claim review procedure requirements as described below. DOL Technical Release 2010-02 provides an enforcement grace period until July 1, 2011, for requirements 2, 5 and 6 below:
1. Expansion of the definition of adverse benefit determination. The definition of “adverse benefit determination” is broadened to include rescissions of coverage (as defined by new PHSA Section 2712 and applicable regulations).

**Practice Pointer:** The interim final regulations issued by the Agencies with regard to rescissions define a rescission as any retroactive cancellation of coverage other than a termination of coverage for non-payment of premiums. A rescission is permitted only in the case of fraud or intentional misrepresentation of a material fact. If a plan is otherwise permitted to rescind coverage, it must provide 30 days’ advance notice.

2. Reduction in time frame for urgent claims. A group health plan must notify a claimant of an urgent care benefit determination as soon as possible, taking into account the medical exigencies—but not later than 24 hours after the receipt of the claim by the group health plan. This is a change from the ERISA Claims Rules, which allow up to 72 hours to determine an urgent care claim. All other requirements of the ERISA Claims Rules applicable to claims involving urgent care continue to apply.

**Practice Pointer:** A claimant with a claim involving urgent care may be entitled to file an expedited external appeal even if the claimant has failed to exhaust the internal review procedures. See “External Appeals” below for more information.

3. Full and Fair Review. Plans must allow the claimant to review the claim file and present evidence and testimony. More specifically, the group health plan must:

- provide the claimant, free of charge, with any new additional evidence relied upon, considered or generated by the group health plan in connection with the claim sufficiently in advance of the due date of the notice of final adverse benefit determination (as set forth in the ERISA Claims Rules) to give the claimant a reasonable opportunity to respond; and

  - if a final adverse benefit determination is based on new or additional rationale, provide the claimant with the rationale, free of charge, sufficiently in advance of the due date of the notice of the final adverse benefit determination (as set forth in the ERISA Claims Rules) in order to give the claimant a reasonable opportunity to respond.

**Practice Pointer:** Must the plan allow in-person testimony? Although not clear, it would not appear that a plan must allow the claimant to present testimony in person; plans should be permitted to limit testimony to written testimony.

4. Avoidance of conflicts of interest. Generally, the group health plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence or impartiality of the persons involved in making the decision.

**Example:** A group health plan cannot provide bonuses based on the number of denials by a claims adjudicator. Similarly, a group health plan cannot contract with a medical expert based on the expert’s reputation for outcomes in contested cases (rather than based on the expert’s professional qualifications).
5. Notices. Notices of adverse benefit determinations must not only satisfy the current requirements set forth in the ERISA Claims Rules, but the notices must also satisfy the following additional requirements:

- A group health plan must provide denial notices in a culturally and linguistically appropriate manner. If the plan covers less than 100 participants at the beginning of the plan year, the plan is considered to comply with this requirement if it provides notices, upon request, in a language in which 25 percent or more of its participants are literate (only in the same non-English language). If the plan covers 100 or more participants at the beginning of the plan year, the plan is considered to comply with this requirement if it provides notices, upon request, in a language in which the lesser of 500 or more participants or 10 percent of all participants are literate (only in the same non-English language).

  **Practice Pointer:** If the threshold requirements described above are met, then the notice must include a statement in the applicable non-English language offering to provide the notice in the non-English language. If an individual requests that notices be provided in the non-English language, all subsequent notices must be provided in the non-English language. In addition, any customer assistance processes (such as a telephone hotline) would need to provide assistance in the non-English language.

- In addition, a group health plan must ensure that any notice of adverse benefit determination include information sufficient to identify the claim involved, including:
  - the date of service, the health care provider and the claim amount;
  - the diagnosis code (such as an ICD-9 or ICD-10 code), the treatment code (such as a CPT code), the denial code and the corresponding meaning of the such codes;
  - the standard used in denying the claim (e.g., if a plan applies a medical necessity standard in denying a claim, the notice must include a description of the medical necessity standard);
  - in the case of a final internal adverse benefit determination, a discussion of the decision;
  - description of the internal and external appeals review processes; and
  - the contact information for any applicable office of health insurance consumer assistance.

The Agencies have issued model notices that can be used to satisfy all of the notice requirements.

You can find the model adverse benefit determination at [http://www.dol.gov/ebsa/IABDMModelNotice2.doc](http://www.dol.gov/ebsa/IABDMModelNotice2.doc).

You can find the model final internal adverse benefit determination at [http://www.dol.gov/ebsa/IABDMModelNotice1.doc](http://www.dol.gov/ebsa/IABDMModelNotice1.doc).

6. Strict Adherence. If a group health plan fails to strictly adhere to all of the internal claims and appeals process requirements, the claimant is deemed to have exhausted the internal claims and appeals process regardless of whether the group health plan asserts that it substantially complied with these requirements or that any procedural error committed was inconsequential. Upon a group health plan’s failure to strictly adhere to the internal claims and appeals process, the claimant may initiate an external review and pursue any available remedies under ERISA 502(a).
7. **Continued Coverage.** A group health plan must provide continued coverage pending the outcome of an internal appeal. This means that a group health plan must comply with the requirements set forth in 29 C.F.R. 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advanced notice and an opportunity for advanced review. For ERISA-covered plans, this is not a new requirement.

**Practice Pointer:** Some have misconstrued this language to impose a coverage continuation requirement for all claims. When this requirement is read in context, it merely imposes the existing ERISA concurrent care requirement on all plans (whether ERISA applies or not).

**B. External Review Requirements**

Group health plans and health insurers must comply with either a state or federal external review process. The Interim Regulations provide a basis for determining which process applies. Ultimately, an applicable state process and the federal process will incorporate, at a minimum, the consumer protection provisions of the Uniform Health Carrier External Review Model Act promulgated by the NAIC (the “Model Act”). Currently, however, as described below, the Agencies have issued interim and transition guidance that does not necessarily incorporate all the Model Act provisions. The Model Act may be found at [http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf](http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf). The Interim Regulations also contain a description of the Model Act provisions.

With respect to plans utilizing the federal external review process, the external review applies to all adverse benefit determinations and final internal adverse benefit determinations other than those determinations based solely on the individual’s eligibility to participate in the plan. With respect to plans utilizing a state external review process, the scope of external review may be narrower as it is determined by the state review process. According to the Interim Regulations, the NAIC model requirement with respect to scope of review is that the state process must provide for “the external review of adverse benefit determinations (including final internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer’s (or plan’s) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.”

**Practice Pointer:** Does the new external review process apply only to claims arising (i.e., incurred) after a plan’s PPACA effective date (e.g., January 1, 2011, for a calendar year plan), or would it arise with regard to any claims as long as it has not been finally adjudicated prior to the PPACA effective date? This issue is not clearly addressed in current guidance. Moreover, the prior DOL group health claims rules (adopted in 2001) specifically stated that the new claim rules only applied with respect to claims incurred after the effective date. Does the absence of such language mean that existing claims could take advantage of the external review process? The answer is unclear.

At least during the transition phase, the external review requirements will have more of an impact on self-insured plans, because such plans generally were not required to have an external review process before PPACA.
**Fully Insured Plans**

Under a transition rule, in the case of fully insured plans, the insurer must comply with the state external review process if the state has such a process in effect on September 23, 2010, regardless of whether that process complies with the Model Act. The Agencies have indicated that all but three states—Alabama, Nebraska and Mississippi—have external review processes in place, so that, with the exception of those states, the state external review process applies to fully insured plans (and to fully insured options under a plan).

**Practice Pointer:** If a plan is fully insured and a state external review applies, the insurer is responsible for complying with the state external review process and the plan has no obligation to comply with either the state or the federal review process.

The transition rule for state external review processes is effective for plan years beginning on or before July 1, 2011. However, for final adverse benefit determinations provided after the first day of the first plan year beginning on or after July 1, 2011, the federal external review process applies unless the otherwise applicable state external review process complies with the minimum consumer protections of the Model Act. HHS will be working with state insurance regulators during the transition period to help bring nonconforming state external review processes in line with the Model Act.

**Example:** Plan A in State X has a calendar year plan year. State X has an applicable external review process but State X’s external review process does not provide the minimum consumer protections set forth in the Model Act. Although the external review process in State X does not comply with the Model Act, the insurer of Plan A must comply with State X’s external review process until January 1, 2012. Beginning January 1, 2012, Plan A must comply with the federal external review process, unless the state external review process has been modified to comply with the consumer protection provisions of the Model Act.

Insurers in the states that do not have an external review process in effect on September 23, 2010, must comply with a federal external review process established by HHS. This process is administered by the Office of Personnel Management. The process may be found at [http://www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf](http://www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf).

**Self-Insured Plans Subject to ERISA**

Self-insured plans that are subject to ERISA must comply with the federal external review process.

**Practice Pointer:** The DOL has issued Technical Release 2010-01, which provides an interim enforcement safe harbor federal external review process. See “Federal External Review Process” below for a more detailed discussion.

Under the Technical Release, self-insured plans may either:

- Comply with the technical release, or
- Voluntarily comply with a state external review process, if the state has chosen to expand their process to self-insured plans.

The federal process incorporates some, but not all, of the consumer protection provisions in the Model Act. DOL has indicated that it will modify the federal external review procedures in the future to incorporate all the Model Act provisions. The federal process contains a standard review process, as well as an expedited review process. The Technical Release is applicable until further guidance is issued.

The requirements for the federal external review process are set forth in detail in Appendix A.

**Self-Insured Plans Not Subject to ERISA**

Self-insured plans that are not subject to ERISA, such as church plans and non-federal governmental plans, may be subject to state external review processes, because ERISA preemption provisions do not apply to such plans.
APPENDIX A

FEDERAL EXTERNAL REVIEW PROCESS

Interim Enforcement Safe Harbor for Self-Insured Plans Not Subject to an Existing State External Review


On August 23, 2010, the Department of Labor (DOL) issued a Technical Release that sets forth an interim safe harbor for non-grandfathered self-insured plans not subject to a state external review process, and therefore subject to the federal external review process. This interim enforcement safe harbor applies for plan years beginning on or after September 23, 2010, and until superseded by future guidance on the federal external review process that is being developed and will apply after this interim period.

During the period that the interim safe harbor is in effect, the DOL will not take any enforcement action against a self-insured group health plan that complies with either of the two compliance methods:

- **Compliance with the procedures outlined in Technical Release 2010-01.** Plans are deemed to comply with the external review process if they satisfy the procedures set forth in Technical Release 2010-01. These procedures are based on the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC Model Act) in place on July 23, 2010.

- **Voluntary compliance with state external review processes.** If a state chooses to expand access to their state external review process, self-insured plans may choose to voluntarily comply with the provisions of that state external review process.

**Technical Release 2010-01**

**Standard External Review**

This section sets forth procedures for standard external review for self-insured group health plans. Standard external review is external review that is not considered expedited (as described later in this section).

1. **Request for external review.** A group health plan must allow a claimant to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:
a) the claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

b) the adverse benefit determination or the final adverse benefit determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

c) the claimant has exhausted the plan’s internal appeal process unless the claimant is not required to exhaust the internal review appeals process under the interim final regulations; and

d) the claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to the claimant (which includes the claimant’s authorized representative). If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3372)). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the plan must allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization (IRO).** The group health plan must assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must ensure independence and take action against bias. Accordingly, plans must contract with at least three IROs for assignment under the plan and rotate claims assignment among them (or incorporate other independent, unbiased methods for selecting IROs). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide the following:

a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

b) The assigned IRO will timely notify the claimant in writing of the request’s eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any required information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.
d) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan’s internal claims and appeals process applicable under the interim final regulations under the Public Health Service Act (PHSA) Section 2719(b). In addition to the documents and information provided, the assigned IRO, to the extent information and documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   i) the claimant’s medical records;
   ii) the attending health care professional’s recommendations;
   iii) reports from appropriate health care professionals and other documents submitted by the plan or insurer, claimant or the claimant’s treating provider;
   iv) the terms of the claimant’s plan to ensure that the IRO’s decision is not contrary to the terms of the plan unless the terms are inconsistent with applicable law;
   v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
   vi) any applicable clinical review criteria developed and used by the plan, if the criteria are inconsistent with the terms of the plan or with applicable law; and
   vii) the opinion of the IRO’s clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the claimant and to the plan.

g) The assigned IRO’s decision notice must contain:
   i) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial);
   ii) the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

iv) a discussion of the principal reason or reasons for reaching its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

v) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to the claimant;

vi) a statement that judicial review may be available to the claimant; and

vii) current contact information, including the phone number, for any applicable office of health insurance consumer or assistance or ombudsman established under PHSA Section 2793.

h) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

4. Reversal of plan’s decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. Request for expedited external review. A group health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:

a) an adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth in paragraph 2 (”Preliminary Review”) of the Standard External Review section above. The plan must immediately send a notice that meets the requirements set forth in paragraph 2 (see “Preliminary Review”) of the Standard External Review section above to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth in paragraph 3 (”Referral to Independent Review Organization (IRO)”) of the Standard External Review section above. The plan must provide or transmit all necessary documents and information considered in
making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone, facsimile or any other available expeditious method.

- The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim *de novo* and is not bound by any decisions or any conclusions reached during the plan’s internal claims and appeals process.

**4. Notice of final external review decision.** The plan’s contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph 3 (“Referral to Independent Review Organization (IRO)”) of the *Standard External Review* section above, as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.
If you would like to receive future *Employee Benefits and Executive Compensation Advisories* electronically, please forward your contact information including e-mail address to *employeebenefits.advisory@alston.com*. Be sure to put “subscribe” in the subject line.

If you have any questions or would like additional information, please contact your Alston & Bird attorney or any one of the following:

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Health Care Reform Guidance Update: New Prescription Requirement for OTC Medicines and Drugs Will Impact Administration of FSAs, HRAs and HSAs; and Guidance on Waiver Process for “Mini-Med” Plans

On Friday, September 3, two new pieces of guidance were issued relating to requirements under the Patient Protection and Affordable Care Act (PPACA):

• The IRS issued Notice 2010-59 (the “OTC Notice”), which clarifies the limitation imposed by the PPACA on the eligibility of over-the-counter (OTC) drugs and medicines for tax-free reimbursement under an employer-sponsored health plan.

• The Department of Health and Human Services (HHS) issued guidance for employers regarding how to obtain a waiver from the restricted annual limits imposed under PPACA. The guidance is issued in the form of a memorandum posted on the HHS website at http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf.

This advisory addresses the impact that this guidance will have on group health plans and what actions need to be taken now in response to the guidance.

New Prescription Requirement for OTC Medicines and Drugs

Section 9003 of PPACA requires that, beginning January 1, 2011, OTC medicines and drugs (other than insulin) must be “prescribed” in order to qualify as “medical care” for purposes of employer-sponsored health plans (including Health FSAs and HRAs) and Health Savings Accounts (the “OTC Rule”).

This change will have a dramatic impact on the way that OTCs are purchased and used by individual consumers. Some are predicting that health care costs will increase as individuals schedule physician office visits to get “OTC prescriptions,” or alternatively, opt for more expensive “prescription-only” medications to ensure coverage under their plans. At a minimum, the OTC Notice has the potential to cause confusion for consumers as they seek to understand the new prescription requirement for OTCs under their health plans. Likewise, third party administrators (TPAs) must employ new procedures to ensure that the OTC prescription requirement is satisfied.
The OTC Notice answers a number of questions arising under the new OTC prescription requirement, including the following:

- When is a medicine or drug considered “prescribed”? In other words, is a physician’s recommendation enough, or must all of the requirements applicable under state law for a valid prescription be satisfied?
- What type of substantiation is required to ensure that a medicine or drug available OTC has actually been “prescribed”?
- How does the new OTC Rule’s effective date affect plans and employee FSA elections that are already in place (e.g., plans that have fiscal plan years or calendar year plans with grace periods)?
- How does the OTC Rule impact the use of health debit cards to purchase OTC medicines and drugs?

This alert provides an overview of the guidance included in the OTC Notice, and concludes with a synopsis of the impact on plan sponsors and TPAs.

**Understanding the New OTC Rule and the OTC Notice**

**The basic rule**

Section 9003 of PPACA provides that expenses for OTC drugs or medicines (other than insulin) incurred on or after January 1, 2011, will only be considered “medical care” for purposes of Code Sections 105 and 106 (health plans, including Health FSAs and HRAs), 220 (Medical Savings Accounts) and 223 (Health Savings Accounts) if they are “prescribed.”

**What is a medicine or drug?**

The determination as to whether a particular OTC item is a medicine or drug is important because the new rules do not apply to OTC medical supplies and equipment, such as contact lens solutions, bandages, crutches or durable medical equipment or diagnostic devices such as blood sugar test kits. Such OTC items may continue to be purchased without a prescription, and once such items are identified, currently compliant health debit card systems can continue to operate as they do today with respect to such items.

Unfortunately, the OTC Notice does not provide further guidance as to what is a “medicine or drug.” Existing guidance under IRS regulation 1.213-1(e)(2) is circular, providing that “medicine or drug” includes any items that are “generally accepted as falling within the category of medicine and drugs.” However, insulin is not a medicine or drug for purposes of this rule.

**When is a medicine or drug (other than insulin) considered “prescribed” for purposes of the OTC Rules?**

The OTC Notice clarifies that an OTC drug is considered prescribed for purposes of the new rule if the individual obtains a “prescription” for such medicine or drug (even though a prescription is not legally required to obtain the medicine or drug). A prescription is defined as an electronic or written order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred, and that is issued by an individual authorized to issue a prescription in that state.
Example #1: Bob lives in California. On January 2, 2011, Bob has a headache. He goes to his physician, who recommends that Bob take two aspirin and call him in the morning. Bob purchases a bottle of aspirin for $5.76. On January 3, 2011, he submits the receipt for aspirin to his FSA administrator. The FSA administrator must deny the claim because Bob did not obtain a prescription for the aspirin. A general physician recommendation (oral or otherwise) that does not satisfy state law will not qualify as a prescription.

Example #2: Same facts, except that Bob’s physician actually writes Bob a “prescription” for aspirin. Since the expense was incurred in California, the prescription must satisfy California’s requirements for prescriptions in order for the aspirin to be reimbursable. California requires, among other things, that the prescription identify the name and quantity of the drug, and that it be signed (if in writing) and issued by certain medical practitioners (e.g., a physician, physician assistant or nurse midwife). If all of the applicable state law requirements are satisfied, Bob can be reimbursed for the aspirin under his FSA plan.

Practice Pointer: The OTC Notice prerequisite that state law requirements for a prescription be satisfied is somewhat awkward in that it requires application of state rules for tax purposes that are NOT required to be satisfied for an individual to purchase a medication—since the medicine is available OTC, after all. Most TPAs are not accustomed to monitoring, and ensuring compliance with, the prescription rules applicable under each state’s laws. Nevertheless, the OTC Notice provides a substantiation solution that will ease administration of this otherwise burdensome compliance requirement. See “What substantiation is required for OTC drugs or medicines” below for more details.

What substantiation is required for OTC drugs or medicines (other than insulin)?
The OTC Notice indicates that proper substantiation is provided if the participant provides either of the following:

- a receipt from the pharmacy that identifies the purchaser (or the individual to whom the prescription was issued), the date, the amount and the Rx number; or

- any other “traditional” manual substantiating documentation without an Rx number (e.g., a sales receipt that identifies the medicine or drug, amount and date purchased), provided the prescription from an authorized issuer is provided.

The first method of substantiation, consistent with prior informal IRS advice, allows the TPA to use the Rx number as a proxy for eligibility under Section 213. Under the latter method, the participant can apparently pick up the OTC and pay for it at the front of the store with no pharmacist interaction, but then the burden falls on the TPA to ensure that the prescription satisfies the applicable requirements for a prescription in the state in which the expense was incurred. In either case, the physician must actually prescribe the drug, but in the latter case the prescription apparently need not be “filled” by a pharmacist.

Practice Pointer: TPAs may find it difficult, if not impossible, to track “prescription” requirements in each state. Therefore, many TPAs may decide to limit approved substantiation to a receipt from the pharmacy with the Rx number unless other ways to ensure that the prescription meets applicable state requirements can be found.
What is the impact of the OTC Notice on use of debit cards to purchase OTC drugs or medicines?

Currently, health debit card systems allow for the purchase of eligible medical expenses (including OTC medicines and drugs) under two alternate adjudication systems. First, arrangements that satisfy IRS requirements for point-of-sale adjudication (so-called “IIAS,” or Inventory Information Adjudication Systems) can be employed by any merchant, regardless of whether it is a health care merchant. Alternatively, certain merchants that qualify as “90% Merchants” can allow for health debit card use without an IIAS system. A 90% Merchant would include any drug store or pharmacy whose gross receipts for medical care (including eligible OTC items) during the prior taxable year did not equal or exceed 90 percent of the store’s gross receipts (determined on a location-by-location basis). As noted below, whether a merchant is a 90% Merchant or any other merchant that employs an IIAS compliant system makes a huge difference under the OTC Notice.

The OTC Notice states that current health debit card systems are “not capable of substantiating compliance with the [new OTC requirement].” As a result, the Notice concludes that health FSA and HRA debit cards may not be used to purchase OTC medicines or drugs on or after January 1, 2011 (subject to the January 15 transition period discussed below). These comments start with the premise that current IIAS arrangements are unable to determine whether a valid prescription was issued. However, the OTC Notice solicits comments “on new designs for debit card systems that could provide substantiation that an over-the-counter medicine or drug was prescribed.” Thus, an electronic debit card point-of-sale system (IIAS or otherwise) that requires proof that a valid prescription has been issued prior to releasing funds should be acceptable to IRS. More guidance on this issue would be welcome.

In the interim, participants may continue to use health debit cards for eligible OTC medical items other than medicines or drugs under an IIAS system. In addition, compliant cards can continue to be used at drug stores and pharmacies that qualify as 90% Merchants, since such stores are not currently required to substantiate medical items at the point of sale or otherwise use an IIAS system. Moreover, in determining whether a store is a 90% Merchant, otherwise eligible OTC medicines and drugs continue to count as eligible medical expenses, regardless of whether a prescription has been issued.

Practice Pointer: The OTC Notice indicates that the IRS will not challenge the use of debit cards for OTC drugs and medicines through January 15, 2011, provided the other requirements set forth in the applicable debit card guidance (e.g., Notice 2006-69) are satisfied.

What is the effective date of the new OTC Rule?

The new rule applies for OTC medicines or drugs (other than insulin) incurred on or after January 1, 2011, without regard to the plan year of the plan. Thus, a plan with a fiscal plan year must begin complying with the rule mid-plan year.

Example: ABC sponsors a health FSA with an October 1 through September 30 plan year. Bob purchases Claritin on December 1, 2010, without a prescription. He submits his reimbursement request and is subsequently reimbursed. On January 2, 2011 (same plan year), Bob again purchases Claritin without a prescription. He submits his request for reimbursement, but this time, it is denied because he did not obtain a prescription.

1 See IRS Notice 2006-69.
2 See IRS Notice 2007-2 for more information on the 90% rule.
Can Bob change his health FSA election as a result of the new rule? Although the OTC Notice does not specifically address election changes, a literal interpretation of the existing change rules and recent, informal remarks from Treasury officials would suggest that Bob could not change his election solely as a result of the rule change.

Also, expenses for OTC drugs and medicines incurred during the two-and-a-half-month grace period following the end of a 2010 calendar plan year must be accompanied by a prescription.

OTC drugs purchased prior to January 1, 2011, may be reimbursed tax-free on or after that date. Thus, if an HSA participant purchases OTC drugs or medicines in 2010 without a prescription, but does not take an HSA distribution for such expenses until 2011, the distribution in 2011 is still tax-free (so long as the expenses were otherwise for medical care).

Do cafeteria plans and HRAs need to be amended?
The OTC Notice states that plans that previously covered OTC drugs or medicines must be amended to reflect the new OTC Rule. Fortunately, the OTC Notice allows plans to be retroactively amended effective January 1, 2011 (or January 15, 2011, with regard to debit card purchases), so long as the amendment is adopted no later than June 30, 2011.

What Steps Should Be Taken at This Time In Light of the New OTC Rule?
Even though the new OTC Rule is not effective until January 1, 2011, plan sponsors and administrators should take steps now to ensure a smooth transition. Steps to undertake include:

- communicating the new OTC Rule to participants prior to 2011 enrollment (and likely again in December) to ensure that participants take the new OTC Rule into consideration when making their new elections;
- checking with TPAs and health debit card processors to ensure that OTC medicines and drugs will not be reimbursed starting January 1, 2011 (January 16 for health debit card purchases eligible for the transition rule), unless the prescription requirement is satisfied;
- implementing new processes and procedures to ensure that every claim for an OTC medicine or drug has a valid Rx number or an accompanying prescription that satisfies all of the requirements of state law; and
- adopting plan amendments (prior to January 1, 2011, if possible) to implement the new OTC Rule.

Application Process for Waiver from Restricted Annual Limits
Section 2711(a)(2) of the Public Health Service Act (PHSA) as added by PPACA provides that for plan years beginning on or after September 23, 2010, and before January 1, 2014, group health plans may impose “restricted” annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of PPACA) as determined by the Secretaries of HHS, Labor and Treasury (collectively, the “agencies”). For plan years beginning on or after January 1, 2014, no annual dollar limits on essential benefits may be imposed. These rules apply to grandfathered group health plans, as well as new group health plans.
“Restricted” Annual Benefits and Limited Benefit Plans

The maximum "restricted" annual dollar limit that may be imposed on essential benefits was set forth in interim final regulations (IFR) published by the agencies on June 28, 2010, as follows:

– For plan years beginning on or after September 23, 2010, but before September 23, 2011—$750,000;
– For plan years beginning on or after September 23, 2011, but before September 23, 2012—$1.25 million; and
– For plan years beginning on or after September 23, 2012, but before January 1, 2014—$2 million.

These annual limitations are problematic for a class of health plans that provides limited coverage, typically referred to as “limited benefit” plans or, sometimes, “mini-med” plans. These plans are used by employers to provide some form of low-cost health insurance to certain employees, such as part-time employees and seasonal workers. For such employees, a “limited benefit” plan or “mini-med” plan may be the only affordable health coverage available to the employee. Applying the annual limits to such plans could mean that the coverage is no longer affordable, and could result in a loss of coverage. [Note: Mini-med plans should not be confused with limited hospital indemnity and specified disease coverages, which often are completely exempt from PPACA as excepted benefit coverage.]

In recognition of this issue, the IFR provided that these restricted annual limits may be waived by the Secretary of HHS if compliance with the IFR would result in a significant decrease in access to benefits or a significant increase in premiums. The preamble to the IFR further provided that guidance from HHS regarding the scope and process for applying for such a waiver would be issued in the near future. The memorandum issued by HHS on September 3, 2010 (the “HHS memorandum”), provides such guidance.

The HHS memorandum does not provide details about the standards that will be applied in determining whether waivers are granted; for example, the memorandum does not indicate what the HHS will consider to be a “significant” increase in premiums. The HHS memorandum does, however, set forth the timing for applications, the information that must be included and deadlines by which HHS will process the applications.

Waiver Process

What plans are eligible for the waiver?
Waivers are available only for plans that were in existence before September 23, 2010.

When does the waiver application have to be submitted?
For plan years beginning before November 2, 2010, the waiver application must be submitted at least 10 days in advance of the start of the year. Otherwise, the application must be submitted at least 30 days before the beginning of the plan year.

3 The regulatory agencies have not yet defined “essential health benefits.” In the absence of further guidance, the agencies have stated that for enforcement purposes, the agencies will take into account good faith efforts to comply with a reasonable interpretation of the statute.

4 The restrictions on annual dollar limits do not apply to grandfathered individual market policies.
When will HHS process the waiver application?
HHS will process complete requests generally within 30 days of receipt, but for plan years beginning before November 2, 2010, HHS will process the application no later than five days in advance of the year.

If granted, for how long will a waiver apply?
Waivers will be granted initially only for the first plan year beginning between September 23, 2010, and September 23, 2011. New waiver applications must be submitted for later years and HHS may change the approval process in the future.

What information must be included in the application?
The application must include the following information:

• the terms of the plan for which a waiver is sought;
• the number of individuals covered by the plan;
• the annual limit(s) and rates applicable to the plan;
• a brief description of why compliance with the IFR on annual limits would result in a significant decrease in access to benefits for those currently covered by the plan, or significant increase in premiums (or contributions in the event of a self-funded plan) paid by those covered by the plan, along with any supporting documentation; and
• an attestation, signed by the plan administrator or chief executive officer of the issuer of the coverage, certifying (1) that the plan was in force prior to September 23, 2010; and (2) that the application of restricted annual limits to the plan would result in a significant decrease in access to benefits for those currently covered by the plans, or a significant increase in premiums paid by those covered by the plan. The plan administrator or CEO should retain documents in support of the application for potential examination by HHS.

This advisory was written by John Hickman, Ashley Gillihan and Carolyn Smith.
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Agencies Outline Preventive Care Coverage Requirements under PPACA

The Departments of Health and Human Services (HHS), Treasury and Labor (collectively the “Agencies”) issued interim final regulations (“Regulations”) on July 14, 2010, regarding the new preventive care coverage requirements set forth in new Public Health Service Act (PHSA) Section 2713, as added by the Patient Protection and Affordable Care Act (PPACA). This rule is effective for plan years beginning on or after September 23, 2010, and it affects all plans that are not grandfathered health plans. The following is an overview of the Regulations.

Recommended Preventive Services

Generally, group health plans that are not “grandfathered health plans” must cover, by the applicable effective date (see “Applicable Effective Date” below for more detail), and waive all cost-sharing requirements (See “Cost Sharing Requirements” below for more details) for the following “recommended preventive services”:

- Evidence-based items or services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF. The Regulations note that HHS is developing these guidelines and expects to issue them no later than August 1, 2011. Recommendations of the USPSTF regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current under the regulations.

The complete list of recommendations and guidelines that must be covered by plans is located at http://www.HealthCare.gov/center/regulations/prevention.html (the “List”) and will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines. You will find the current list in Appendix A attached to this overview.

Plans are not required to provide coverage (or waive cost-sharing) for any item or service that ceases to be a recommended preventive service, such as if the USPSTF downgrades a recommended preventive service from
a rating of “B” to a rating of “C” or “D.” Likewise, plans may provide coverage for items and services in addition to those included in the recommendations and guidelines (and such services may be subject to cost sharing).

NOTE: The Regulations provide that a plan or issuer may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive services, to the extent such specifications are not specifically included in the relevant recommendations or guidelines.

Applicable Effective Date

Non-grandfathered plans must cover the recommended preventive services beginning with plan years beginning on or after September 23, 2010. However, for recommendations or guidelines that went/go into effect after September 23, 2009, specified services must be covered for plan years that begin on or after the date that is one year after the date the recommendation or guideline was/is issued.

Cost Sharing Requirements

Generally, cost sharing for network providers with respect to “recommended preventive services” is prohibited. “Cost sharing,” for purposes of these rules, includes deductibles, co-payments and coinsurance. Cost sharing is permitted for any item or service that ceases to be a recommended preventive service or for services or treatments in addition to those included in the specified recommendations. Also, the Regulations indicate that a plan may impose cost-sharing requirements for a treatment not included in the specified recommendations, even if the treatment results from a recommended preventive service. Finally, the regulations clarify that nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for a required preventive care item or service to the extent not specified in the recommendation or guideline.

Example: Child A visits an in-network pediatrician for a preventive care screening. As a result of the preventive care screening, the pediatrician recommends that Child A undergo surgery for a heart disorder. Because the preventive care screening is a recommended preventive service, the plan cannot impose a cost sharing requirement. However, the plan may impose a cost sharing requirement for Child A’s heart surgery, which resulted from the preventive care screening.

Furthermore, the Regulations clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit:

- Cost sharing with respect to the office visit is prohibited if . . .
  - the primary purpose of the office visit is the recommended preventive service and the recommended preventive service is NOT billed separately (or tracked separately as individual encounter data).

Example: Child B covered by a group health plan visits an in-network pediatrician to receive an annual physical exam that is a recommended preventive service. During the office visit, the child receives additional items and services that are not recommended preventive services. The provider bills the plan for the office visit. Because the primary purpose for the office visit was to provide recommended preventive services, and the plan was not billed separately for the recommended preventive services, the plan may not impose a cost-sharing requirement with respect to the office visit.
Cost sharing with respect to the office visit *is permitted* if . . .

– the recommended preventive service is billed separately from the office visit (or is tracked separately as individual encounter data). Although cost sharing with respect to the office visit is permitted, cost sharing with respect to the separately billed/tracked recommended preventive service is not permitted.

**Example:** Joe, who is covered by a group health plan, visits an in-network health care provider. While visiting the provider, Joe is screened for cholesterol abnormalities with a rating of A or B (i.e., recommended preventive services). The provider bills the plan separately for the office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the separately billed laboratory work of the cholesterol screening test. However, the plan may impose cost-sharing requirements for the office visit since it was billed separately from the recommended preventive service.

– the preventive service is *not* billed separately (or is not tracked as individual encounter data separately) from an office visit but the primary purpose of the office visit is *not* the delivery of such an item or service.

**Example:** Bob visits his network provider for abdominal pain. During the visit, he has a blood pressure screening that is a recommended preventive service. The provider bills the plan for the office visit (i.e., there is not a separate bill for the blood pressure screening). The plan may impose cost sharing on the office visit because the primary purpose of the office visit was not the delivery of a recommended preventive service.

**Impact on Network Plans**

The Regulations clarify that a network-based plan is not required to provide coverage for recommended preventive services delivered by an out-of-network provider and may impose cost-sharing requirements for any such out-of-network services that are offered.

*This advisory was written by Keavney Klein and Elinor Hiller of the Health Care Legislative & Public Policy Group and Ashley Gillihan, Anne Tyler Hamby, John Hickman and Carolyn Smith of the Employee Benefits and Executive Compensation Group.*
Grade A and B Recommendations of the United States Preventive Services Task Force:

- Screening for abdominal aortic aneurysm
- Counseling to reduce alcohol misuse
- Screening for anemia
- Aspirin to prevent CVD: men
- Aspirin to prevent CVD: women
- Screening for bacteriuria
- Screening for blood pressure
- Counseling for BRCA screening
- Screening for breast cancer (mammography)
- Chemoprevention of breast cancer
- Counseling for breast feeding
- Screening for cervical cancer
- Screening for chlamydial infection: non-pregnant women
- Screening for chlamydial infection: pregnant women
- Screening for cholesterol abnormalities: men 35 and older
- Screening for cholesterol abnormalities: men younger than 35
- Screening for cholesterol abnormalities: women 45 and older
- Screening for cholesterol abnormalities: women younger than 45
- Screening for colorectal cancer
- Chemoprevention of dental caries
- Screening for depression: adults
- Screening for depression: adolescents
- Screening for diabetes
- Counseling for diet
- Supplementation with folic acid
- Screening for gonorrhea: women
- Prophylactic medication for gonorrhea: newborns
- Screening for hearing loss
- Screening for hemoglobinopathies
- Screening for hepatitis B
- Screening for HIV
- Screening for congenital hypothyroidism
- Iron supplementation in children
- Screening and counseling for obesity: adults
- Screening and counseling for obesity: children
- Screening for osteoporosis
- Screening for PKU
- Screening for Rh incompatibility: first pregnancy visit
- Screening for Rh incompatibility: 24-28 weeks gestation
- Counseling for STIs
- Counseling for tobacco use: adults
- Counseling for tobacco use: pregnant women
- Screening for syphilis: non-pregnant persons
- Screening for syphilis: pregnant women
- Screening for visual acuity in children

Recommended Immunizations (compilation of vaccines on all required schedules):

- Hepatitis B
- Rotavirus
- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Pneumococcal
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Varicella
- Hepatitis A
- Meningococcal
- Human Papillomavirus
- Zoster

Recommendations for Preventive Pediatric Health Care:

- History (Initial/Interval)
- Measurements (Length/Height and Weight; Head Circumference; Weight for Length; Body Mass Index; Blood Pressure)
- Sensory Screening (Vision/Hearing)
- Developmental/Behavioral Assessment (Developmental Screening; Autism Screening; Developmental Surveillance; Psychosocial/Behavioral Assessment; Alcohol and Drug Use Assessment)
- Physician Examination
- Procedures (Newborn Metabolic/Hemoglobin Screening; Immunization; Hematocrit or Hemoglobin; Lead Screening; Tuberculin Test; Dyslipidemia Screening; STI Screening; Cervical Dysplasia Screening)
- Oral Health
- Anticipatory Guidance

SACHDNC Recommended Uniform Screening Panel CORE CONDITIONS:

- Propionic academia
- Methylmalonic acidemia (methylmalonyl-CoA mutase)
Methylmalonic acidemia (cobalamin disorders)
- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- 3-Hydroxy-3-methylglutaric aciduria
- Holocarboxylase synthase deficiency
- β-Ketothiolase deficiency
- Glutaric acidemia type I
- Carnitine uptake defect/carnitine transport defect
- Medium-chain acyl-CoA dehydrogenase deficiency
- Very long-chain acyl-CoA dehydrogenase deficiency
- Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency
- Trifunctional protein deficiency
- Argininosuccinic aciduria
- Citrullinemia, type I
- Maple syrup urine disease
- Homocystinuria
- Classic phenylketonuria
- Tyrosinemia, type I
- Primary congenital hypothyroidism
- Congenital adrenal hyperplasia
- S, S disease (Sickle cell anemia)
- S, β-thalassemia
- S, C disease
- Biotinidase deficiency
- Classic galactosemia
- Severe Combined Immunodeficiencies
- Cystic fibrosis
- Hearing loss

SACHDNC Recommended Uniform Screening Panel SECONDARY CONDITIONS:
- Methylmalonic acidemia with homocystinuria
- Malonic acidemia
- Isobutyrylglycinuria
- 2-Methylbutyrylglycinuria
- 3-Methylglutaconic aciduria
- 2-Methyl-3-hydroxybutyric aciduria
- Short-chain acyl-CoA dehydrogenase deficiency
- Medium/short-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency
- Glutaric acidemia type II

- Medium-chain ketoacyl-CoA thiolase deficiency
- 2,4 Dienoyl-CoA reductase deficiency
- Carnitine palmitoyltransferase type I deficiency
- Carnitine palmitoyltransferase type II deficiency
- Carnitine acylcarnitine translocase deficiency
- Argininemia
- Citrullinemia, type II
- Hypermethioninemia
- Benign hyperphenylalaninemia
- Bioperin defect in cofactor biosynthesis
- Bioperin defect in cofactor regeneration
- Tyrosinemia, type II
- Tyrosinemia, type III
- Various other hemoglobinopathies
- Galactoepimerase deficiency
- Galactokinase deficiency
- T-cell related lymphocyte deficiencies
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Departments Issue Core Interim Regulations

On June 22, 2010, the U.S. Departments of Treasury, Labor and Health and Human Services jointly issued another set of interim final regulations ("Interim Regulations"), this time implementing the provisions of the Patient Protection and Affordable Care Act (PPACA) on preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions and patient protections. For group health plans and group health insurance coverage, the Interim Regulations are effective for plan years beginning on or after September 23, 2010 (except for preexisting condition exclusion limitations for individuals 19 or older, which apply for plan years beginning on or after January 1, 2014). The regulations reiterate that the requirements relating to preexisting condition exclusions, lifetime and annual limits, and rescissions apply to grandfathered group health plans (in certain cases, compliance is not required by grandfathered health plans that are individual health insurance coverage). The rules relating to patient protections, however, do not apply to grandfathered health plans. While the Interim Regulations also address individual health insurance coverage, this advisory is limited to the rules as they apply to group health plans and group health insurance coverage. For convenience, the term “group health plans” is used in this advisory to refer to both group health plans and group health insurance coverages. Comments on the Interim Regulations are due 60 days after publication in the Federal Register (June 28, 2010).

Practice Pointer: As with all of the health insurance reforms that were added to Title 27 of the PHSA, these rules do not apply to “excepted” benefits as defined in PHSA 2791(c).

NOTE: The DOL has recently provided helpful links to the following:

- Regulations

- Fact Sheet

- Lifetime limits model notice
  http://www.dol.gov/ebsa/lifetimelimitmodelnotice.doc

- Patient protection model notice
  http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc

They have even provided a model enrollment notice for adult children under age 26, which you can find at http://www.dol.gov/ebsa/dependentsmodelnotice.doc.
Prohibition on Preexisting Condition Exclusions

PPACA prohibits group health plans from denying coverage based on an applicant’s preexisting condition. Essentially adopting the existing HIPAA definition, the Interim Regulations define preexisting condition exclusion as a benefit limitation or exclusion or denial of coverage based on the fact that the condition was present before the effective date of group health plan coverage (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. It includes benefit limitations or exclusions as a result of health conditions identified through a pre-enrollment questionnaire or physical examination, or review of medical records relating to the pre-enrollment period. A benefit limitation or exclusion is not a preexisting condition exclusion, however, if it applies regardless of when the condition arose relative to the effective date of coverage.

The prohibition on preexisting exclusions is effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans), with respect to individuals who are under age 19. For all other individuals, the prohibition on preexisting condition exclusions is effective for plan years beginning on or after January 1, 2014. In the interim, HIPAA’s current preexisting condition exclusion and limitation rules apply.

Example: A group health plan provides benefits through an insurance policy issued by Issuer A. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer B. B’s policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy. This is a preexisting condition exclusion because it excludes benefits based on the fact that the condition was present before the effective date of coverage under the policy. For individuals under age 19, this provision is impermissible starting with plan years beginning on or after September 23, 2010.

Lifetime and Annual Dollar Limits

PPACA generally prohibits group health plans from imposing lifetime or annual limits on the dollar value of “essential health benefits.” This prohibition applies to group health plans, without regard to their grandfathered status, for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans), except that “restricted annual limits” on essential health benefits are allowed for plan years beginning before January 1, 2014. PPACA’s prohibition on lifetime and annual dollar limits does not prohibit a complete exclusion of benefits for any particular condition (although other laws, such as the Americans With Disabilities Act, might), but if coverage is provided to any extent with respect to a condition, PPACA’s annual and lifetime dollar limit rules apply.

Practice Pointer: Only essential health benefits are subject to these rules. Plans may impose per beneficiary, lifetime and annual limits on non-essential health benefits.
What Are Essential Health Benefits?

PPACA defined “essential health benefits” to include, but not be limited to, the following categories and items and services covered within the 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; and pediatric services, including oral and vision care. No guidance has been issued to date regarding which other benefits qualify as “essential health benefits.” Until guidance is issued, the regulators have stated that for plan years beginning before additional guidance is issued, they will take into account consistent and good faith efforts to comply with a reasonable interpretation of the term “essential health benefits.”

Practice Pointer: An interpretation of the term “essential health benefits” is not reasonable or consistent if a plan applies a lifetime limit to a particular benefit—thus taking the position that it is not an essential health benefit—and at the same time treats that particular benefit as an essential health benefit for purposes of applying the restricted annual benefit.

Restricted Annual Limits on Essential Health Benefits

The Interim Regulations adopt a three-year phase-in approach for restricted annual limits on essential health benefits. Annual limits on the dollar value of essential health benefits may not be less than the following amounts per individual for plan years beginning before January 1, 2014:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011
- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012
- $2 million for plan years beginning on or after September 23, 2012, but before September 23, 2013

Practice Pointer: While not specifically addressed in the regulations, a non-monetary limitation (e.g., a limitation on the number of days or incidences of treatment) seems to be permissible under these rules. For example, plans could, instead of an annual maximum on hospitalization, limit the number of hospital visits covered under the plan.

The Interim Regulations specifically exempt health flexible spending arrangements (FSAs) as defined in Code Section 106(c)—which may also include many health reimbursement arrangements (HRAs) where the benefit is less than five times the value of coverage. In addition, the preamble to the Interim Regulations states that the annual limit rules do not apply to Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs) or retiree-only HRAs. Also, when HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual limit restriction, the fact that benefits under the HRA by itself are limited does not violate the annual limit restriction. Despite the exemption for “health flexible spending arrangements,” the preamble specifically requests comments regarding application of these rules to stand-alone HRAs that are not retiree-only plans.
**HHS Waivers:** The preamble notes that for plan years beginning before January 1, 2014, the Department of Health and Human Services (HHS) may establish a program under which a waiver may be provided to plans with non-compliant annual limits if compliance with the annual limit requirements would result in a significant decrease in access to benefits under the plan or would significantly increase premiums for the plan. If established, this may provide much needed relief to so called “mini-med” plans that are otherwise subject to these lifetime and annual limit restrictions.

**Transition Rules**

For any individual whose coverage or benefits ended due to reaching a lifetime limit and who becomes eligible (or is required to become eligible) on the first day of the first plan year on or after September 23, 2010, for benefits not subject to lifetime limits by reason of PPACA, the plan is required to give the individual a written notice that the lifetime limit no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. In addition, if the individual is not enrolled, or if an enrolled individual is eligible but not enrolled in any benefit package under the plan, then the plan must also give such an individual at least 30 days in which to enroll. This notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage for individuals who enroll in this manner must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

An individual eligible for an enrollment opportunity must be treated as a HIPAA special enrollee. Specifically, the individual must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment, and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit.

**Prohibition on Rescissions**

PPACA prohibits a group health plan from rescinding health coverage except in the case of fraud or intentional misrepresentation of a material fact. The prohibition on rescissions applies to plans and insurers (including grandfathered plans) for plan years beginning on or after September 23, 2010.

The Interim Regulations define rescission as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance is not a rescission if it has prospective effect, or if it is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. The Interim Regulations also require that a group health plan provide at least 30 days’ advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group.

**Example:** Employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual C has coverage under the plan as a full-time employee. The employer reassigns C to a part-time position. Under the terms of the plan, C is no longer eligible for coverage. The plan mistakenly continues to provide health coverage to C. After a routine audit, the plan discovers that C no longer works at least 30 hours per week. The plan rescinds C’s coverage effective as of the date that C changed from full-time employee to part-time employee. In this example, the plan cannot rescind C’s coverage because there was no fraud or intentional misrepresentation of material fact.
Patient Protections

Background

PPACA imposes a set of three requirements relating to the choice of a health care professional and requirements relating to benefits for emergency services (collectively referred to as “patient protections”). The patient protections apply to plans beginning in plan years on or after September 23, 2010. None of the patient protections apply to grandfathered plans.

Choice of Health Care Professional

Generally, the requirements relating to choice of health care professionals apply only with respect to a plan with a network of providers. A plan or insurer that has not negotiated with any provider for the delivery of health care but merely reimburses individuals covered under the plan is not subject to the requirements relating to the choice of a health care professional. The patient protections provide that if a plan or insurer requires designation by a participant of a participating primary care provider, then the plan or insurer must permit such individual to designate any participating primary care provider who is available to accept the participant. Similarly, if the plan or insurer requires designation of a primary care provider for a child by a participant, the plan or insurer must permit the designation of a pediatrician as the child’s primary care provider if the provider participates in the network of the plan or insurer and is available to accept the child. If a plan or insurer requires designation by a participant of a primary care provider or pediatrician, the plan or insurer must provide a notice informing each participant of the terms of the plan regarding such designation.

Plans or insurers that provide coverage for obstetrical or gynecological care and require the designation of an in-network primary care provider may not require authorization of referral by the plan, insurer or any person (including a primary care provider) for a female participant who seeks obstetrical or gynecological care. However, nothing precludes the plan or insurer from requiring an in-network obstetrical or gynecological provider to otherwise adhere to policies and procedures regarding referrals, prior authorization treatments and the provision of services pursuant to a treatment plan approved by the plan or insurer.

Notice

The Interim Regulations provide model language for providing notice to participants to (i) choose a primary care provider or pediatrician when a plan or issuer requires designation of a primary care physician, or (ii) obtain obstetrical or gynecological care without prior authorization. The notice must be provided whenever the plan or insurer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. The model language for the notice is as follows:
Model Language for Choice of Health Care Provider Notice

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Emergency Services

A plan or insurer providing emergency service benefits must do so without the individual or health care provider having to obtain prior authorization, and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. Generally, emergency services must be provided without regard to any other term or condition of the plan other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under ERISA, the PHSA or the Code, or applicable cost-sharing requirements. For a plan or insurer with a network of providers that provides benefits for emergency services, the plan or insurer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

The Interim Regulations define emergency services in accordance with the Emergency Medical Treatment and Labor Act (EMTLA) as, with respect to an emergency medical condition:

- a medical screening examination (as required under Section 1867 of the Social Security Act (42 U.S.C. § 1395dd)); and
such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under Section 1867 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.

**Emergency Services and Cost-Sharing**

The Interim Regulations impose certain cost-sharing requirements for emergency services. Cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. However, a participant may be required to pay (in addition to in-network cost-sharing) the excess of the amount of the out-of-network provider charges over the amount the plan or insurer is required to pay (so-called “balanced billing”), provided that the plan pays a reasonable amount.

In order to ensure that a plan pays a “reasonable amount” of the cost of emergency services, the Interim Regulations provide that a plan or insurer satisfies the copayment and coinsurance limits in the statute if it provides benefits for out-of-network emergency services in an amount equal to the greatest of the following three amounts:

(1) The amount negotiated with in-network providers for the emergency service furnished;

- If there is more than one negotiated amount for a particular emergency service, the median of these amounts is used. In this regard, each amount negotiated with each provider must be treated as a separate amount in determining the median. For example, if for a given emergency service a plan negotiated a rate of $100 with three providers, a rate of $125 with one provider and a rate of $150 with one provider, the amounts taken into account to determine the median would be $100, $100, $100, $125 and $150, and the median would be $100. If there is an even number of amounts, the median is the average of the middle two. Cost sharing imposed with respect to the participant is deducted from this amount before comparing with (2) and (3) below.

(2) The amount for the emergency service calculated using the same method the plan generally uses to determine payment for out-of-network services, but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions;

- This amount is determined without reduction for out-of-network cost-sharing. For example, if a plan generally pays 70 percent of the usual, customary and reasonable amount for out-of-network services, the amount for (2) for an emergency service is the total (i.e., 100 percent) of the usual, customary and reasonable amount for the service, not reduced by the 30 percent coinsurance (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

(3) The amount that would be paid under Medicare for the emergency service.
Example: A plan imposes a $60 copayment on emergency services without preauthorization, whether provided in network or out of network. If emergency services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition. In this example, by requiring an individual to pay more for emergency services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover emergency services without the need for any prior authorization determination.

For plans and health insurance coverage under which there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount in (1) above is disregarded, meaning that the greatest amount is going to be either the out-of-network amount or the Medicare amount.

The Interim Regulations impose an anti-abuse rule with respect to other cost-sharing requirements. Any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, may be imposed on out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits. The purpose of the rule is to prohibit a plan or health insurance coverage from structuring plan rules so as to require a participant to pay more for emergency services than for general out-of-network services.
If you would like to receive future Employee Benefits and Executive Compensation Advisories electronically, please forward your contact information including e-mail address to employeebenefits.advisory@alston.com. Be sure to put “subscribe” in the subject line.

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Summary of Interim Final Rules on Grandfather Provisions Under PPACA

Long-awaited regulations under the grandfather provisions of Section 1251 of the Patient Protection and Affordable Care Act (PPACA) were formally issued by the Departments of Health and Human Services, Treasury and Labor (the “agencies”) on June 14, 2010. The regulations are in the form of an interim final rule, and are effective immediately. They were published in the Federal Register on June 17, 2010. Comments on the regulations are due 60 days after publication in the Federal Register.

As anticipated, the regulations provide that certain changes to a grandfathered plan will result in loss of grandfathered status. However, what was not anticipated is how restrictive a view the agencies would take with respect to the types of changes that may be made without causing the loss of the grandfather. Indeed, it can be expected that most plans will lose grandfather status over time. The effect of losing grandfather status may vary on a plan-by-plan basis, and may depend on a variety of factors, including plan size and current plan provisions.

Now that the regulations have clarified a number of aspects as to what changes result in loss of grandfathered status, plan sponsors that are considering plan changes can compare the consequences (i.e., costs) of failing to make the changes compared to losing grandfather status. In some cases, the consequences of losing grandfather status may not be entirely clear, because needed regulations have not yet been issued. For example, grandfathered plans are not subject to the requirement (effective for plan/policy years beginning on or after September 23, 2010) that preventive services be covered without cost sharing. However, guidance as to the scope of preventive services that will be subject to this requirement has not yet been issued. A listing of the requirements of PPACA showing which requirements apply to grandfathered plans appears at the end of this advisory.

Grandfathered plans remain subject to the requirements of the Public Health Service Act (PHSA), ERISA and the Internal Revenue Code (the “Code”) that were applicable before the changes made by PPACA, except to the extent supplanted by the changes made by PPACA. Thus, for example, HIPAA portability and nondiscrimination requirements and the mental health parity provisions continue to apply.

In addition to addressing the grandfather issues, the preamble to the regulations provides helpful guidance (described below) with respect to which plans and products are subject to (and exempt from) the reforms included in PPACA.

The agencies may issue additional administrative guidance other than in the form of regulations prior to issuing final regulations.
Scope of PPACA – Excepted Benefits and Retiree-Only Plans

As a result of drafting ambiguities, questions have arisen as to whether retiree-only plans and plans that provide excepted benefits as defined under HIPAA (including stand-alone vision and dental plans, specified disease and hospital indemnity plans, and accident and disability plans) are subject to PPACA. The preamble to the regulations confirms the agencies’ view that the health care reforms (such as the prohibition on lifetime and annual dollar limits and required coverage of dependents to age 26) are not intended to apply to such plans.

Specifically, the preamble states the following:

- The exceptions in the Code and ERISA for self-insured retiree-only plans and HIPAA-excepted benefits remain in effect with respect to the provisions of PPACA.
- States have the primary authority to enforce the PHSA provisions with respect to group and individual market health insurance issuers, and HHS will only step in to the extent HHS believes the state has failed to substantially enforce these provisions. HHS will encourage states not to apply the market provisions of the PHSA under PPACA to fully insured retiree-only plans or to excepted benefits.
- HHS will not use its resources to enforce the requirements of PPACA with respect to nonfederal governmental retiree-only plans or excepted benefits provided by nonfederal governmental plans.

Stricter State Rules Not Preempted

The preamble confirms that states may impose requirements that are stricter than those imposed by PPACA.

Definition of Grandfathered Plan – In General

A “grandfathered plan” means coverage provided by a group health plan or a health insurance issuer in which an individual was enrolled on March 23, 2010.

A group health plan or group health insurance coverage does not stop being a grandfathered health plan merely because individuals enrolled on that date cease to be covered, provided that the plan or coverage has continuously covered at least one person (not necessarily the same person) since March 23, 2010.

The regulations apply separately to each benefit package available under a grandfathered health plan. That is, changes may result in one benefit package under a grandfathered health plan losing grandfather status while other benefit packages retain grandfather status. Thus, for example, disqualifying changes to a PPO offered under a grandfathered health plan will not cause an HMO option offered under the plan to lose grandfather status.

Entering into a new policy, certificate or contract of insurance after March 23, 2010 (as compared to renewing a policy) creates a new plan. Thus, for example, if a benefit option under a grandfathered self-insured plan became fully insured, grandfathered status would be lost, because the new policy would be considered a new plan. An exception exists for certain collectively bargained plans. (Note that the regulations are silent on the effect of a change from a fully insured plan to a self-insured plan; comments on that issue are specifically requested.)
Adding New Individuals to a Grandfathered Plan

A grandfathered health plan remains grandfathered if family members of an individual enrolled on March 23, 2010, enroll after that date. This rule applies with respect to grandfathered group health coverage and individual coverage.

New employees (including newly hired and newly enrolled employees) and their families may be enrolled in a grandfathered group health plan or grandfathered group coverage after March 23, 2010, without loss of grandfather status.

An anti-abuse rule limits an employer’s ability to transfer employees between grandfathered plans unless there is a bona fide employment-based reason for the transfer. This rule is designed to prevent efforts to retain grandfather status by using a transfer to indirectly make changes that would result in loss of grandfather status if made directly. The regulations also provide that if a principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan, the plan ceases to be a grandfathered plan. This rule is intended to “prevent grandfather status from being bought and sold as a commodity in a commercial transaction.”

Special Rules for Collectively Bargained Plans

There is no delayed effective date for collectively bargained plans, whether fully insured or self-insured. Thus, plans maintained pursuant to one or more collective bargaining agreements in effect on March 23, 2010, must comply with the new rules at the same time as other grandfathered plans. For example, effective for plan years beginning on or after September 23, 2010, grandfathered plans must comply with the requirement to extend dependent coverage until age 26; for plan years beginning before January 1, 2014, grandfathered group health plans may exclude an adult child if the child is eligible for other employer-sponsored coverage other than through a parent. The rules for coverage of adult dependent children apply to grandfathered collectively bargained plans the same as they do to other grandfathered plans, regardless of when the applicable collective bargaining agreement terminates.

The regulations provide that fully insured (but not self-insured) collectively bargained plans retain their grandfather status until the current agreement (i.e., the agreement in effect on March 23, 2010) expires. Thus, a change in carriers under a fully insured collectively bargained plan does not result in loss of grandfather status if the change is made before the current agreement (i.e., the agreement in effect on March 23, 2010) expires.

Changes to benefits that apply while the current collective bargaining agreement is in effect, such as increasing co-payments, do not result in loss of the grandfather. However, whether the grandfather applies after the expiration of the collective bargaining agreement is measured by comparing the benefits in effect at that time to the benefits in effect on March 23, 2010. If the changes are not within the permitted parameters (described below), then the plan will cease to be grandfathered when the relevant agreement expires.
Maintenance of Grandfather Status

As mentioned above, the regulations severely limit the changes that may be made under a plan without resulting in a loss of grandfather status. Any one of the following changes will result in the loss of grandfathered status with respect to the benefit package affected by the change:

- **Changes in insurance carriers:** Except with respect to insured grandfathered collectively bargained plans, a change in insurance carrier ends grandfather status for that benefit package option.

- **Changes in the scope of benefits:** The elimination of benefits to diagnose or treat a particular condition, even if the condition affects relatively few individuals under the plan, results in loss of grandfather status. The elimination of benefits for any necessary element to diagnose or treat a particular condition also results in loss of grandfather status. For example, if a plan covers a particular mental health condition, the treatment for which includes prescription drugs and counseling, elimination of counseling would result in loss of grandfather status. This provision is especially difficult for employers that are re-evaluating their mental health coverage in light of recent Mental health Parity and Addiction Equity Act of 2008 regulations.

- **Increases in percentage cost sharing requirements:** Any increase in any percentage cost-sharing amount (such as increasing a 20 percent coinsurance requirement for in-patient surgery to 30 percent) results in loss of grandfather status.

- **Increases in fixed amount cost sharing:** For fixed amount cost sharing other than co-payments (e.g., deductibles) the maximum permitted increase in the fixed amount (since March 23, 2010) without loss of grandfathered status is medical inflation (from March 23, 2010), plus 15 percentage points. For co-payments, the maximum permitted increase (since March 23, 2010) without loss of grandfather status is the greater of (a) the maximum percentage increase as described in the preceding sentence, and (b) $5 increased by medical inflation. These restrictions apply to changes in any cost sharing requirement. Medical inflation is defined by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor (OMCC). In March 2010, OMCC was 387.142. The increase in the OMCC is computed by subtracting 387.142 from the OMCC “for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.” An example from the regulations for co-payments helps to illustrate how this works:

  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. Within the 12-month period before the $40 co-payment takes effect, the greatest value of the OMCC is 475.

  The increase in the co-payment from $30 to $40, expressed as a percentage, is 33.33% (40 - 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%). Medical inflation from March 2010 is 0.2269 (475 – 387.142 = 87.858; 87.858 ÷ 387.142 = 0.2269). The maximum percentage increase permitted is

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1 See [http://www.bls.gov/cpi/#tables](http://www.bls.gov/cpi/#tables) for links to previous CPI reports.

2 Note that 475 is a number provided in the regulations for illustrative purposes only and does not necessarily reflect an accurate OMCC value for purposes of calculating changes that become effective on January 1, 2011. Plan sponsors must check the actual numbers for the overall medical care component as published in the CPI-U (unadjusted) by the Department of Labor for the applicable 12-month period in order to make an accurate calculation.
37.69% (0.2269 = 22.69%; 22.69% + 15% = 37.69%). 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.

It is important to note that although the regulations indicate that the increase must be “determined as of the effective date of the increase,” the OMCC is computed using “any month in the 12 months before the new change is to take effect.” In other words, it appears from the examples in the regulations that for a change that becomes effective on July 15, 2011, the OMCC between July 2010 and June 2011 with the “greatest value” can be used, and not necessarily the OMCC for July 2011.

- **Changes in rate of employer contributions for premiums:** A decrease in the employer contribution rate of more than five percent below the rate on March 23, 2010, for any tier of coverage for similarly situated individuals results in loss of grandfather status. In general, the employer contribution rate is the amount of contribution made by an employer compared to the total cost of coverage, as determined under the COBRA continuation rules. In the case of a self-insured plan, contributions by the employer are equal to the total cost of coverage minus the employee contributions toward the total cost of coverage. According to the examples in the regulations, pre-tax salary reduction contributions are considered employee contributions for this purpose. Under this rule, although the dollar amount of employee contributions may increase, there is no loss of grandfather status as long as the rate (i.e., the relative proportion) of employee contribution does not increase more than permitted.

- **Changes in annual limits:** The addition of an overall annual limit on the dollar value of benefits to a grandfathered plan that did not impose an overall annual or lifetime dollar limit on March 23, 2010, results in loss of grandfather status. If a grandfathered plan that had only a lifetime dollar limit on March 23, 2010, is modified to add an annual dollar limit on benefits, grandfather status is lost unless the annual limit is not less than the lifetime limit. If a grandfathered plan lowers an annual dollar limit on benefits below the limit in effect on March 23, 2010, grandfather status is lost. (Note, lifetime limits are prohibited for plan/policy years beginning after September 23, 2010; this prohibition applies to grandfathered plans.)

According to the preamble, changes other than those described in the regulations as resulting in loss of grandfather status do not affect the grandfather. Changes that do not result in loss of grandfather status include changes required to comply with federal or state law, changes to voluntarily comply with PPACA or increase benefits, and changes in third-party administrators with respect to a self-insured plan. (Note, the regulations specifically request comments as to whether changes in network providers should result in loss of grandfather status.)
Transition Rules

The regulations also include transition rules for plans and issuers that made changes after March 23, 2010.

• **Changes Treated as Made Before March 23, 2010**: Changes made as a result of the following situations will not result in the loss of grandfathered plan status and are considered part of the plan or policy terms on March 23, 2010, even though they are not effective until after March 23, 2010:
  
  – Changes made pursuant to a legally binding contract entered into on or before March 23, 2010;
  
  – Changes pursuant to a filing with a state insurance department on or before March 23, 2010; or
  
  – Changes pursuant to a written plan amendment adopted on or before March 23, 2010.

• **Grace Period for Changes Made After March 23, 2010**: Changes made after March 23, 2010, and before the date the regulations were publicly available (i.e., June 14, 2010), that would otherwise affect grandfather status may be revoked or modified in order to preserve the grandfather. Any such revocation or modification must be effective as of the first day of the first plan year (policy year in the case of the individual market) beginning on or after September 23, 2010. This transition rule applies to changes that are effective before June 14, 2010, or changes that are effective on or after such date pursuant to a legally binding contract, a state insurance filing or a written plan amendment entered into or made before such date.

• **Good Faith Compliance**: For enforcement purposes, the agencies will take into account good faith efforts to comply with reasonable interpretations of the statute prior to the issuance of regulations, and may disregard changes to plan and policy terms that “only modestly” exceed the parameters for changes that result in loss of grandfathered status set forth in the regulations and that are adopted before June 14, 2010.

Disclosure Requirements

In order to maintain grandfather status, a plan or health insurance coverage must include a statement in any plan materials provided to participants that the plan believes it is a grandfathered health plan and must provide contact information for questions (and complaints). A model notice is included in the regulations for this purpose.

Substantiation Requirements

For as long as a plan or insurance carrier takes the position that the plan or coverage is grandfathered, the following records must be maintained:

• Records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010; and

• Any documents necessary to support the status as a grandfathered plan (for example, a copy of a legally binding contract in effect on March 23, 2010).

These documents must be made available for examination by participants, beneficiaries, individual policy subscribers and federal agency officials.
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<th>Applicable to Grandfathered Plans?</th>
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<td>No</td>
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<tr>
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<td>No</td>
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<tr>
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<tr>
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<td>No</td>
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<tr>
<td>Guaranteed availability of coverage (applicable to health insurance issuers) § 2702</td>
<td>Currently applies to small group (individual policies if conversion criteria met), expanded to individual and large group first policy year on/after 2014</td>
<td>No</td>
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<td>First plan year beginning on or after January 1, 2014. The essential benefits requirement does not apply to self-funded plans and generally does not apply to large group health insurance plans.</td>
<td>No</td>
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<tr>
<td>Insurance Reform (PHSA §)</td>
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<td>Applicable to Grandfathered Plans?</td>
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<tr>
<td>Participation in clinical trials § 2709*</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No</td>
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<tr>
<td>Nondiscrimination based on health status § 2705</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No (grandfathered plans remain subject to the rules in effect before health care reform)</td>
</tr>
<tr>
<td>Prohibition on preexisting condition exclusion § 2704</td>
<td>First plan year beginning on or after September 23, 2010 for individuals under age 19; first plan year beginning on or after January 1, 2014 for other individuals</td>
<td>Group – Yes</td>
</tr>
<tr>
<td>Restricted/prohibited annual limits § 2711(b)</td>
<td>First plan year beginning on or after September 23, 2010 “Restricted” annual limits are permitted until 2014; for plan years beginning on or after January 1, 2014, no annual limits are permitted</td>
<td>Group – Yes</td>
</tr>
<tr>
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<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
</tr>
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<td>Prohibition on rescissions § 2712</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
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<tr>
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<td>First plan year beginning on or after September 23, 2010 for grandfathered group plans, coverage required before 2014 only if the child is not eligible for other employer coverage (other than through parents)</td>
<td>Yes</td>
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<tr>
<td>Uniform explanation of coverage § 2715</td>
<td>First plan year beginning on or after September 23, 2010 (provision dependent on regulations; first disclosures not required under statute until March 23, 2012)</td>
<td>Yes</td>
</tr>
<tr>
<td>Bringing down the cost of health coverage (minimum medical loss ratio) § 2718</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes (provision applies to insured plans only)</td>
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<tr>
<td>Limitation on waiting periods § 2708</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>Yes (not applicable to individual coverage)</td>
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* Due to drafting errors, there are two sections 2709 of the PHSA after PPACA. The section referred to in the table is a new section. The other section 2709 (relating to disclosure of information) is renumbered from prior law PHSA section 2713. Grandfathered plans remain subject to the pre-PPACA requirements that are still in effect.

This advisory was written by Carolyn Smith.
If you would like to receive future *Employee Benefits and Executive Compensation Advisories* electronically, please forward your contact information including e-mail address to *employeebenefits.advisory@alston.com*. Be sure to put “subscribe” in the subject line.

If you have any questions or would like additional information, please contact your Alston & Bird attorney or any one of the following:

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Optimizing Employee Benefit Costs Under PPACA: Avoid False Dichotomies

BY DAVID R. GODOFSKY

Summary: Most employers will find that the optimal financial choice is to continue to provide access to employer-sponsored health insurance after PPACA is fully implemented. However, many employers will be able to improve the cost effectiveness of their benefits plans by passing more costs on to employees in the form of pretax premiums, and increasing salaries or wages. PPACA leaves intact, and adds to, the reasons for providing access to coverage, while at the same time strengthens the reasons for requiring substantial employee pretax premiums. Avoiding PPACA’s excise taxes entirely will not normally produce the best result, but most employers will want to avoid the “sledgehammer” penalty.

Ever since the enactment of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. No. 111-148) in March of 2010, the literature in the both the popular press and the trade press has been filled with a false choice for employers: shoulder the additional costs associated with PPACA mandates on the one hand, or, on the other hand, exit the healthcare system, pay the associated excise taxes, and let your employees buy subsidized health insurance on the new exchanges that will be available in 2014.1

As the narrative goes, it will cost less to pay the excise taxes ($2,000 per employee) than to continue to provide health insurance coverage, and so employers will exit the market. However, this narrative is based on two false assumptions:

1. that the $2,000 excise tax is the only cost that would be incurred as a result of exiting the healthcare system; and
2. that these are the only two options.

The truth is that there are many reasons for employers to continue to offer health insurance to their employees, and there are many ways of dealing with the additional costs that PPACA imposes.2 Most employers

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1 The analysis in this article is based on PPACA provisions in effect as of Jan. 1, 2014, and does not assume any amendments to the statute before then. Amendments are likely, but the direction of those amendments is unknown at this time.

2 In order to avoid excise taxes, employers will generally be forced to eliminate exclusions for pre-existing conditions, cover adult children to age 26, limit deductibles and co-insurance, eliminate annual dollar limits and lifetime dollar limits, and extend coverage availability to all full-time employees. Each of these mandates will increase costs. Proponents of PPACA claim that modification of incentives will reduce costs, but such reductions are speculative, while the cost increases from the mandates are clear and obvious. Whether the net result will be cost increases or decreases in the long run is beyond the scope of this article. For purposes of this article, it is...
will discover that eliminating coverage entirely will not be the optimal financial choice.

**We All Work for Food**

As I go to work, I often pass (seemingly) homeless people with signs saying, “I will work for food.” Every day, when I go to work, I work for food. However, my firm does not pay me in chickens. It pays me in dollars, which I then trade for chickens as well as other foods and other goods. Why, if my employer pays me dollars instead of chickens, should it offer me insurance as part of my compensation package? And why health insurance, when it does not include, as part of my pay package, homeowners insurance or car insurance? The answers are both deceptively simple and extremely complex, depending on how deeply you probe:

- **Employees are willing to work for lower dollar wages when an employer offers health insurance; and**
- **Employers derive other economic benefits from having insured employees.**

Why would employees trade wages for insurance, when they clearly would not prefer chickens over dollars? Reasons include the following:

- Health insurance purchased by the employer is not taxable income, and employee premiums are generally pretax. This form of wage also avoids FICA tax of 15.3 percent. This means that employer-sponsored health insurance has a much lower after-tax cost than insurance purchased by an individual, even in an exchange after PPACA. (Employer provided chickens enjoy no such tax subsidy.)

- The incidence of anti-selection (sick people buy insurance, healthy people do not) is much less with employer-provided coverage. Consequently, even healthy individuals who want insurance will pay a higher price if it is purchased on the individual market.

- Health insurance is extremely complex and an individual purchasing coverage is more likely to purchase an inappropriate product or a rip-off.

- Paying for medical care is more effective through insurance than if you pay for your care directly. This is because insurers negotiate discounts with providers. Consequently, providers greatly over-charge individual purchasers. (Because of the prevalence of insurance, the term “discount” may be slightly misleading—it may be more accurate to say that insurers negotiate with providers to overcharge uninsured individuals.) The net effect is that you do not want to pay for medical care from your own wallet, because paying through insurance is less expensive.

With all these advantages, it would seem that an employee would be willing to trade more than $100 of wages for $100 worth of insurance coverage. Indeed, some employees would gladly take salaries reduced by much more than the cost to the employer of purchasing insurance. (How many companies in the US manage to employ a highly skilled workforce without offering insurance?) However, many employees do not need insurance, or do not particularly want it. Some have insurance through a spouse, parents, or Medicare. So, it is not clear that paying $100 for insurance will save an employer as much as $100 in direct wages. The actual assumed that costs will increase. If costs decrease, the logic of staying in the health insurance system is even stronger.

conversion ratio will vary from one employer to another based on the demographics of its workforce, competitive factors, and many other factors. However, it is fair to say the conversion ratio is well above zero.

PPACA modifies this balance in several ways:

- The cost of not providing insurance is increased by $2,000 per year per employee, which is the same as saying the cost of providing insurance is decreased by $2,000. However, assuming some employees will turn down the employer-sponsored option (because they are covered by Medicare, a spouse or parent’s policy, or just do not want it), the net cost of providing insurance to the remaining employees is decreased by more than $2,000 each.
- The cost of insurance is increased by the costs of the mandates: no pre-existing condition exclusion, no annual or lifetime dollar limit, etc.

- Employees will be able to buy insurance on the exchanges, and in some cases, that coverage will be subsidized by the government. However, even after the subsidy, costs will be substantial (and not tax-subsidized) and many employees will not find employer-covered insurance to be cost effective or affordable.

- Demand for insurance by individuals may increase slightly or decrease slightly due to the misnamed “individual mandate.” In actuality, PPACA imposes a rather modest tax on some, but not all, individuals who choose to be uninsured. The amount of the tax is not nearly enough to induce someone to buy insurance if they do not want it or cannot afford it. However, a few individuals who are on the fence will certainly be induced to purchase insurance. On the flip side, the availability on the exchange of insurance with no exclusion for pre-existing conditions will convince some individuals that purchasing insurance is not necessary as long as they remain healthy. Experts do not agree on whether the net effect will be an increase or a decrease in coverage, but the net effect is likely to be modest in either direction.

- For certain employees, the employer must offer a “free choice voucher” equal to the amount of the employer subsidy if the employee purchases coverage on the exchange instead of from the employer.

As we will see, the net effect of these changes is likely to leave intact, for almost all employers, the basic premise that employer-sponsored insurance is a cost-effective part of a pay package. However, the degree of subsidy provided by the employer may change drastically due to PPACA.

**Structure of the ‘Penalties’**

The structure and amount of the excise taxes (also referred to as “penalties”) is important in the analysis.

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3 This is what is colloquially referred to as the “sledgehammer penalty.” Actually, the penalty applies to the number of full time employees minus 30. So, if you have 10,000 full time employees, the sledgehammer penalty is $2,000 x 9,970. However, for large employers, the subtraction of 30 is insignificant, and for the sake of convenience, in the remainder of this article we simply use the approximation of # of employees x $2,000.

4 Suppose, for example, that you have 10,000 employees, but if you offer insurance, only 5,000 employees will take it. The sledgehammer penalty (if you do not offer insurance at all) is $20 million. So, the cost of providing insurance to 5,000 is reduced by $20 million, or $4,000 each.
Sledgehammer Penalty: One penalty applies if coverage is not offered to all full-time employees. If even one full-time employee (1) lacks coverage availability from the employer; (2) purchases insurance through an exchange; and (3) receives an income-based government subsidy, then the employer pays a penalty of $2,000 per employee per year multiplied by the number of full-time employees minus 30. To avoid the sledgehammer penalty, the employer must offer minimum essential coverage. However, the employer can pass nearly the entire cost of coverage on to employees in the form of pre-tax employee premiums, without incurring the sledgehammer penalty.

Example: XYZ Company employs 10,000 full-time employees. Its health insurance plan covers 9,999 employees. One full time employee is ineligible. That employee purchases insurance on an exchange and receives a subsidy. XYZ pays the sledgehammer penalty equal to $2,000 x 9,970 or approximately $20 million.

Tack Hammer Penalty: The tack hammer penalty is $3,000 per employee per year, but applies only to those employees who purchase insurance on the exchange and receive a government subsidy. Thus, the employee count for the tack hammer penalty excludes all of the following:

- Employees who choose to subsidize the child's employer in this way.
- Employees who purchase insurance only through work for $100 per month. If your company offers a "family" premium and the employee also has a minor child, then the adult child's coverage is free to the employee. Why would that adult child pay $100 per month when he could stay on his parents' coverage for free? More to the point, why would your company choose to subsidize the child's employer in this manner?

Employer Subsidies—Which Direction?

Traditionally it has been thought that, as costs rise, the employer subsidy also rises. Indeed, most employers have been unable or reluctant to pass on to employees the full cost increases. This may continue to be true. However, for those employers who are considering exiting the insurance market (that is, reducing employer subsidies to zero), a significant reduction in the subsidy may be preferable to complete elimination.

Increasing the Employee Pretax Premium

Increasing the employee pretax premium will have the following advantages and disadvantages.

- Disadvantage: More employees will choose to be uninsured. Many employers prefer their employees to have health insurance, for a variety of reasons, including positive effects on morale and absenteeism, community reputation, goodwill, and moral reasons. However, the degree to which an employer values this benefit varies greatly depending on the demographics of its workforce, the nature of the business, the state of its government relations, and the locations of its operations.

- Advantage: Fewer employees will choose employer-coverage. Increasing the employee premium saves much more than the direct reduction of the subsidy. It eliminates the subsidy entirely for those employees who choose to remain uninsured and for many employees who choose to purchase their insurance elsewhere. For example, some employees will have lower-cost coverage through a spouse or parent.

- Advantage: Employees can choose the form of wage they value most. Many employees do not need or do not want insurance (at least not as much as the money it costs), or have it available at a lower cost elsewhere. Simultaneously increasing the employee premium and the employee's wages will give some employees much greater satisfaction.

- Advantage: The higher wage is more visible. When accepting a job, most employees ask if there is insurance, but not the amount of the employee premium. For many non-economic reasons (such as status), employees value having a high salary. Further, most employees vastly underestimate the cost of health insurance, and so have no idea how much their actual pay package is. For these reasons, employees may be more likely to accept a higher salary over a lower premium.

- Advantage: Ameliorates the sticky wage problem. In our low-inflation environment, it is difficult to lower an employee's salary when the employee is less productive than anticipated or than he was previously, or when there is downward pressure on the price of the employer's products. (Economists refer to this phenomenon as "stickiness" in the wage.) However, when increasing the employee premium, it is not necessary to increase the salary by the same amount. This gives the employer the opportunity to adjust the overall wage package downward for some employees.

Myth-buster: Insuring fewer employees will NOT increase the cost of coverage. A common myth is that insurance costs go down when you are able to insure most of your employees. The average cost goes down; the total cost goes up. Consider: Jill costs $1,000; Jack costs $9,000; together, their average cost is $5,000. If Jill drops coverage, the average cost goes up from $5,000 to $9,000, but the total cost still goes down by $1,000.

Family Pricing Is Obsolete

PPACA requires that employer coverage include children up to age 26, regardless of the availability of other insurance. Consider the 23 year old child of your employee who is employed and can purchase insurance through work for $100 per month. If your company offers a "family" premium and the employee also has a minor child, then the adult child's coverage is free to the employee. Why would that adult child pay $100 per month when he could stay on his parents' coverage for free? More to the point, why would your company choose to subsidize the child's employer in this manner? PPACA will drive many if not all companies to

ISSN BNA 6-3-10
charge on a “per insured individual” basis, not to lump coverage into a “family” premium.

Examples The following examples illustrate the point that, typically, it will be more cost effective under PPACA to increase employee premiums rather than exit the insurance market entirely.

Example 1 Consider XYZ company, which employs 10,000 individuals in the United States. XYZ provides health insurance at an average cost of $6,000 per employee, and charges the employee $150 per month in pretax premiums ($1,800 per year), and therefore has a subsidy of $4,200 per year per employee. Most employees choose to be insured.

XYZ estimates that the PPACA mandates will increase the cost of health insurance by $1,000 per employee. Its workforce is not highly paid, and that cost increase is unsustainable. Thus, XYZ is considering eliminating its insurance altogether, on the theory that employees can buy insurance on an exchange. As an alternative, it is considering raising the employee premium.

Scenario 1—Drop Insurance In scenario 1, XYZ company drops insurance entirely. Cost impacts are as follows:

- Eliminate employer subsidy: $4,200 x 10,000 = $42 million savings
- Increase direct wages: employees demand higher wages as alternate employment is more attractive. Additional cost: $18 million.5
- Sledgehammer penalty: $2,000 x (10,000-30) = approximately $20 million.
- Net effect: $4 million in savings. (And, many employees are left uninsured.)

Scenario 2—Increase Employee Premium In scenario 2, XYZ increases the average employee premium to $500 per month ($6,000 per year), leaving the employer subsidy at $1,000 (as compared with the new $7,000 average cost). XYZ also increases wages by $15 million to compensate for the reduction in the employer subsidy.6

In scenario 2, 70 percent of the employees drop employer coverage, leaving 3,000 insured. Those 3,000 are not the healthiest, so the new employer subsidy increases from $1,000 per employee to $2,000 per employee, but applies to only 3,000 employees.

Of the 7,000 employees who drop coverage:
- 3,500 choose to be uninsured
- 1,500 add coverage through a spouse or parent (now available to age 26)
- 1,000 end up on Medicare or Medicaid
- 1,000 purchase subsidized coverage on an exchange7

Cost impacts are as follows:

- Cost of new employer subsidy: $2,000 x 3,000 = $6 million. Prior subsidy was $42 million. Cost savings = $36 million.
- Increased direct wages = $15 million.
- Tack hammer penalty = $3,000 x 1,000 = $3 million.
- Free choice vouchers = 1,000 x $2,000 = $2 million
- Net effect: cost savings of $16 million. (And, many employees are left uninsured.)

Note, in scenario 2, the cost savings is $12 million more than in scenario 1. The difference between the sledgehammer penalty and the tack hammer penalty, in these scenarios, is $17 million.

One might argue that, under the facts above, XYZ should have eliminated its health insurance coverage even before passage of PPACA, but now PPACA gives the employer an incentive not to eliminate coverage.

For some employers, the conversion of benefits to wages is more efficient—that is, a greater wage increase is needed as benefits are eliminated. However, that factor will affect both scenarios. Almost any reasonable adjustment to the assumptions above is going to leave the basic result intact—less subsidized coverage is more cost effective for the employer than no coverage, because of the huge disparity between the sledgehammer penalty and the tack hammer penalty.

Example 2 ABC company has 10,000 employees, primarily low wage, and does not presently offer any health insurance.

Scenario 1 – Continue to offer no insurance
- Sledgehammer penalty = $2,000 x (10,000-30) = approximately $20 million

Scenario 2 – Offer insurance with a low subsidy, like XYZ company in Scenario 1.
- Subsidy = $2,000 x 3,000 = $6 million
- Tack hammer penalty = $3,000 x 1,000 = $3 million
- Free choice vouchers = $2,000 x 1,000 = $2 million
- Decrease in direct wages—for purposes of this analysis, assume zero.8
- Reduced employer FICA taxes = (approximately) $1.5 million
- Total cost = $9.5 million

In this example, the cost of the tack hammer penalty and the cost of the employer subsidy, combined, is still less than the cost of the sledgehammer penalty. In addition, some of the employees benefit by being able to pay premiums on a pretax basis. This employer may decide to begin offering insurance with a relatively small subsidy.

Other Rational Responses to PPACA

Other ways that employers may react to PPACA include the following.

- Outsourcing. PPACA has nondiscrimination provisions that will make it much more difficult to optimize financial results if the employer has two distinctly different employee populations. For example, consider an

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5 Before PPACA, this cost would have been higher. However, as XYZ has a primarily low-wage workforce, the availability of subsidized exchange coverage reduces the demand by employees for employer coverage.

6 One might argue that such a large increase in premium would require a greater wage increase. However, the wage increase required in scenario 2 is, by definition, less than the wage increase required in scenario 1.

7 In this scenario, the increased employee premium is still much less expensive than unsubsidized exchange coverage. Therefore, no employees are assumed to buy exchange coverage unless they qualify for a subsidy.

8 Clearly, over time, an employer that offers insurance will be able to offer lower wages, to some extent. However, because the outcome does not depend on this amount, and the amount is speculative, we have ignored it in this example.
employer with a large number of highly paid engineers, and a large number of low-paid factory workers. The optimal strategies for these two populations may be distinctly different. Consequently, the employer may choose to sell the factory and outsource the manufacturing. The two entities, once split, will each be able to pursue a financial strategy appropriate to its population.

- **Move Jobs to Another Country.** By increasing the cost of employing people in the U.S., PPACA will make it more attractive for companies to start new operations, or move operations, to countries that have lower employment costs.  
- **Reduce Employment Through Automation.** PPACA changes the relative balance between the cost of human labor and the cost of automation. Although automation often makes sense for purely economic reasons, PPACA puts a thumb on the scale in favor of automation, even in cases where it would not otherwise make economic sense. (Note that automation shifts jobs more than it eliminates jobs—someone has to build all those robots and computers. However, some of that job shifting will be to other countries that have lower wages, and some of the job shifting will move costs to higher paid jobs where a smaller percentage of the total cost consists of health insurance.)

**Reduce Hours for Summer Help and Other Seasonal/Hourly Employees.** In order to avoid the sledgehammer penalty, many employers will limit hours to fewer than 30 hours per week in order to avoid allowing student-interns, other seasonal employees, and many hourly employees from obtaining “full-time” status.

**Conclusion**

PPACA is a complex statute with numerous unintended consequences. Clearly, many of the strategies outlined in this article are results not intended by Congress. That, and the tremendous political controversy attendant to PPACA makes it likely that the statute will be amended and modified before 2014. However, it is clear that simplistic reactions to PPACA would be highly counterproductive for employers. Reaching optimal financial results will require a more thorough and refined analysis. The analysis will differ from one employer to the next, depending on workforce demographics, the employer’s current benefit plans, the employer’s business plans, and many other factors.
HHS Issues Interim Regulations on Early Retiree Health Insurance Program – Plan Sponsors Must Be Ready to Act Quickly to Take Advantage of the Program

On May 5, 2010, the Department of Health and Human Services (HHS) issued interim final regulations ("Interim Regulations") for the early retiree reinsurance program (the "Program") enacted as part of the Patient Protection and Affordable Care Act (PPACA). The Program is intended to help offset the costs of health claims for employers that provide health benefits for retirees ages 55 through 64 ("early retirees") and will reimburse plan sponsors for a portion of the cost of benefits provided to early retirees and their spouses and dependents. PPACA expressly provides that reimbursements are not taxable income. PPACA directs the Secretary of HHS (the "Secretary") to establish the Program within 90 days of enactment (June 21, 2010). The Interim Regulations are effective June 1, 2010. The Program is scheduled to run through January 1, 2014 or, if earlier, when the $5 billion set aside for the program is exhausted. Plan sponsors must apply for the Program and be certified by HHS in order to participate. HHS has indicated that the application will be available by the end of June. Because the Program is limited by the amount of funds set aside and applications are reviewed on a first-come, first-served basis, there is a premium on submitting a fully completed application early. Applications will be denied if not complete, and will be considered a new application if additional information is needed. After a plan is certified, properly documented claims should also be submitted promptly.

This document contains a summary of key aspects of the program, followed by a more detailed description.

Comments on the Interim Regulations are due by June 4.

GENERAL OVERVIEW OF THE PROGRAM

In order to be eligible to receive reimbursements under the Program:

- The plan sponsor must apply to the Secretary;

- The Secretary must approve the application and certify that the plan sponsor and the plan sponsor’s employment-based plans meet the requirements for participation; and

- The certified plan sponsor must submit claims, with supporting documentation.

For each early retiree enrolled in a certified plan in a plan year, the plan sponsor is eligible to receive reimbursements equal to 80% of the costs for eligible health benefit claims incurred during the plan year that are between $15,000 and $90,000 (as indexed for medical inflation after October 1, 2011). Claims of the early retiree’s spouse, surviving spouse and dependents are taken into account in determining the amount of reimbursement.
A plan sponsor may use the reimbursements from the Program to reduce the sponsor’s health benefit premiums or costs and/or to reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants, including plan participants who are not early retirees.

It is expected that many employers who will seek to participate in the retiree reinsurance Program are already familiar with the Medicare retiree drug subsidy program (“RDS Program”). Therefore, many elements of the Program are defined in accordance with the RDS Program.

I. ELIGIBILITY TO PARTICIPATE IN THE PROGRAM

Eligible Plans

The Program is available to “employment-based plans” that provide health benefits for “early retirees.” An employment-based plan is defined the same as under the RDS Program, except that plans of the federal government (and its agencies and instrumentalities) are excluded. Thus, employment-based plans include group health plans maintained by a private employer, state or local governments (and their agencies and instrumentalities), VEBAs, employee organizations, multiemployer plans, and church plans. Both insured and self-insured plans are eligible to participate, including self insured plans covering retirees only. The plan may qualify whether or not it covers active employees or retirees only.

Early Retiree

An “early retiree” is a plan participant who is age 55 or older, is not eligible for Medicare, and is not actively employed by any employer maintaining the plan, as determined by the plan sponsor in accordance with the rules of the plan. Notwithstanding this rule, an individual is presumed to be actively employed if he or she is considered under the Medicare Secondary Payer rules to be receiving coverage under the employment-based plan by virtue of their current employment status. Under the Interim Regulations, claims of COBRA-qualified beneficiaries and employees receiving disability benefits from the employer for more than six months would appear to qualify for reimbursement, because both of these categories of individuals are not considered to be in current employment status. Some have raised an issue as to whether this is intentional, particularly with respect to COBRA, as the employer is required to make COBRA coverage available, and the provision is intended as an encouragement to voluntarily offer retiree coverage. On the other hand, even in situations where the employer does not contribute toward the cost of COBRA coverage, the provision will serve the purpose of reducing costs to early retirees.

Enrolled spouses, surviving spouses, and dependents (as defined under the plan) are also included in the definition of early retiree and can be any age. Thus, reimbursements for such individuals qualify for reimbursement under the Program.

Plan Sponsor

Application for the Program must be made by the plan sponsor and reimbursements under the Program are paid to the plan sponsor. In general, the plan “sponsor” means: (i) the employer, in the case of a single employer plan; (ii) in the case of a plan maintained by an employee organization, the employee organization; (iii) in the case of a multiemployer plan, the board of trustees or other group of representatives of the parties maintaining the plan; and (iv) in the case of a plan maintained jointly by one employer and an employee organization, and for which the employer is the primary source of financing, the employer.
Plan and Plan Sponsor Requirements

To be eligible for the Program, the plan must include programs that have generated or have the potential to generate cost savings with respect to participants with “chronic and high-cost conditions” (see discussion below).

In addition, the plan sponsor must:

- maintain and make available to the Secretary such records and documentation as specified by the Secretary for six years, and must require its insurer or plan, as appropriate, to maintain and produce such records;
- have a written agreement with its insurer or plan regarding disclosure of information (including protected health information), data, documents and records to the Secretary;
- ensure that policies and procedures are in place to protect against fraud, waste and abuse, and timely comply with requests from the Secretary to produce the policies and procedures and any documents or data to substantiate the implementation of the policies and procedures and their effectiveness; and
- submit to the Secretary an application for participation in the Program within the time frame and in the manner specified by the Secretary.

Cost Savings with Respect to Chronic and High-Cost Conditions

A “chronic and high-cost condition” means a condition for which $15,000 or more in health benefit claims are likely to be incurred during a plan year by any one participant. Thus, in order to be eligible for the Program, there must be programs and procedures in place that generate or have the potential to generate cost savings for plan participants with conditions that are likely to result in claims exceeding $15,000 in a plan year for one participant. The preamble to the Interim Regulations provides that sponsors are not required to put new programs and procedures in place, nor are programs and procedures required to be in place for all conditions for which claims are likely to exceed $15,000 in a plan year for a plan participant. Instead, plan sponsors are expected to take a reasonable approach when identifying conditions and selecting programs and procedures to lower the cost, as well as improve the quality of care. Upon audit, the sponsor must be able to demonstrate that the programs and procedures have generated or had the potential to generate cost savings, consistent with the representations the sponsor made in its program application.

Example: A plan sponsor determines that diabetes, if not managed properly, is likely to lead to claims in excess of $15,000 for a plan year for one plan participant. An example of a program and procedure that generates cost savings for a participant with such a chronic condition would include implementation of a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization.
II. APPLICATION FOR PARTICIPATION IN THE PROGRAM

The sponsor must submit an application for the Program in accordance with the Interim Regulations. The information that must be included in the application is set forth below. In addition, the following are key aspects of the application process:

- **Importance of timely and complete application.** Applications will be processed in the order in which they are received. No more applications will be accepted once the Secretary determines that no further funds will be available. If an application is incomplete, it will be denied and the applicant must submit a new application, which will be processed based on when the new application is received. Therefore, it is important that applicants submit complete applications upon their first submission. The Interim Regulations specify that HHS will be providing assistance to plan sponsors to help ensure that applications are complete the first time. No details on how this assistance will be made available are provided.

- **One application per plan.** An application must be submitted for each plan of the sponsor.

- **Identification of plan year cycle.** The application must identify the plan year cycle for which the plan sponsor is applying (i.e., the starting and ending month and day; no year is required). In general, the plan year is the plan year designated in the plan document. If the plan document does not designate a plan year, if the plan year is not a 12-month plan year, or if there is no plan document, the plan year is (i) the deductible or limit year used under the plan; (ii) the policy year, if the plan does not impose deductibles or limits on a 12-month basis; (iii) the sponsor’s taxable year if the plan does not impose deductibles or limits on a 12-month basis and either the plan is not insured or the insurance policy is not renewed on a 12-month basis; or (iv) the calendar year in any other case.

- **Signature of an authorized representative.** To verify the accuracy of the information contained in the application, the application must be signed by an authorized representative. The Interim Regulations define an authorized representative to mean an individual with legal authority to sign and bind a plan sponsor to the terms of a contract or agreement.

- **Annual application approval not required.** Once a plan is certified, the application approved, and the plan sponsor continues to satisfy the requirements of the statute, the plan and plan sponsor will continue to be certified and the application approved.

**Application Requirements**

The application for the Program must include the following:

- the applicant’s TIN;
- the applicant’s name and address;
- the applicant’s contact information;
- an agreement between the plan sponsor and HHS (a “sponsor agreement”) signed by an authorized representative that includes information set forth in the Interim Regulations (including an assurance that
the sponsor has a written agreement with the insurer or plan regarding disclosure and an attestation that policies are in place to detect fraud, waste and abuse) and such other information as the Secretary may require;

• a summary of how the sponsor will use reimbursements, including
  – how the sponsor will use the reimbursement to reduce plan participant or plan sponsor costs or a combination of both;
  – the sponsor’s plans to implement programs and procedures to generate savings for plan participants with chronic and high-cost conditions; and
  – how the sponsor will use the reimbursement to maintain its level of contribution to the plan;

• projected reimbursement amounts for the first two plan-year cycles;

• all benefit options under the plan that may be claimed by any early retiree for whom the applicant may receive program reimbursement; and

• any other information the Secretary requires.

The Interim Regulations contemplate that an application will be issued, which may include requirements for additional information.

III. CLAIMS SUBMISSION

Documentation

A plan must be certified before claims may be submitted. The Program will only accept claims that represent costs for health benefits for an early retiree that have already been incurred and paid. A “claim” includes documentation specifying the health benefit provided, the incurred date, the individual for whom the health benefit was provided, the date and the amount of payment minus any known negotiated price concessions and the plan and benefit option under which the health benefit was provided. Plan sponsors should only submit claims that are between $15,000 (cost threshold) and $90,000 (cost limit). Claims that are below $15,000 or above $90,000 will not be reimbursed. Claims must be submitted based on the amounts actually paid, which may include amounts paid by the early retiree, if the sponsor provides prima facie evidence that the retiree paid such amount. Such evidence may include an actual payment receipt.

All claim submissions must include a list of early retirees for whom claims are being submitted. Both the documentation of actual cost of claims and the list of early retirees must be submitted in a form and manner to be specified by the Secretary. For an insured plan, the claims and the list of early retirees can be submitted directly to the Secretary by the insurer. Plan sponsors are responsible for ensuring that insurers submit the information required in a claim.

1 For plan years beginning on or after October 1, 2011, the $15,000 and $90,000 figures will be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index.
In the case of a plan where the provider does not produce a claim in the normal course of business—for example, a staff-model HMO—the information required must be produced and provided to the Secretary. The plan sponsor must ensure that the insurer submits the required information, which must be reasonable in light of the specific market the insurer is serving.

A sponsor may appeal to the Secretary within 15 days of an adverse determination with respect to a claim. No appeal is available if the claim was denied due to lack of further funding under the Program.

**Definition of Health Benefits Eligible for Reimbursement**

Claims may be submitted for reimbursement of “health benefits,” which is defined as medical, surgical, hospital, prescription drug and such other benefits as determined by the Secretary, whether self-funded or provided through insurance or otherwise. Health benefits also include benefits for the diagnosis, cure, mitigation or prevention of physical or mental disease or condition with respect to any structure or function of the body. This is not intended as an exhaustive list of health benefits.

Health benefits do not include “excepted benefits” as defined under HIPAA. These benefits provide limited types of coverage. Thus, for example, the Program will not reimburse benefits under the following if provided under a separate policy: long-term care benefits, limited scope vision and dental, benefits for a specified disease, or hospital indemnity or other fixed indemnity benefits.

**HIPAA Privacy**

Certain information required to be disclosed for claims reimbursement would be considered protected health information (PHI) under the HIPAA privacy rules, but can be disclosed to HHS. Because this information belongs to the plan and not the employer, the Interim Regulations require the plan sponsor to have an agreement in place to directly disclose this information to HHS. This disclosure will be considered to qualify for the exception to the HIPAA privacy rules for disclosures required by law.

**IV. REIMBURSEMENT AMOUNT**

The Program provides reimbursement in an amount equal to 80% of the portion of the health benefit costs that exceed $15,000 (cost threshold) but are below $90,000 (cost limit), and that are paid by the employment-based plan, the insurer or an early retiree. Costs are considered paid by an early retiree if paid by that individual or another person on behalf of the early retiree, and the early retiree is not reimbursed through insurance or other third-party payment arrangement. Because enrolled spouses, former spouses and dependents are considered separate early retirees, the cost threshold and cost limit would appear to apply separately to each of these individuals.

In determining amounts eligible for reimbursements in the case of an insured plan, amounts the insurer pays and the amount the early retiree pays are taken into account. Thus, the sponsor’s premiums are irrelevant.

Rather than reimbursement being available only for discrete health benefit items or services whose reimbursement total falls between $15,000 and $90,000, the Program will reimburse cumulative health benefits incurred in a given plan year that fall between such amounts. In addition, all costs for health benefits paid by the plan or by the early retiree for all benefit options the early retiree is enrolled in will be combined for purposes of determining the amounts below the cost threshold and above the cost limit for any given early retiree.
**Example:** An early retiree is simultaneously enrolled in two different benefit options within one group health plan—Option 1 as a retiree and Option 2 as a spouse of a retiree. For purposes of determining when the early retiree satisfies the cost threshold, all claims incurred and paid for that early retiree under each benefit option will be aggregated.

In determining the amount of a claim under the Program, the employment-based plan must take into account any negotiated price concessions (i.e., discounts, direct or indirect subsidies, or rebates) obtained by the plan. The Interim Regulations define negotiated price concession as any direct or indirect remuneration that would serve to decrease the costs incurred under the health plan.

**Transition Rule**

The Interim Regulations provide a transition rule for claims in 2010. With respect to claims incurred before June 1, 2010, the amount of such claims up to $15,000 count toward the cost threshold and cost limit. However, the amount of claims incurred before June 1, 2010, that exceed $15,000 are not eligible for reimbursement.

**Example:** Joe is an early retiree who incurs $20,000 in eligible health benefit expenses as of June 1, 2010, and $30,000 after June 1, 2010. Under the transition rule, the $20,000 of pre-June 1 expenses count toward the cost threshold. The sponsor may receive reimbursement of 80% of the $30,000 incurred after June 1 (i.e., $24,000).

**V. USE OF REIMBURSEMENTS**

The Interim Regulations take a fairly expansive view of how reimbursements may be used. Thus, reimbursements may be used to reduce sponsor costs or plan participant costs (e.g., deductibles and copayments). Although reimbursements are limited to claims for early retirees, reimbursements may be used to reduce costs for all plan participants, not just early retirees. Reimbursements may not be used as general revenue of the sponsor.

The Interim Regulations contemplate that plan sponsors will provide at least the same level of contribution to support the applicable plan as it did before the Program. Thus, for example, although reimbursements could be used to reduce increases in sponsor premiums, it is expected that reimbursements may not be used to pay current level premiums. HHS is expected to provide additional guidance with regard to how the Secretary will monitor the appropriate use of reimbursements.

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Health Care Reform:
A New Era Begins for Employer-Sponsored Coverage

In March, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (HCERA). The bills were signed on two separate days, thus creating two separate effective dates for provisions that are effective based on the “date of enactment” of the provision. H.R. 3590 became law on March 23, while H.R. 4872 became law on March 30. This advisory will refer to the two bills collectively as “health care reform.”

Health care reform includes a number of provisions that will have a significant impact on employer sponsored group health plans. Some of these provisions are effective immediately, while others become effective later (in some cases, as late as 2018). The key to complying with health care reform is understanding what applies to your plan and when.

To help you understand your obligations as an employer/plan sponsor, we have provided a detailed discussion of health care reform as it relates to group health plans, beginning with a general timeline of the applicable provisions. **NOTE:** References to “the Secretary” are references to the Secretary of Health and Human Services (HHS).


**Effective in 2010**

- **Credit for Small Employers.** Effective for taxable years beginning on or after January 1, 2010, small employers with 25 or fewer “full-time equivalent” employees and average annual wages of $50,000 or less are eligible for a tax credit equal to a portion of the employer’s cost to provide health insurance. The credit begins to phase out for employers with more than 10 full-time equivalent employees and/or average annual wages of more than $25,000.

- **Change in Definition of “Dependent” for Purposes of Tax Free Health Coverage.** Effective March 30, 2010, health care reform expanded the definition of “dependent” for purposes of tax free health coverage to include a “child” who will not yet turn age 27 during the year, regardless of whether the child otherwise qualifies as a tax dependent. See IRS Notice 2010-38. A “child” for this purpose is defined as in Internal Revenue Code (IRC) Section 152(f)(1), and includes children, stepchildren, adopted children and eligible foster children. This provision will have an immediate impact on plans such as flexible spending arrangements (FSAs) or health reimbursement arrangements (HRAs) that condition eligibility on a child qualifying as a tax dependent for health coverage purposes (i.e., under IRC Section 105(b)).
NOTE: Health care reform changed the definition of “dependent” for purposes of tax free health coverage only; it did not change the definition of “tax dependent” for purposes of the individual income tax rules.

- **Retiree Reinsurance.** By June 21, 2010 (90 days of March 23, 2010), HHS will establish a retiree reinsurance program that will reimburse eligible employer based plans for 80 percent of eligible claims between $15,000 and $90,000 for retirees (and their covered dependents) who are age 55 or older and are not eligible for Medicare. Both fully insured and self insured plans are eligible for the program. All reimbursements must be used to lower the cost of the plan. Plans must apply in accordance with procedures established by HHS. HHS has indicated that applications will be available in June and that the application process will be similar to that for the Medicare Part D subsidy.

- **High-Risk Pools.** By June 21, 2010 (90 days of March 23, 2010), HHS will establish a high-risk pool for individuals with a preexisting condition who could not otherwise obtain coverage. Until the high-risk pool is terminated in 2014, a group health plan must reimburse the high-risk pool for medical expenses incurred by the pool for individuals found to have been offered financial incentives to disenroll from the group health plan.

- **“Immediate” Health Insurance Reforms.** Health care reform contains two waves of individual and group health insurance reforms. The first of these “waves” is effective for the first plan year beginning on or after September 23, 2010 (i.e., the immediate reforms are generally not effective for calendar year plans until January 1, 2011). The immediate health insurance reforms include but are not limited to a prohibition on annual and/or lifetime limits on “essential benefits,” coverage of adult dependent children up to age 26, and a prohibition on preexisting condition exclusions for enrollees under the age of 19. See “Health Insurance Reforms” below for a more detailed discussion of these health insurance reforms.

### Effective 2011

- **Limitation on Over-the-Counter Reimbursements.** Effective for tax years beginning on or after January 1, 2011, over-the-counter (OTC) medicines or drugs are not eligible for reimbursement under an FSA, HRA or HSA unless the medicine or drug is “prescribed” (regardless of whether a prescription is required to obtain the item). This requirement would not apply to eligible OTC medical items other than medicines or drugs (e.g., bandages or contact lens solution). **NOTE:** This limitation takes effect January 1, 2011, without regard to the plan year of the health FSA or HRA.

- **HSA Distributions.** The excise tax for nonqualified distributions from HSAs is increased from 10 to 20 percent.

- **“SIMPLE” Cafeteria Plan Safe Harbor.** A new safe harbor from the applicable nondiscrimination rules for cafeteria plans (and certain plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance benefits) is provided for plans maintained by eligible employers to the extent certain requirements are met. An eligible employer is an employer with 100 or fewer employees during either of the two preceding years (provided it is a full year).

- **W-2 Reporting.** Beginning with the 2011 calendar year, employers must begin to report the “value” (i.e., the COBRA cost) of employer-provided health coverage on each employee’s W-2. Thus, the first W-2 affected will be the W-2 sent no later than January 31, 2012.
Effective 2012

- **CER Fee.** Effective for policy/plan years ending after September 30, 2012, insurers of fully insured plans and self-insured plans will be charged a fee equal to $2 ($1 in the case of policy/plan years ending during fiscal year 2013—i.e, the federal governmental fiscal year, October 1, 2012, to September 30, 2013) multiplied by the average number of covered lives. The fee is for funding comparative effectiveness research. The fee applies to accident or health insurance policies other than policies covering benefits exempt under HIPAA. The fee does not apply to policy/plan years ending after September 30, 2019.

Effective 2013

- **FSA Cap.** Effective for taxable years beginning on or after January 1, 2013, health FSA salary reductions are limited to $2,500 each year. The cap does not apply to employer contributions. The limit is indexed for inflation based on the CPI beginning in 2014.

- **Deduction of Retiree Medical Costs.** Effective for tax years beginning on or after January 1, 2013, the deduction previously permitted for amounts allocable to the Medicare Retiree Part D subsidy is eliminated.

- **Increased Medicare Tax.** Beginning in 2013, there is a 0.9 percent increase in Medicare taxes for those earning more than $200,000 for single individuals and $250,000 for joint filers. Also, such individuals would also be subject to a 3.8 percent tax on their net investment income (to the extent that total income exceeds the thresholds).

- **Compensation Deduction Limitation.** Effective for taxable years beginning after December 31, 2012, the deduction for compensation for workers who provide services to a “covered health insurance provider” is limited to $500,000 per year. There is no exception for performance-based compensation and the limitation also applies to deferred deduction remuneration (deferred compensation). For years beginning after 2012, a “covered health insurance provider” is a health insurance issuer with 25 percent or more of their gross premiums received from providing minimum essential coverage. A special rule applies the deduction limitation to any deferred deduction remuneration attributable to services performed during any taxable year beginning after December 31, 2009, and before 2013 but which is paid after December 31, 2012. For purposes of this rule, a covered provider is not limited to providers that provide minimum essential coverage. Thus, this rule may apply to insurers, such as those that provide only disability benefits, even though they are not subject to the restriction after 2012. This appears to be a drafting error, which hopefully will be addressed in regulations.

- **“Exchange” Reporting.** Effective March 1, 2013, employers must begin providing notice to employees of the existence of the exchange, how to qualify for a subsidy and the fact that the employee will lose the employer’s contributions for health coverage if he/she enrolls in the exchange (except as otherwise required for the free choice voucher).

- **Electronic Transaction Standards.** Plans must implement certain electronic transaction standards and certify compliance to HHS. The timing of certification varies depending on the type of transaction. For example, the health plan must certify compliance with electronic fund transfer, health claim status and health care payment and remittance advice standards established by health care reform by no later than December 31, 2013. Compliance with other standards, such as the health claims or equivalent encounter standard, is due no later than December 31, 2015.
**Effective 2014**

- **Exchange.** Effective January 1, 2014, the state-based exchanges are created. Although primarily for individuals, small employers (employers with 100 or fewer employees) may participate. For years before 2016, a state may limit small employers to those with 50 or fewer employees. Beginning in 2017, states may allow employers of any size to participate.

- **Individual Responsibility.** Effective January 1, 2014, most individuals are required to maintain “minimum essential coverage” or pay a penalty.

- **Employer Responsibility Requirements.** Effective January 1, 2014, employers become subject to a variety of requirements, including the “Pay or Play” mandate and free choice vouchers. See “Employer Responsibility” below for more detail on the employer responsibility requirements.

- **Fee on Insurance Providers.** Effective January 1, 2014, an annual fee is imposed on health insurance providers. The aggregate amount of the fee in each year on all “covered entities” is set forth in the statute and is allocated among covered entities based on market share. Covered entities subject to the fee generally include any entity that provides health insurance for United States health risks. The fee does not apply with respect to self-insured plans or to administrative fees received by insurers. Insurance that provides coverage described in IRC Section 9832(c) (i.e., coverage only for accident or disability income insurance, or any combination thereof, coverage only for a specified disease or illness, and hospital indemnity or other fixed indemnity insurance), long-term care insurance and Medicare supplemental health insurance are not taken into account for purposes of the fee. Certain tax exempt entities and VEBAs (other than those established by an employer) are also exempt from the fee.

- **Health Insurance Reforms.** Wave #2 of the health insurance reforms go into effect for plan years beginning on or after January 1, 2014. Such health insurance reforms include but are not limited to a prohibition on exclusions based on preexisting conditions for all enrollees, cost sharing limitations and a requirement to provide essential benefits for fully insured plans in the small group market. See “Health Insurance Reforms” below for more detail regarding the second wave of health insurance reforms.

**Effective 2018**

- **High Cost Plan Tax.** Beginning in 2018, the value of coverage in excess of certain thresholds is subject to a 40 percent excise tax. See “High Cost Plan Tax” below for more detail regarding the nuances of the high-cost plan tax.

**II. Health Insurance Reforms**

As noted above, health care reform includes several health insurance improvements and reforms, some of which are effective for plan years beginning on or after September 23, 2010, and others that are effective for plan years beginning on or after January 1, 2014. These reforms are added to the “HIPAA portability” subpart of the Public Health Service Act (generally applicable to health insurers and non-federal governmental plans), ERISA and the IRC. Thus, it would appear that such reforms do not apply to benefits that are “excepted benefits” under HIPAA (e.g., stand alone dental or vision, and non-coordinated cancer or hospital indemnity...
offered pursuant to a separate contract, etc). “Grandfathered” plans are also exempt from some but not all of the requirements. While the jury is still out, it would seem that these health insurance reforms also do not apply to self-insured stand alone retiree health plans.

Plans subject to collective bargaining agreements that were ratified prior to March 23, 2010, are not subject to the health insurance reforms until the later of the general effective date or the date the last applicable collective bargaining agreement expires.

We identify and discuss the health insurance reforms below, and provide a chart that identifies the insurance reforms applicable to “grandfathered” health plans. Provisions that are applicable to grandfathered plans (i.e., applicable to all plans) are denoted with an “NGF” (“no grandfather”) designation below.

A. The following health insurance reforms are effective for plan years beginning on or after September 23, 2010.

- **(NGF) Annual and lifetime limits on the dollar value of benefits.** Plans may not impose lifetime limits and only restricted annual limits, as determined by the Secretary, on the dollar value of essential benefits for any participant or beneficiary. For plan years beginning on or after January 1, 2014, group health plans and group health insurers may not impose any annual limits on essential benefits. Otherwise permissible lifetime or annual limits may be imposed on specified covered benefits that are not essential health benefits.

- **(NGF) Prohibition on rescissions.** Plans may not rescind coverage except in cases of fraud or intentional misrepresentation. This does not appear to prohibit employers from terminating group health plans.

- **Coverage of preventive care.** Plans must provide first dollar coverage (i.e., no cost sharing) for certain evidence-based preventive care, including well child care and certain immunizations.

- **(NGF) Coverage of adult children.** Plans that cover dependent children must provide for coverage of children until age 26. There is no requirement to cover children of covered dependent children, and the requirement is applicable even if the child is married or is not a tax dependent. Until January 1, 2014, grandfathered plans do not have to extend coverage if the child is eligible for other employer coverage.

- **Nondiscrimination rules for insured plans.** The nondiscrimination rules of IRC Section 105(h) previously applicable only to self-insured health plans are extended to fully insured group health plans.

- **(NGF) Preexisting condition exclusions.** With respect to enrollees under age 19, plans may not impose a preexisting condition exclusion or limitation.

- **(NGF) Cost reporting and rebate requirements.** A health insurance issuer that insures group health coverage must submit to the Secretary a report relating to loss ratios. Rebates to enrollees must be provided if the medical loss ratio is 85 percent (80 percent in the small group market) or such higher amount as permitted under State law. These requirements do not apply to self-insured plans.

- **Claims procedures.** Plans must establish an internal claims appeals process that:
  - provides notice in a culturally and linguistically appropriate manner of the review process and availability of any applicable health insurance ombudsman created by a state to assist claimants with appeals;
  - allows claimants to review the entire claim file and present evidence;
allows claimants to continue receiving coverage during the appeals process; and
- complies with the claims review procedures set forth in Department of Labor (DOL) regulations that apply to plans covered by ERISA.

Plans must also establish an external review process that complies with applicable state law and that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act developed by the National Association of Insurance Commissioners (NAIC) or, in the case of self-insured plans, meets similar requirements as provided by the Secretary. The Secretary may deem the existing external review process of a group health plan to be in compliance with the provisions of health care reform.

- **Patient protections.** Plans that require or provide for a designation of a primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. Health care reform also requires plans to comply with requirements regarding access to emergency services and obstetrical and gynecological care, and to allow designation of a pediatrician as a primary care provider for children.

- **Transparency requirements.** Group health plans and health issuers in the group market are subject to the same transparency requirements applicable to plans offered in the state exchanges. Under these requirements, such plans and issuers must provide to the Secretary, the applicable state insurance commissioner and the public the following information: claims payment policies and data, financial disclosures, enrollment (and disenrollment) data, data on rating policies, information on cost sharing and payments with respect to out-of-network coverage, information on participant rights and other information as determined by the Secretary.

- **Ensuring quality of care.** Plans must annually report to HHS and to enrollees (during each open enrollment period) regarding benefits under the plan that improve health, such as case management, disease management and wellness and health promotion activities. *NOTE:* HHS is to develop the reporting standards within two years of March 23, 2010.

- **(NGF) Uniform explanation of coverage.** The plan administrator (in the case of a self-insured plan) or the insurer (in the case of a fully insured plan) must prepare and distribute a paper or electronic summary of coverage to all applicants and all enrollees, both at the time of initial enrollment and at annual enrollment. This is in addition to the Summary Plan Description otherwise required by ERISA. The summary must satisfy certain uniform standards developed by the Secretary. HHS is directed to establish the standards within 12 months of March 23, 2010, and the summary must be provided within 24 months after that date. In addition, the plan or the issuer (as applicable) must notify enrollees of material changes to the coverage reflected in the most recent summary no less than 60 days in advance of the effective date of such coverage. Failure to comply may result in a $1,000 penalty for each failure. *NOTE:* This rule is effective for grandfathered plans beginning with plan years beginning on or after the date of enactment. Nevertheless, it does not appear as though the rule will have a practical effect until after HHS develops the reporting criteria.
B. The following health insurance reforms are effective for plan years beginning on or after January 1, 2014.

- **(NGF) Prohibition on preexisting exclusion limitations.** No preexisting condition exclusions or limitations are permitted for any enrollee regardless of age.

- **Fair health insurance premiums.** Health care reform identifies the factors that determine premium rate variances for coverage insured by health insurers in the small group market. For example, premiums may vary only by (i) individual or family coverage; (ii) rating area (as described in health care reform); (iii) age, except the rate may not vary by more than 3 to 1 for adults; (iv) tobacco cessation, except that the rate may not vary by more than 1.5 to 1.

- **Guaranteed availability of coverage.** Every health insurance issuer in the individual or group market in a state must generally accept every small employer and every individual in the state who applies for such coverage.

- **Guaranteed renewability of coverage.** Every health insurance issuer in the individual or group market must renew each employer and individual’s coverage (as applicable) upon request.

- **No discrimination based on health status.** Essentially, the same rules that currently exist under the Health Insurance Portability and Accountability Act (HIPAA) are included in health care reform. Health care reform does, however, raise the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage for those participating in the program (and allows the Secretaries of DOL, HHS and Treasury leeway to increase the percentage to 50 percent).

- **Prohibition on discrimination against providers.** No discrimination against a provider who is acting within the scope of his or her license is permitted. This does not mean, however, that a health plan must contract with any willing provider.

- **Cost-sharing limitations.** Certain cost-sharing requirements must be satisfied so out-of-pocket (OOP) expenses do not exceed the amount applicable to HSA-related coverage, and deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage (as indexed). Although unclear, there is some language that suggests the limit on deductibles only applies to fully insured plans in the small group market (100 employees or fewer).

- **Requirement to provide essential benefits.** Fully insured plans in the small group market (100 or fewer employees) must provide the “essential benefits” required to be offered by insurers in the exchange.

- **(NGF) Limitation on waiting periods.** Plans may not impose a waiting period in excess of 90 days.

- **Participation in clinical trials.** A plan may not prohibit qualifying individuals from participating in certain clinical trials or deny the coverage of routine patient costs for items and services furnished in connection with the clinical trial.
**What is a grandfathered plan?**

Under health care reform, group health plans in effect on the date of enactment are exempt from many of the health care reforms. The grandfather rule is not limited to individuals enrolled on the date of enactment, but rather new employees (and their families) may be covered under an employer’s grandfathered plan and family members of current employees who are covered by the grandfathered plan may also be added. Current employees without coverage are not expressly addressed.

The most significant outstanding issue surrounding grandfathered plan status is whether changes made to the plan in the future will terminate the plan’s grandfather status. Given the literal language and legislative history of health care reform, it would appear that future plan changes will not jeopardize grandfathered status, but this issue likely will need to be addressed by regulations.

The following chart identifies which insurance reforms apply to grandfathered plans.

<table>
<thead>
<tr>
<th>Insurance Reform</th>
<th>Effective Date</th>
<th>NGF – i.e., Applicable to Grandfathered Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prohibition on lifetime limits</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Restricted annual limits</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Prohibition on preexisting condition exclusion for enrollees under age 19</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Prohibition on rescissions</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Coverage of preventive care</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>No</td>
</tr>
<tr>
<td>Coverage of adult children</td>
<td>First plan year beginning on or after September 23, 2010; for group plans, coverage required before 2014 only if the child is not eligible for other employer coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Nondiscrimination rules for insured plans</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>No</td>
</tr>
<tr>
<td>Cost reporting and rebate requirements</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Claims appeal procedures</td>
<td>First plan year beginning on or after September 23, 2010</td>
<td>No</td>
</tr>
<tr>
<td>Transparency requirements</td>
<td>First plan year beginning on or after September 23, 2010*</td>
<td>No</td>
</tr>
<tr>
<td>Insurance Reform</td>
<td>Effective Date</td>
<td>NGF – i.e., Applicable to Grandfathered Plans</td>
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<tr>
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<td>----------------------------------------------</td>
</tr>
<tr>
<td>Ensuring quality of care</td>
<td>First plan year beginning on or after September 23, 2010*</td>
<td>No</td>
</tr>
<tr>
<td>Uniform explanation of coverage</td>
<td>First plan year beginning on or after September 23, 2010*</td>
<td>Yes</td>
</tr>
<tr>
<td>Prohibition on preexisting condition exclusions</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>Yes</td>
</tr>
<tr>
<td>Prohibition on annual limits</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>Yes</td>
</tr>
<tr>
<td>Fair health insurance premiums</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No</td>
</tr>
<tr>
<td>Non-discrimination based on health status</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No**</td>
</tr>
<tr>
<td>Prohibition on discrimination against providers</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No</td>
</tr>
<tr>
<td>Cost sharing limitations</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No</td>
</tr>
<tr>
<td>Requirement to provide essential benefits</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No</td>
</tr>
<tr>
<td>Limitation on waiting periods</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>Yes</td>
</tr>
<tr>
<td>Participation in clinical trials</td>
<td>First plan year beginning on or after January 1, 2014</td>
<td>No</td>
</tr>
</tbody>
</table>

*Requirements contingent on guidance from HHS, which is not expected until a later date.

**Although not subject to the new health insurance reform added by health care reform, grandfathered plans would presumably still be subject to the existing requirements under HIPAA that currently prohibit such discrimination for group health plans.
III. Employer Responsibility

Effective for months beginning on or after January 1, 2014 (except as noted below), employers must satisfy several requirements related to group health plan coverage.

- **Automatic Enrollment.** Subject to regulations to be issued by the DOL, large employers with 200 or more full-time employees that offer at least one health plan benefit option must automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The auto-enrollment program should include adequate notice and the opportunity for an employee to opt out of the “auto” coverage and elect another option, or opt out altogether. *NOTE:* The auto-enrollment requirement will be effective as of the date set forth in the regulations, and applies to large employers subject to the Fair Labor Standards Act.

- **Pay or Play Mandate.** Notwithstanding the obligation to comply with the reform requirements identified above, there is generally no requirement for employers to offer the same coverage that insurers offering coverage in the exchanges must offer. In fact, there is generally no requirement for employers to offer any coverage. However, employers with 50 or more full-time employees (Applicable Large Employers) are subject to penalties related to coverage that they offer or fail to offer to full-time employees (and their dependents).

An *Applicable Large Employer* is defined as an employer (and any other employer within the same controlled group) who employed on average at least 50 full-time employees on business days during the preceding year. However, an employer is not considered to be an Applicable Large Employer if the employer did not employ more than 50 full-time employees for more than 120 days during the preceding year. A “full-time employee” is defined as an employee who is employed on average at least 30 hours of service per week. An employer who would be an Applicable Large Employer based solely on “seasonal employees” (employees who work fewer than 120 days) is not considered to be an Applicable Large Employer. *NOTE:* Although not clear, it appears that seasonal employees are relevant only to the Applicable Large Employer determination. If the employer is an Applicable Large Employer without regard to the employer’s seasonal employees, it would appear that failure to offer coverage to such employees could trigger a penalty. Part-time employees are taken into account solely for the purpose of determining if an employer is an applicable large employer. The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time by 120.

  - **Failure to offer minimum essential coverage to full-time employees.** Applicable Large Employers who fail to offer any full-time employees “minimum essential coverage” must pay a penalty with respect to each full-time employee in any month in which any employee enrolls in and receives a subsidy for an exchange. The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer for that month (including those employees who did not receive a subsidy for the exchange) and 1/12 of $2,000. The first 30 employees are disregarded for calculating the penalty. Thus, for example, a business with 51 employees that does not offer coverage is subject to a tax equal to 21 times the applicable payment amount.

  - **Offering unaffordable coverage to full-time employees.** Applicable Large Employers offering “minimum essential coverage” for any month to a full-time employee who is certified as having enrolled in an exchange and received a tax subsidy are subject to a penalty equal to the product of the total number of such employees (i.e., employees receiving the credit) and 1/12 of $3,000. The amount of the tax in this instance is limited to 1/12 of $2,000 multiplied by the total number of the
employer’s full-time employees. An employee who is offered minimum essential coverage is not eligible for the subsidy unless the employee’s required premium for the coverage exceeds 9.5 percent of the individual’s household income or the plan’s share of allowed costs under the plan is less than 60 percent of the plan’s benefit cost (presumably 60 percent of the COBRA cost of the plan, less the 2 percent administrative fee).

“Minimum essential coverage” is defined in new IRC Section 5000A (as added by health care reform) as an “eligible employer sponsored plan” or a “grandfathered plan.” It appears that any group health plan coverage offered by an employer (other than excepted benefits) will qualify as minimum essential coverage for purposes of the pay or play rules to the extent it complies with the applicable health insurance reforms mentioned above.

- **Reporting requirements.** Applicable Large Employers must also report to the Secretary of Treasury each year, certifying:
  - whether coverage is offered to full-time employees;
  - the waiting period for any such coverage;
  - the number of full-time employees of the employer during each month; and
  - the name, address and Taxpayer Identification Number (TIN) of each full-time employee and the months during which they were covered under the plan.

- **“Free choice vouchers.”** Employers that offer minimum essential coverage and make a contribution must offer “free choice vouchers” to qualified employees for the purchase of qualified health plans through the exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their household income does not exceed 400 percent of the federal poverty level, and the required contribution under the employer’s plan would be between 8 and 9.8 percent of their household income. Free choice vouchers are excludible from employees’ incomes and deductible by the employer, and voucher recipients are not eligible for tax subsidies through the exchange. Although HCERA revised the minimum threshold percentage to qualify for a subsidy for the exchange to 9.5 percent, and this same percentage should likely be the maximum percentage to qualify for a free choice voucher, HCERA did not change the maximum percentage specifically identified in the free choice voucher section. This appears to have been an oversight.

### IV. High-Cost Plan Tax

Beginning in 2018, a nondeductible 40-percent excise tax is imposed on the monthly value of high-cost coverage in excess of 1/12 of $10,200 for single coverage and 1/12 of $27,500 for family coverage. The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, construction workers, miners) and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage. These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018. The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter. An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer’s age and gender demographics are not representative of a national average. Additionally, the higher family threshold applies to both single and family coverage offered under a multiemployer plan.
“Coverage providers” are defined to include the following:

- in the case of fully insured plans, the health insurer;
- in the case of HSA or medical savings accounts (MSA) contributions, the employer making the contributions; and
- in the case of a self-insured plan, the person who administers the plan (e.g., the third-party administrator).

In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (and may also include HSA contributions). The coverage provider’s applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider’s coverage to the total value of employer-sponsored coverage. Although the coverage provider is responsible for paying the tax, the employer must calculate the tax, including each coverage provider’s applicable share, and notify each coverage provider.

The coverage subject to this rule includes the following:

- The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee. The value of certain excepted benefits (as defined by HIPAA) are not included, such as (i) non-integrated dental or vision, (ii) long-term care insurance, (iii) any coverage identified in IRC 9832(c)(1) other than onsite health care, (iv) hospital indemnity and/or specified disease coverage that is paid for with after-tax dollars—even if a group plan;
- Both non-elective and salary reduction contributions to a health flexible spending arrangement (FSA); and
- Employer contributions to an HRA and HSA (presumably including salary reductions to an HSA).

In addition, employers must include the value of all such coverage on the employee’s Form W-2. The W-2 reporting requirement applies for all tax years beginning on or after January 1, 2011.
If you would like to receive future Employee Benefits and Executive Compensation Advisories electronically, please forward your contact information including e-mail address to employeebenefits.advisory@alston.com. Be sure to put "subscribe" in the subject line.

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Members of Alston & Bird’s Employee Benefits & Executive Compensation Group
Employee Benefits and Executive Compensation Practice

Overview

At Alston & Bird, we have developed a large group of lawyers with a unique set of skills and experience, all geared toward solving increasingly critical benefits and compensation issues for our clients. Thirty lawyers, based in Atlanta, New York and Washington, D.C., practice exclusively in the area of employee benefits and executive compensation. This is one of the largest practice groups of its kind in the country.

Our employee benefits and executive compensation lawyers are grouped in four practice areas: health & welfare plans, tax-qualified retirement and savings plans, executive compensation and ERISA litigation. Each lawyer in our group focuses his or her practice in one of these four areas. The breadth, depth and focus of our practice allow us to provide solutions to complex problems quickly and efficiently.

Health and Welfare Plans

It has been said that the only constant in life is change. Nowhere is this maxim more evident than in the realm of health and welfare benefit plan design, administration and compliance. Given current legislative and regulatory trends, the dynamic rate of change affecting health and welfare benefits will only accelerate. Against this back-drop of rapid change, prudent employers and plan administrators struggle to “know the law” and properly apply it as it develops. Members of our Health & Welfare Benefits Practice (the “H&W Practice”) provide the advice and practical know-how necessary to ensure ongoing compliance for health and welfare benefit plans and avoid potential liability.

Alston & Bird was one of the first firms to recognize and act upon the need for focused health and welfare benefits expertise. John Hickman leads an experienced core of attorneys devoted to assisting clients with health and welfare benefit issues. Members of the H&W Practice have attained national recognition through publishing, lecturing and day-to-day client representation. In addition to serving as special benefits counsel for H&W matters for several Fortune 100 firms, Alston & Bird H&W members serve as counsel to benefit trade associations and interact on a daily basis with key regulatory agencies (e.g., IRS, DOL and DHHS).

In addition to technical expertise, we also understand the human element of administering health and welfare benefits. Our nationwide clients benefit from regular newsletter and email updates, and attend monthly client discussion group teleconferences and meetings. With Alston & Bird, answers to complex health and welfare compliance issues are never more than a phone call away. On a daily basis we advise our clients in connection with:

- compliance with health care reform implementation issues arising under the Affordable Care Act
health care confidentiality issues arising under HIPAA
issues arising from the establishment and maintenance of consumer-directed health care arrangements such as Health Savings Accounts, Health Reimbursement Arrangements and other defined contribution arrangements
assessing and limiting potential liability associated with health benefit plan design and managed care arrangements;
the preparation and review of “readable” plan documents, summary plan descriptions and benefit summaries
participation in and compliance with government programs such as Medicare Part D
compliance issues arising under the health care continuation requirements of COBRA
addressing new technological applications (Internet, email, etc.) to the benefit delivery process
negotiating administration agreements for health, life, disability and tuition benefits
plan design approaches to limit potential risk under the Age Discrimination in Employment Act (ADEA), Americans with Disabilities Act (ADA) and the Family and Medical Leave Act (FMLA)
cafeteria and flexible benefits compliance and design issues, including credit-based flex plans, health and dependent care spending accounts, vacation buy/sell arrangements and other forms of “flexible” compensation
ERISA and tax compliance issues relating to complex pre-funding arrangements, VEBAs and captive insurance
preemption issues arising in connection with managed care and innovative health care delivery systems
ERISA, tax and related compliance issues arising in connection with domestic partner (and non-traditional dependent) benefit arrangements
pre-tax transportation (parking and mass transit) arrangements
handling benefit claim disputes and appeals
design and administration issues arising in connection with tuition aid, severance, employee assistance (EAP), disability and life insurance arrangements
minimizing exposure to worker misclassification and contingent worker claims
assisting with health and welfare plan aspects of mergers and acquisitions
evaluating potential retiree medical exposure and cost-reduction strategies
client advocacy before the DOL, IRS, HCFA and other federal agencies relating to health and welfare plan matters
• internal health and welfare plan audits relating to federal requirements such as tax, HIPAA, ERISA and COBRA
• preparing prototype documentation and service agreements for worksite marketing and plan service providers

Representative Transactions: Health and Welfare Plans

• We conducted a health care confidentiality audit and established a HIPAA-compliant health care confidentiality policy for several Fortune 100 clients.
• We conducted high-level meetings with the IRS and DOL concerning potential prohibited transaction issues relating to re-insuring employee welfare benefits.
• We prepared an issues paper for several Fortune 100 clients addressing tax and ERISA compliance issues when health and welfare benefits are extended to domestic partners.
• We conducted a comprehensive health and welfare benefits compliance audit (tax, HIPAA, COBRA, ERISA, ADA, ADEA, etc.) for a large financial institution.
• We conducted an exposure audit, and reviewed and updated service agreements for self-funded health, life and disability benefits for a company that has over 200,000 employees.
• We designed and implemented one of the first salary reduction qualified transportation programs (parking and mass transit).
• We reduced Form 5500 and audit obligations for a Fortune 100 client by combining over 40 discrete welfare benefit programs into a single wrap umbrella plan.
• We established for an insurer client the largest ever worksite marketing program through the creation of a prototype flexible benefits plan that has been adopted by over 100,000 employers.
• We prepared and reviewed prototype administration agreements for use by an insurer in connection with administering Fortune 100 benefit arrangements.
• We assisted several large financial institutions, and administrators with the design and implementation of health savings account products.

Tax-Qualified Retirement and Savings Plans

We have a large and experienced group of lawyers who work with 401(k) plans, ESOPs and pension plans to bring unique solutions to each client’s situation. Few other law firms can offer the following:

• In Washington, D.C., we have several benefits lawyers who maintain regular contact with government officials at the Internal Revenue Service, Department of Labor, Pension Benefit Guaranty Corporation and Securities and Exchange Commission. For example, Tom Schendt spent seven years as chief of Branch 7 of the IRS National Office (responsible for coordinating IRS employee plan audit policies) before joining our Washington, D.C., office in 1996 as a partner. He focuses on government audits and rulings, and self-compliance
initiatives. Tom has continued his government relationships as chair of several high profile conferences between government and private practitioners.

- Carolyn Smith was the third-ranking staffer of the Joint Committee on Taxation of the United States Congress before joining Alston & Bird. Carolyn was instrumental in drafting much of the legislation affecting our clients, and has invaluable relationships in the government.

- David Godofsky, a partner in our Washington, D.C., office, is also a fellow of the Society of Actuaries (F.S.A.), and was vice chairman of the Education and Examination Committee of the Society of Actuaries. We are the only major law firm in the country to have an admitted, practicing lawyer who is also a fellow of the Society of Actuaries. David was a member of the task force appointed by the American Academy of Actuaries to advise Treasury, the IRS and the Department of Labor on regulations under the Pension Protection Act.

- Craig Pett, one of our partners in the Atlanta office, is also an adjunct professor teaching employee benefits law at Emory University Law School.

- Our lawyers often speak at major employee benefits conferences and are prolific authors. We often have articles in the Benefits Law Journal, Benefits and Compensation Law Alert and other benefits oriented legal journals. Our partners are frequently quoted in BNA, Employee Benefit News and similar publications.

On a daily basis, we advise our clients in connection with the following:

**Plan Design and Compliance**
- 401(k) plans
- ESOPs
- Traditional pension plans
- Cash balance and pension equity plans

**Complex Audits and Self Audits**
- IRS, Department of Labor and PBGC audits
- Compliance self-reviews
- CAP, VCR and SVP

**Mergers and Acquisitions**
- Due diligence
- Structuring covenants
- Solving complex plan transitions

**Fiduciary Advice**
- Plan investment advice to plan sponsors
- Advice to investment advisors
- DOL prohibited transaction exemptions
Representative Transactions: Tax Qualified and Savings Plans

Representative business transactions and engagements that exhibit our range of experience include the following:

- We represented a major regional financial services company in a merger of equals, including the design and implementation of dozens of employee benefits plans for the combined entity.
- We filed with the Internal Revenue Service the largest single “self-compliance” filing ever received by the IRS National Office.
- We have worked with our capital markets attorneys in conducting due diligence and structuring transitions in literally hundreds of purchase, sale, merger and spin-off transactions in the last five years.
- We designed and drafted in the late 1980s one of the first cash balance pension plans in the country, and have since successfully defended class action challenges to several clients’ cash balance plans.
- We structured and implemented a $125 million leveraged ESOP, including creation of convertible preferred stock issued to the ESOP.
- We created a unique software program that allows a client with multiple qualified plans to quickly try "what if" scenarios for Separate Line of Business (SLOB) testing.
- We advised a major client on fiduciary implications in the purchase of a pension annuity contract for several hundred million dollars.
- We regularly advise venture capital funds on "plan asset" rules, including VCOC exemptions.
- We regularly advise real estate funds and pension funds on fiduciary and UBIT aspects of real estate investments.

Executive Compensation

The executive compensation practice at Alston & Bird is one of the country’s preeminent groups of lawyers who focus solely on executive compensation matters. Unlike many firms, where employee benefits generalists may spend a portion of their time on executive compensation matters, the executive compensation lawyers at Alston & Bird are "full time" executive compensation lawyers who focus on the tax, securities and corporate governance laws and regulations that have a direct effect on executive compensation for public, private and multi-national companies.

Executive pay has soared into public focus in recent years, creating a lightning rod for sweeping legislative and cultural reforms. With these reforms comes an entirely new and continually evolving regulatory environment: The Emergency Economic Stabilization Act of 2008 (EESA) and the American Recovery and Reinvestment Act of 2009 (ARRA), Sarbanes-Oxley compliance, regulation of deferred compensation under IRC Section 409A, changes to the accounting regime for stock-based compensation and evolving proxy disclosure rules for executive compensation and related party transactions are only a handful of challenges facing public companies on a daily
basis. Our compensation team stays up-to-the-minute on fast-breaking issues and makes sure our clients are among the first to know of and understand how new developments affect them.

One of our partners, Laura Thatcher, co-authored the *Compensation Committee Handbook, 3rd Edition* (John Wiley & Sons, 2008), which serves as a single-source guidebook for compensation strategies and practices, addressing a full range of functional issues facing compensation committees of public companies, including organization, planning, compliance and sound corporate governance. Ms. Thatcher is Chair of the Advisory Board of the Certified Equity Professional Institute (CEPI) of Santa Clara University and serves on the Executive Compensation Task Force of CompensationStandards.com, which is dedicated to promoting responsible compensation practices.

Our executive compensation attorneys are frequent speakers and authors on topics relating to executive compensation and related matters, with articles and interviews appearing in numerous national publications.

Our executive compensation attorneys play an integral role in virtually all major M&A transactions in the firm, as well as the more business-as-usual matters that are a part of every public company’s business environment.

**Scope of Executive Compensation Services**

- Advising board compensation committees as to trends and responsible practices in evaluating, setting, monitoring and disclosing executive compensation
- Proxy disclosure of executive compensation and related party transactions
- Corporate governance advice from the viewpoint of Sarbanes-Oxley, SEC rules, stock exchange requirements and institutional investor policies and preferences
- “Real time” current reporting of events and transactions under Form 8-K and Section 16 rules
- Analysis of director independence under various regimes, including in Section 16, IRC Section 162(m), SEC regulations and stock exchange rules
- Strategies for optimizing shareholder approval of new equity plans and arrangements in light of institutional investor policies and voting guidelines
- Designing equity-based compensation and incentive programs to avoid inadvertent costs under evolving accounting principles, deferred compensation rules (IRC 409A) and tax deduction limits (IRC Section 162(m))
- Director compensation plans, and tracking trends in director compensation
- Tracking the evolution of director and officer fiduciary duties under Delaware and other laws, including developing strategies to minimize liability and provide maximum protection through indemnification, exculpation and adherence to sound practices in corporate governance
• Employment, retention, severance and change in control agreements for senior executive officers
• Deferred compensation strategies, including analysis, compliance, reporting and corrections under IRC Section 409A
• Design of performance compensation vehicles that meet the requirements for full deductibility under IRC Section 162(m)
• Executive compensation issues relating to business combinations, including due diligence analysis of compensation arrangements and detailed analysis of “golden parachute” excise tax issues
• Securities Act registration of incentive and benefit plans, including prospectus delivery and exchange listing requirements
• Advice regarding securities implications and risks of providing issuer stock as an investment alternative in participant-directed plans, such as 401(k) plans and non-qualified deferred compensation arrangements
• Short-swing profit and insider trading issues
• Periodic sales and purchase programs under Rule 10b5-1
• Global stock plans
• Executive compensation issues relating to restructurings and spin-offs

**Representative Transactions: Executive Compensation**

• We represented the largest specialty retailer of toys in the United States in the compensation and benefits aspects of its leveraged buyout in which it was acquired by three major private equity firms.
• We represented a leader in the paper products industry in the creation of a tracking stock for its timber products line of business, which was one of the first transactions of its type in the United States and was replete with novel incentive compensation issues.
• We represented an NYSE-listed global financial security company with a stock option repricing, providing guidance with respect to the shareholder approval process, tax and corporate governance issues and international considerations. We have represented numerous public and private companies in working through the issues relating to an option repricing.
• We worked directly with the board of a multibillion-dollar NYSE-listed company from the outset of its spin-off of a major business segment, helping to develop strategies to address stock options, restricted stock, employee stock purchase plans and other incentive compensation arrangements. Since that time, we have worked with several public companies in working through the challenging issues of equitable treatment of equity awards in the context of a spinoff.
We have developed hundreds of incentive compensation plans and programs for public and private companies, in each case after an analysis of the unique position and needs of the company, including its stage of life and plans for the future.

We serve as the “go-to” firm for executive compensation and employee benefits for many major public companies whose other legal work is principally handled by other firms.
## Representative Employee Benefits and Executive Compensation Clients

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TAB H
Faculty
David R. Godofsky, F.S.A.
Partner

David Godofsky is the leader of the firm's Employee Benefits & Executive Compensation Group. He has a multidisciplinary practice which is unique in the United States. His ability to integrate legal analysis with cost, funding, administration and benefit design considerations is informed by his education and years of experience as an actuary and consultant. Mr. Godofsky also provides unique subject matter expertise as part of a team of litigators who have represented several major employers in cutting-edge, class action litigation and other “bet the company” litigation matters.

Mr. Godofsky is a fellow of the Society of Actuaries and has held several prestigious posts in the actuarial profession. Before joining Alston & Bird, he spent 18 years designing, implementing and administering employee benefit plans, determining costs, and helping employers control costs and get the most for their employee benefits budgets. His clients seek his advice for practical, workable solutions to complex problems, and the ability to make highly technical concepts understandable to executives, employees, judges and arbitrators.

In addition to being a fellow of the Society of Actuaries, Mr. Godofsky is an enrolled actuary and a former director of the Conference of Consulting Actuaries. Mr. Godofsky is also on the program committee (and a past chairman) of the Enrolled Actuaries Meeting, an annual continuing education program attended each year by more than 25 percent of the pension actuaries in the United States.

Mr. Godofsky is the author of the Society of Actuaries’ study note on prudent investing of pension funds and edited its study note on purchasing annuity products for pension investment purposes. He was vice chairman of the Education and Examination Committee of the Society of Actuaries.

Mr. Godofsky was a member of the executive committee of a prestigious actuarial firm immediately before joining Alston & Bird. He served as actuary for a $20 billion pension fund and for several major corporations, hospitals and municipalities.
John R. Hickman  
Partner

John Hickman is head of the firm’s Health Benefits Practice where he leads five attorneys devoted exclusively to HIPAA privacy, flexible benefits, and other health and welfare benefit issues. Mr. Hickman has been a pioneer in the consumer-directed health care arena and has worked closely with health plans, financial institutions and employers as well as the IRS, Treasury and DOL in developing guidance for tax-favored health reimbursement arrangements (HRAs) and health savings accounts (HSAs).

Mr. Hickman has been listed in The Best Lawyers in America, Super Lawyers magazine and Who’s Who Legal in the employee benefits area. Mr. Hickman has lectured widely and published articles on HIPAA, ERISA litigation, cafeteria and health plan issues. He is co-author of the Cafeteria Plans Manual, HIPAA Portability and Privacy, and Consumer-Driven Health Care (published by the Employee Benefits Institute of America). Mr. Hickman has been called upon by benefits and trade associations to testify before the IRS and DOL on issues affecting health and welfare benefit plans including HIPAA, cafeteria plan regulations, DOL claims procedures and the HIPAA health care privacy regulations.

Mr. Hickman is an adjunct professor of law at Emory University School of Law. He is on the editorial advisory board of the Benefits and Compensation Law Alert and the Employee Benefits Adviser, is on the board of the Employers Council on Flexible Compensation (ECFC), and is on the publications committee of the Self Insurance Institute of America.

He received his J.D. from Emory University School of Law, graduating with distinction, where he received the Order of the Coif award.
Ashley Gillihan
Counsel

Ashley Gillihan is counsel in the Atlanta office and a member of the firm's Employee Benefits & Executive Compensation and ERISA Litigation Groups. Mr. Gillihan focuses his practice exclusively on health and welfare employee benefit compliance and litigation issues for employers, health plan administrators and other health and welfare benefit plan service providers. He also has extensive experience assisting financial institutions and insurance companies who serve as Health Savings Account trustees or custodians.

Mr. Gillihan is active in publishing and speaking on various health and welfare benefit plan related topics and serves as a faculty member and/or technical advisor for several health and welfare benefit plan focused organizations.

Ashley is a member of the Employer's Council on Flexible Compensation (ECFC) Technical Advisory Council and the board of editors for the Benefits and Compensation Law Alert, published by M. Lee Smith Publishers. He was named to the Benefits Committee for the Self-Insurance Institute of America, Inc. and served from 2007-2008. He is also a faculty member for the Institute for Applied Management and Law (IAML), and is the primary author of the Flexible Benefits Answer Book published by Aspen Publishers.

Ashley received his undergraduate degree from Western Kentucky University and his law degree from Samford University's Cumberland School of Law in 1996. He is a member of the Alabama Bar Association, Tennessee Bar Association and the Georgia Bar Association.
Carolyn E. Smith
Counsel

Carolyn’s practice encompasses a full range of executive compensation and employee benefits issues as well as a variety of federal tax regulatory and legislative matters.

Carolyn brings to her practice a unique blend of technical and policy experience. Prior to joining Alston & Bird, Carolyn was Associate Deputy Chief of staff of the Joint Committee on Taxation, U.S. Congress. During her 20+ years on the Joint Committee staff, she was responsible for major pension, health, and tax legislation from the Tax Reform Act of 1986 through the Pension Protection Act of 2006. Recent provisions for which she had primary responsibility include the PPA funding and cash balance provisions, Code Section 409A, HIPAA rules, and Health Savings Accounts. She was a primary author and project manager of Congressional reports on Federal tax issues, including the Joint Committee staff reports relating to the investigation of the tax and compensation practices of Enron and simplification of the tax laws. She served as technical and policy adviser to the members and staffs of the House Ways and Means and Senate Finance Committees on a broad spectrum of Federal tax issues. She also worked closely with the Department of Treasury, the Internal Revenue Service, the House Education and Labor Committee, the Senate Committee on Health, Education, Labor and Pensions, the Pension Benefit Guaranty Corporation and the Department of Labor.

Carolyn capitalizes on her prior experience in her current practice by offering cost effective strategic and creative solutions. She assists clients not only in compliance, but in planning for and keeping ahead of the increasingly changing and dynamic regulatory, legislative, and economic environments.

Before joining the Joint Committee staff, Carolyn was in private practice, focusing on executive compensation and employee benefits. She served as a law clerk to Judge Samuel Conti of the Northern District of California.

Carolyn received her J.D. from the Boalt Hall School of Law, University of California, Berkeley, where she was editor of the Industrial Relations Law Journal. She received her B.A., summa cum laude, in economics from the University of California, San Diego where she was awarded the Seymour E. Harris Award for Excellence in Economics.

In recognition of her achievements while working for the Congress, she was featured in the National Journal’s 2007 Special Report on “The Hill People.”
Johann Lee
Associate

Johann Lee concentrates his practice on health and welfare benefits law issues for employers, associations, insurers, and health care and administrative service providers. His extensive experience in this area covers the full spectrum of issues involved in the proper and efficient design, financing and delivery of employee health & welfare benefits and related services, including issues under ERISA, HIPAA and the Internal Revenue Code.

Mr. Lee is a contributing author of the *Flexible Benefits Answer Book* (5th ed., Aspen Publishers), and a frequent author and speaker on complex health and welfare benefit issues that impact businesses. He received his J.D. from the Northwestern University School of Law and his B.A. in philosophy from the University of Michigan.

**Services**
Tax
Employee Benefits & Executive Compensation

**Education**
Northwestern University
(J.D., 1997)
University of Michigan
(B.A., 1994)

**Admitted to Practice**
District of Columbia
Michigan
Laurie K. Kirkwood
Associate

Laurie K. Kirkwood is a member of the firm’s Employee Benefits & Executive Compensation Group. Ms. Kirkwood concentrates her practice on health and welfare benefit plans, including compliance with the tax, ERISA, HIPAA and other federal law matters that arise in the administration of such plans. She also has experience assisting clients with executive compensation plans and 409A compliance.

Ms. Kirkwood is a member of Women in Pensions. She has spoken on common ERISA plan compliance errors before an audience of human resource specialists and has assisted with presentations on 409A compliance. She is also a member of the State Bar of Georgia and the Atlanta Bar Association.

Services
Tax
Employee Benefits & Executive Compensation

Education
Emory University
(J.D., 2005)

Georgia State University
(B.A., 1994)

Admitted to Practice
Georgia
Anne Tyler Hamby
Associate

Anne Tyler Hamby is an associate and a member of the Employee Benefits & Executive Compensation Group with a practice focus on health and welfare benefits and qualified plans. Ms. Hamby’s practice includes working on design, implementation, and administration matters related to health and welfare benefits and qualified plans. She also assists with employee benefits issues related to corporate mergers and acquisitions and works on various aspects of executive deferred compensation arrangements, including compliance with Internal Revenue Code 409A.

In addition, Ms. Hamby has experience working with health plans regarding compliance with ERISA and HIPAA requirements, including related programs such as cafeteria plans and health reimbursement arrangements. Ms. Hamby has co-authored several health and welfare benefit and qualified plan client advisories and is currently co-authoring a chapter on “Laws Related to Group Health Plans” that will be published in the 2010 Benefits Law Manual.

Ms. Hamby received her J.D. from the University of Alabama in 2006, where she was an articles editor for the Alabama Law Review and studied international tax at the University of Fribourg in Switzerland. Anne Tyler received her Masters in Tax Law (Certificate in Employee Benefits), with distinction, from Georgetown Law Center in 2007. She served as SGA president at Birmingham-Southern College, where she received a B.A. in finance and economics, magna cum laude, in 2000. Ms. Hamby was selected as a Rotary Scholar and received her Masters in International Development from the University of Bath (England) in 2002. Upon returning to the U.S., she worked for the Senate Commerce Committee in Washington D.C. as a legislative correspondent.
Additional EBEC Practice Group
Attorneys
Employee Benefits & Executive Compensation Group Members

**Robert A. Bauman**, Counsel, Washington, D.C.

Bob Bauman is a member of the firm’s Tax Group, as well as its Employee Benefits & Executive Compensation Group. Mr. Bauman concentrates his practice on employee benefit law, ERISA and qualified retirement plans.

**Saul Ben-Meyer**, Partner, New York

Saul Ben-Meyer concentrates on employee benefits, executive compensation, and employment-related tax matters with an emphasis on multinational transactions and related issues. Mr. Ben-Meyer has over 30 years of experience advising global organizations and individuals on the compensation and benefits implications of multinational business transactions and cross-border hiring, transfer and separation of executives, as well as multinational executive compensation programs, including global stock options and other nonqualified deferred compensation arrangements.

Mr. Ben-Meyer also counsels large employers on every facet of retirement plan design, implementation and administration. He provides advice on regulatory compliance with the Internal Revenue Code and ERISA. His practice covers all types of tax-qualified plans, as well as non-qualified deferred compensation plans and funding arrangements. In addition, he handles the ERISA and deferred compensation aspects of executive employment agreements, change in control agreements and severance programs, including compliance with Code Section 409A and 457A.

**Patrick C. DiCarlo**, Partner, Atlanta

Patrick DiCarlo focuses his practice on ERISA litigation with a particular emphasis on the ERISA and securities issues that arise in the retirement plan context. His practice has long focused on disclosure issues under ERISA as well as the federal and state securities laws.

Mr. DiCarlo’s practice involves not only defense of litigation, but also counseling clients on regulatory compliance issues with an emphasis on ERISA and securities issues surrounding the development and sale of financial products in the retirement plan context. In the health and welfare context, Mr. DiCarlo serves as lead counsel for one of America’s largest disability insurers in their matters nationwide.
Anna M. Grant, Counsel, Atlanta

Anna Grant advises clients on implementation and administration and compliance matters relating to qualified plans and executive compensation arrangements. Anna also represents both acquirers and target companies in private equity transactions and strategic mergers and acquisitions.

Before entering the legal field, Anna was head of the human resource department of a large manufacturing conglomerate comprised of over 40 operating companies. In this role, she managed compliance and administration for U.S.-based retirement and welfare plans and developed an extensive knowledge of benefits and compensation issues related to mergers, acquisitions and divestitures. She supervised and conducted due diligence on benefits and compensation matters in connection with mergers and acquisitions and following such transactions she was responsible for all post-acquisition benefit plan and human resources integration.

H. Douglas Hinson, Partner, Atlanta

Doug Hinson is the leader of the firm’s ERISA Litigation Group. He has led the defense of numerous Fortune 500 clients in various types of ERISA class actions, including 401(k)/employer stock, benefit termination, defined benefit calculation and severance matters. In addition, Mr. Hinson has substantial experience and expertise in securities, complex commercial and insurance class action litigation.

James (Jamie) S. Hutchinson, Partner, New York

Jamie Hutchinson is Chair of the firm’s Partners’ Committee and Partner-in-Charge of the New York office. He has practiced in the benefits and compensation area since joining Alston & Bird in 1979. He has special expertise involving executive deferred compensation and rabbi trusts, ERISA fiduciary issues, and mergers and spin-offs of pension, 401(k) and other tax-qualified plans.

Lindsay B. Jackson, Associate, Washington, D.C.

Lindsay Jackson’s practice includes working on design, implementation, compliance and administration matters related to qualified plans. She is proficient in German.
David C. Kaleda, Partner, Washington, D.C.

David Kaleda has extensive experience with qualified plan compliance, design and drafting. His practice includes managing compliance projects for plans with as many as 30,000 participants, serving as a regulatory technical advisor and working on Internal Revenue Service and Department of Labor self-correction projects and audits. He also has experience advising plan sponsors, plan service providers and plan fiduciaries on issues arising under Title I of ERISA. Mr. Kaleda also advises clients on compliance, design and drafting issues related to Section 409A of the Internal Revenue Code.

Blake C. MacKay, Partner, Atlanta

Blake MacKay concentrates his practice on ERISA, qualified plans and executive compensation. His practice involves advising clients on matters related to qualified retirement plans (including pension, cash balance, profit-sharing, 401(k) and ESOPs), 403(b) plans, 457(b) plans and other retirement and deferred compensation plans for tax-exempt entities. Mr. MacKay assists clients with the voluntary correction of errors involving qualified retirement plans with the IRS and DOL, as well as with legal audits with the IRS, DOL and PBGC. He also assists clients with employee benefits issues related to corporate mergers and acquisitions. He advises clients with respect to the ERISA and deferred compensation aspects of executive deferred compensation arrangements, employment agreements, change-in-control agreements and severance programs, including compliance with Internal Revenue Code Section 409A.

Emily W. Mao, Partner, Washington, D.C.

Emily Mao focuses her practice on advising employers on all aspects of employee benefits and executive compensation, including design, drafting, compliance, administration and termination of tax-qualified and non-qualified plans. In addition to advising clients on ERISA, tax and executive compensation issues on a day-to-day basis, Emily also counsels public companies and private companies on employee benefits matters arising from corporate mergers, acquisitions, outsourcings and restructurings. Her transactional work has also involved handling numerous plan mergers and terminations. Emily also regularly advises clients with regard to ERISA Title I matters, including the special responsibilities of plan fiduciaries and issues relating to employee benefit plan investments in hedge funds, real estate funds and other investment vehicles.

Emily also counsels employers on how to comply with changes in the law, including the Pension Protection Act of 2006 and Section 409A of the Internal Revenue Code which imposes substantial new rules on non-qualified, deferred compensation arrangements. In addition, Emily has been involved in the legislative process on behalf of clients seeking changes or clarifications to existing laws. Finally, Emily advises employers on the administration of health plans and welfare plans, including compliance with tax, ERISA and other federal laws.
Sean K. McMahan, Associate, Atlanta

Sean McMahan is an associate in the ERISA Litigation Group. His practice is focused on ERISA and includes class action litigation involving employer securities in 401(k) plans, calculation of pension benefits, fiduciary liability, welfare plan claims and disclosure responsibilities under ERISA.

Craig R. Pett, Partner, Atlanta

Craig Pett concentrates his practice on ERISA, qualified retirement plans and executive compensation. His practice includes advising clients on matters involving defined benefit pension plans, 401(k) plans and ESOPs; executive compensation issues arising under Code Section 409A; legal audits and dispute and voluntary resolution with the Internal Revenue Service, Department of Labor and Pension Benefit Guaranty Corporation (including IRS, DOL and PBGC audits and voluntary correction of errors involving qualified retirement plans); merger and acquisitions involving ERISA plans; 403(b) plans and other qualified and non-qualified retirement plans for tax-exempt entities; early retirement windows and initiatives; and executive incentive and deferred compensation. Mr. Pett has assisted many clients with the Internal Revenue Service voluntary correction and compliance programs and Department of Labor correction programs.

Thomas G. Schendt, Partner, Washington, D.C.

Tom Schendt focuses his practice on employee plan litigation, agency civil and criminal audits, investigations and disputes and voluntary compliance initiatives involving the Internal Revenue Service, Department of the Treasury, Department of Labor, Pension Benefit Guaranty Corporation, U.S. Securities and Exchange Commission and the Department of Justice. Tom also regularly counsels large employers on the practical effect of various qualification requirements that are issued by appropriate government agencies. This includes assisting clients with the execution of various plan administration and qualification requirements under Titles I & II of ERISA. Tom also focuses on fiduciary issues affecting plan providers, including plan fee disclosure, exemption issues, and implications of recent PPA provisions.

Prior to joining the firm, from 1988 to 1996, Tom held a number of positions with the Internal Revenue Service. As technical assistant to the associate chief counsel, Employee Benefits and Exempt Organizations (EBEO) for the Office of Chief Counsel, Internal Revenue Service, Tom assisted in the coordination of national employee benefits litigation for the IRS, including plan disputes and compliance initiatives. He also acted as a liaison between the National Office of the Internal Revenue Service and various field offices, including Exam and Appeals.

John B. Shannon, Partner, Atlanta

John Shannon focuses his practice on all aspects of executive compensation, including the tax, securities, accounting and corporate governance issues that directly impact executive pay arrangements. He regularly advises public and private clients with
respect to equity-based and other incentive compensation arrangements, nonqualified deferred compensation, executive employment, severance and change-in-control agreements. Mr. Shannon has significant experience in tax and securities issues relating to executive compensation, including proxy and Form 8-K disclosure of executive compensation arrangements, Section 16 reporting and insider trading regulation, 10b5-1 plans, 280G golden parachute matters, Section 162(m), and deferred compensation regulations under Section 409A.

**Maya D. Simmons**, Associate, Atlanta

Maya Simmons is an associate in the ERISA Litigation Group. Her practice focuses primarily on ERISA, specifically class action litigation involving employer securities in 401(k) plans and complex litigation involving pension and welfare plan claims, as well as other issues that arise in the retirement plan context such as fiduciary liability and disclosure requirements.

**Michael L. Stevens**, Partner, Atlanta

Mike Stevens concentrates his practice on executive compensation matters, with a particular emphasis on tax, securities, and corporate governance issues relating to incentive compensation arrangements, executive employment and change in control agreements and deferred compensation. Mr. Stevens frequently advises clients with respect to executive compensation issues relating to mergers and acquisitions and other corporate transactions. His clients include large multinational corporations, closely-held businesses and individual executives.

**Jahnisa P. Tate**, Associate, Atlanta

Jahnisa Tate is an associate in the ERISA Litigation Group. Her practice focuses primarily on ERISA, specifically class action litigation involving employer securities in 401(k) plans and complex litigation involving pension and welfare plan claims, as well as other issues that arise in the retirement plan context such as fiduciary liability and disclosure requirements. Ms. Tate also has experience defending against individual ERISA claims involving disability and life insurance claims.

**Laura G. Thatcher**, Partner, Atlanta

Laura Thatcher leads the executive compensation practice with a distinct and individualized focus on the tax, securities, accounting, corporate governance and labor laws and regulations that have a direct effect on executive compensation. She and her team have daily experience in the compensation matters that are part of every corporate environment: advising boards and management with regard to equity-based and other incentive compensation arrangements; nonqualified deferred compensation; executive employment, separation and change-in-control agreements; proxy and 8-K reporting of executive
compensation arrangements; Section 16 reporting and insider trading regulation; corporate
governance issues; and director and officer indemnification and fiduciary concerns. Her team stays up
to the minute on fast-breaking issues and makes sure our clients are among the first to know of and
understand how new developments affect them. Her team also serves an essential role in virtually all
major M&A transactions in the firm, providing analysis of equity incentives and guidance as to the
most efficient treatment of executive transitions under golden parachute rules.

Kerry T. Wenzel, Associate, Atlanta

Kerry Wenzel represents both public and private clients in establishing and
administering executive compensation arrangements, including both plan-based
compensation arrangements and executive employment and change in control
agreements. Ms. Wenzel’s practice focuses on tax and securities issues relating to
executive compensation, including Section 16 reporting and insider trading regulation,
proxy disclosure rules, Form 8-K reporting obligations, 280G golden parachute rules,
Section 162(m), deferred compensation regulations under Section 409A and director and officer
indemnification and fiduciary issues.

Kyle R. Woods, Associate, Atlanta

Kyle Woods is an associate in the Employee Benefits & Executive Compensation Group.

He received his J.D., magna cum laude, from Brigham Young University. He has also
studied human rights and comparative constitutional law at Central European University
in Budapest, Hungary.