National Rural Electric Cooperative Association®
A Touchstone Energy® Cooperative

# Frequently Asked Questions
# How the Affordable Care Act Affects Co-ops

**Updated June 5, 2013**

## What's New?

The impact of the Affordable Care Act continues to change due to government guidance and regulations, legal challenges and acts of Congress. Here's the latest.

**Updated**

- Q. 9, p. 9, to clarify that all funds for the Early Retiree Reinsurance Program have been exhausted, and HHS will officially end all program activities January 1, 2014
- Q. 42, p. 21, to announce that the distribution due date for the state insurance exchange notices is October 1, 2013
- Q. 44, p. 21, to announce that the state insurance exchanges are now called the Health Insurance Marketplace
- Q. 45, p. 21, to add the latest guidance on what the exchange notices should include
- Q. 46, p. 22, to provide the links to the model notices provide by the DOL for the exchange notices
- Q. 51, p. 23, to add the latest guidance on minimum value, including acceptable methods for determining it

**Added**

- Q. 36, p. 19, to define the Patient-Centered Outcomes Research Institute (PCORI)
- Q. 37, p. 19, to explain the PCORI fee being imposed to fund certain PCORI research
- Q. 38, p. 20, to list the dollar amounts of the PCORI fee for the next few years
- Q. 39, p. 20, to explain what plans are subject to the PCORI fee
- Q. 40, p. 20, to explain the various methods for calculating the PCORI fee, including what co-ops should do if they do participate in the NRECA Medical Plan, and what they should do if they don't participate in it
- Q. 41, p. 21, to explain how the PCORI fees will be calculated
- Q. 43, p. 21, to describe how co-ops and other employers must deliver exchange notices

### Important Dates

**Later in 2013**

- PCORI fee due (Q. 41, p. 21)
- Health Insurance Exchange (state insurance exchanges) notice (Q. 42, p. 21)

**2014**

- Employer shared responsibility (pay or play) penalty (Q. 51, p. 23)
- Reinsurance fee (Q. 53, p. 25)
- 90-day waiting period limits (Q. 58, p. 26)
- New wellness program incentive rules (Q. 65, p. 28)
- HIPPA certificates discontinued (Q. 66, p. 29)

*Plan-specific answers in this FAQ apply to medical plans sponsored by NRECA and to 125 Plan health flexible spending accounts and health reimbursement arrangements administered by Cooperative Benefit Administrators (CBA). Cooperatives in non-NRECA plans may be affected by the Affordable Care Act differently. Answers reflect NRECA's interpretation of agency guidance. NRECA cannot provide legal advice to co-ops. Speak with your co-op legal counsel before making any decisions about how to meet requirements of the Affordable Care Act.*

- Q. 53, p. 25, to describe what is the reinsurance fee
- Q. 54, p. 26, to announce the reinsurance fee for 2014, plus how much is expected to be collected the next few years
- Q. 55, p. 26, to explain who is responsible for the reinsurance fee
- Q. 56, p. 26, to address if tax-advantaged side accounts are subject to the reinsurance fee
- Q. 57, p. 26, to explain how the reinsurance fee will be collected
- Q. 61, p. 27, to address how to handle employees who are already in a waiting period before January 1, 2014 effective date for the 90-day waiting period limit
- Q. 62, p. 27, to explain how days are counted for the 90-day waiting period
- Q. 63, p. 28, to announce which waiting period options will no longer be available January 1, 2014
- Q. 66, p. 29, to announce that plans will no longer be required to issue HIPAA certificates of creditable coverage as of December 31, 2014

**Note:** All FAQs that have been revised or added since the original publication date of this document (April 29, 2010) are individually dated. The updates and additions for this version of the document are highlighted in red.

## Sections



## Topics (with question number)

| Topics (with question number) | Page(s) |
|---|---|

## General issues and affect on co-ops in the NRECA Medical Plan

**1. The changes in the Affordable Care Act appear overwhelming. What are co-ops to do?**

The Affordable Care Act is broad and sweeping legislation, but many of the changes in the law do not directly affect electric cooperatives. The NRECA Group Benefits Program (GBP) already complies with many provisions of the law, and many other requirements that will impact co-ops do not take effect immediately. The changes that do affect co-ops require NRECA, as plan administrator, to do most of the work on behalf of co-ops.

It's also important to remember that there is potential for changes to the application of the law as the government issues guidance and regulations. Changes also could result from legal challenges to the new law and actions of future Congresses. We will work with you to ensure that we all understand what co-ops must do to meet the requirements as efficiently as possible. **Updated June 29, 2010**

**2. What are the positive effects on co-ops of the Affordable Care Act?**

NRECA has been working with policymakers from the beginning of the health care debate to protect the interest of electric cooperatives. On the positive side, we preserved the ability of each co-op to tailor its employer-provided health benefits package as allowed now under the federal Employee Retirement Income Security Act (ERISA). We were able to get plans that cover electric line workers classified as high risk, giving co-ops a higher threshold than most other plans before the 40% "Cadillac Tax" kicks in. We also participated in the successful effort to push this tax back to 2018. We supported provisions that permit employers to offer stronger incentives to individuals who participate in wellness and chronic disease management programs, which will decrease costs in the long run. The new law also includes individual insurance reforms that we supported, like preventing insurers from dropping coverage or excluding pre-existing conditions. It also gets millions of currently uninsured Americans into health insurance coverage—a central tenet of reducing the "cost shift" to plans like ours from uncompensated care provided to the uninsured.

**3. What other impacts are there on co-ops from the Affordable Care Act?**

While there were many positives for co-ops in the final law, there are some negatives too. Several areas of the law cause us concern because they will increase rather than decrease our health care costs. Specific areas include the 40% "Cadillac tax" on high-cost plans—though this new tax won't take effect until 2018. Also, while the new law significantly expands access to coverage for millions of Americans, it remains to be seen if it has done enough to change the trend in which health care costs double every seven years. The new law also creates new fees and taxes levied across the health care industry on medical device manufacturers, drug companies and others that will simply be passed along to co-ops, and other health care users, to pay for these increased costs. The law also creates new limits on tax-advantaged side accounts (like 125 Plan health flexible spending accounts that many co-op employees rely on) and cuts Medicare payments to providers to pay for "reforms" four full years before many coverage provisions even begin. We are very concerned that this will merely intensify the current health care "cost-shift" from government plans like Medicare to

employers like co-ops as the medical system tries to make up for the shortfall. NRECA already is working with Congress and meeting with regulators on technical corrections to the law to address these concerns.

**4. What is NRECA doing to ensure that co-ops maintain the full flexibility to make plan design changes to meet their benefits needs and manage costs?**

Based on recent guidance and our own analysis of the health care legislation, NRECA has determined that there are restrictions imposed on grandfathered plans that require them to maintain their current plan designs with little or no modifications. Operating under these limitations would be contrary to our primary objective of retaining the flexibility for co-ops to make plan design changes that meet their benefit needs and help them manage costs. We believe being a non-grandfathered plan will allow co-ops to continue to provide the best benefits for employees and their families while meeting the business needs of the co-op.

**Added July 13, 2010**

**5. What are the implications of being a non-grandfathered plan?**

Fortunately, the NRECA Group Benefits Program's medical plans already comply with nearly all of the applicable requirements of the Affordable Care Act, and can comply with those that remain with manageable changes. The plan changes that take effect on January 1, 2011 for non-grandfathered plans are minimal and require action by NRECA only. In fact, we were already taking many of these steps as of January 1, 2011 regardless of our grandfathered status because we determined they were in the best interest of co-ops. These changes include eliminating all cost-sharing for preventive care, reimbursing out-of-network emergency room services at the in-network level and including external review as part of the claims and appeals process. Also, because the NRECA Medical Plan will be a non-grandfathered plan, co-ops in the NRECA plan will not be able to exclude adult children up to age 26 from coverage if they have their own employer-provided coverage (see FAQ 17).

**Added July 13, 2010**

**6. What plan changes could jeopardize the grandfathered status of my co-op-sponsored health reimbursement arrangement (HRA)?**

HRAs are plans sponsored directly by co-ops and are managed separately from the NRECA Group Benefits Program. CBA only provides administrative services for these plans. So, while the NRECA Group Benefits Program has chosen non-grandfathered status, CBA-administered HRAs in existence on March 23, 2010 remain grandfathered unless a co-op implements changes that jeopardize the HRA's grandfathered status. Grandfathered plans need not implement the more burdensome requirements of the Affordable Care Act until 2014.

Plans changes that could cause a loss of grandfathered status include, but are not limited to, the following:

- Eliminating all benefits to diagnose or treat a particular condition;
- Increasing the percentage cost-sharing requirement;
- Increasing deductibles or out-of-pocket limits;

- Increasing fixed-amount copayments by a certain amount; or
- Reducing the employer's "contribution rate" toward the cost of any tier of coverage by more than five percent. Contribution rate is defined as the amount of employer contributions compared to the "total cost of coverage" determined in the same manner as the COBRA premium.

Since CBA-administered HRAs have no cost-sharing provisions that could change or condition-specific benefits that could be eliminated—and employers always contribute one hundred percent of the contributions to these plans—all CBA-administered HRAs in existence on March 23, 2010 should retain grandfathered status.

*The above is our interpretation of the Affordable Care Act and HRA rules. We cannot give co-ops legal advice about their co-op-sponsored plans. Co-op's are encouraged to speak with their legal or tax advisor.*

**Note:** Sample documentation for CBA-administered grandfathered and non-grandfathered HRA plans is available on the Employee Benefits web site. Go to Administration > My Co-op's Insurance > Tax-Advantaged Side Accounts > HRA - What You Need. The sample documentation for grandfathered plans contains a statement that the co-op intends for the HRA plan to be a grandfathered plan. The sample documentation for non-grandfathered plans contains sample language for the changes to the claims and appeals procedures that must be implemented by non-grandfathered plans for 2011. **Updated December 1, 2010**

## 2010 changes that affect co-ops in the NRECA Medical Plan

Unless otherwise noted, the changes addressed in the questions in this section take effect in 2010.

**7. How is the Medicare Part D Prescription Drug Plan coverage gap or "doughnut hole" being closed? How does it affect NRECA Medicare Part D plans?**

Standard Medicare Part D prescription drug coverage currently has a $3,610 coverage gap, sometimes referred to as the "doughnut hole," where Medicare Part D participants pay 100% of their prescription costs. The new law closes this gap over time.

In 2010, eligible Medicare Part D participants will receive a one-time check for $250 from the government to begin to bridge this gap. All participants will receive this rebate after they have more than $2,830 in total drug costs for 2010, even if their plans do not have a coverage gap. It may take up to four months to receive the check once a participant reaches the coverage gap. The first checks were mailed on June 10 and are being mailed monthly thereafter.

From 2011 to 2020, the coverage gap will continue to close gradually through manufacturer discounts on brand-name drugs and reduced participant cost-sharing for brand-name and generic drugs. **Updated June 29, 2010**

**8. Will this gradual elimination of the coverage gap have any impact on my co-op's FAS 106 liability?**

It may. While the change directly affects only NRECA's Basic, Basic Plus and Copayment Medicare Part D plans, which have a coverage gap, over time gradual elimination of the coverage gap may help to reduce the cost of the Enhanced and Enhanced Plus plans to co-ops and participants. Any reduction in the cost for Enhanced and Enhanced Plus plans could be a reduction in liability under Financial Accounting Standard (FAS) 106, which may result in long-term savings. If your co-op offers and pays all or part of the cost of NRECA's Enhanced or Enhanced Plus Medicare Part D plans, you may want to ask NRECA, or your consulting actuary, to recalculate your FAS 106 liability. **Updated May 18, 2010**

**9. Can you explain the Early Retiree Reinsurance Program and how NRECA will take advantage of it?**

The law provides for a $5 billion Early Retiree Reinsurance Program (ERRP) to assist qualified employer plans that apply to participate and are selected by the government. Under this program, claims ranging from $15,000 to $90,000 for early retirees age 55 to 64 and their dependents are eligible for an 80% reinsurance reimbursement from the government. Funds for the program have been exhausted, and HHS will officially end all program activities January 1, 2014. The reinsurance occurs at the plan level, not the co-op (employer) level, so no action is required by co-ops.

In August 2010, the NRECA Group Benefits Program was approved for the Early Retiree Reinsurance Program. As of December 2011, we have received reimbursements of over $9 million. We are using this money to support programs that help all participants achieve better health outcomes and contain costs, such as the Centers of Excellence programs, MyHealth Coaches and disease management programs. We have additional reimbursements of over $1 million pending.

As of November 30, 2011 Health and Human Services (HHS) reported that $500 million in ERRP funds remain. It's anticipated that most of those funds would be disbursed by the end of the year, so HHS announced that no claims submissions would be accepted for expenses incurred after 12/31/11. However, HHS looked to recover some funds through an audit process. Recovered funds would then be disbursed to employer plans that are "next in line" to receive reimbursement after the initial $5 billion was fully exhausted. NRECA filed its next reimbursement request in early January 2012 to receive any funds that were still available from the original $5 billion and to be in line for funds recovered through the audit process.
**Updated June 5, 2013**

**10. Why doesn't the reinsurance money go back directly to co-ops and specifically for early retirees?**

Retirees who are under 65 are charged the same premium as active employees, even though active employees are younger and healthier as a group. This is the reason that even co-ops that provide no contribution towards retiree's insurance have to recognize the liability associated with this subsidy for FAS 106 purposes. So even if the pre-65 retiree pays

the full premium without any co-op contribution, co-ops that make coverage available to pre-65 retirees effectively bear some of the cost of providing coverage to this group.

While the savings resulting from the reinsurance program will benefit pre-65 retirees, they may do so principally by slowing the rate of premium increases for all participants.

**Added December 1, 2010**

**11. What is the current status of the Early Retiree Reinsurance Program?**

As of the date of this FAQ update, the $5 billion in appropriated funds has been exhausted. No new funding is expected. **Added February 20, 2013**

## 2011 changes that affect co-ops in the NRECA Medical Plan

Unless otherwise noted, the changes addressed in the questions in this section take effect on January 1, 2011.

**12. How does the requirement to cover children to age 26 affect the NRECA Medical Plan?**

The new law requires group health plans that offer dependent coverage to now provide coverage for children up to age 26 regardless of student status, marital status or support by the employee, if the employee chooses to cover them. This new rule does not require the plan to cover the child's spouse or their children.

As of January 1, 2011, NRECA Group Benefits Program will require co-ops that choose to cover dependents to provide coverage of children up to age 26 regardless of student status, marital status or support by the employee, as required by the new law. This requirement goes into effect on January 1 for all co-ops, regardless of their renewal date. Coverage will terminate as of midnight on the last day the covered child is 25 years of age.

**Note:** Providing dependent coverage to age 26 under the medical, prescription drug, dental, and vision plans does not trigger imputed income. The IRS Notice 2010-38 confirming this is at www.irs.gov/pub/irs-drop/n-10-38.pdf. Coverage to age 26 under the child life and family AD&D insurance plans may trigger imputed income for the employer-paid portion of coverage.

*The above is our interpretation of the Affordable Care Act. We cannot give co-ops legal or tax advice on imputed income. Co-ops are encouraged to speak with their legal or tax advisor to determine imputed income impacts.* **Updated July 13, 2010**

**13. Does the tax-free treatment for coverage of adult children to age 26 also extend to health savings account reimbursements?**

Since the Affordable Care Act did not change the health savings account (HSA) rules for reimbursement, those rules continue to limit reimbursements to the Internal Revenue Code definition of a dependent (i.e., must be a dependent on the employee's federal tax return). Any reimbursements from HSAs for expenses incurred by an adult child would not be considered reimbursements of "qualified medical expenses" and would not be eligible for

favorable tax treatment. Thus, these reimbursements would be included in the employee's income and subject to the excise tax, which will be increased from 10% to 20% effective 1/1/2011 (see FAQ 27).

However, in cases where adding an adult child increases the employee's deductible from individual to family, the "family portion" of the deductible that is contributed by the co-op to the HSA would still continue to be excluded from the employee's income as employer-provided coverage under an accident or health plan, which the Affordable Care Act addressed to include coverage of adult children. **Added May 18, 2010**

**14. To which NRECA benefits does coverage of children up to age 26 apply?**

Where offered by the co-op, coverage up to age 26 applies to medical, prescription drug, dental, vision and child life and family AD&D insurance benefits. **Updated May 18, 2010**

**15. Since coverage of children up to age 26 applies to medical plans, does it also apply to 125 Plan accounts and HRAs?**

Coverage under the CBA-administered 125 Plan Premium-Only Plan (POP), 125 Plan health flexible spending account (health FSA) and health reimbursement arrangement (HRA) has been extended to children up to age 26, effective May 1, 2010. This is an across-the-board change for all CBA-administered POPs, Health FSAs and HRAs that is consistent with the age 26 coverage for group benefit plans.

For POPs, this change means that employee premiums for health coverage for children up to age 26 may be paid by employees on a tax-free basis. For health FSAs, this change means that eligible medical, prescription drug, dental and vision expenses for children up to age 26 can be reimbursed from this account. For HRAs, this change means that eligible medical and prescription drug expenses for children up to age 26 can be reimbursed from this account.

Co-ops will need to amend their 125 Plan and HRA documents by December 31, 2010 to reflect these changes. Sample amendments and summaries of material modifications for 125 plans and HRAs are available on the Employee Benefits web site. Go to Administration > My Co-op's Insurance > Tax-Advantaged Side Accounts > 125 Plans - What You Need.

**Note:** For the 2010 plan year, this coverage change only applies to children who were covered dependents on May 1, 2010 and who would otherwise have lost eligibility for coverage because of their age, marriage or loss of student status before the end of the year. **Updated December 1, 2010**

**16. Can the co-op charge the cost of adding a non-dependent adult child to the employee? And will NRECA create additional rating tiers to accommodate this?**

While early analysis from the Obama administration indicated that charging the cost of the additional coverage to the employee for these so-called adult children was an option, it is the opinion of our legal staff that the interim final rules issued by HHS, DOL and Treasury

don't permit the premiums for an adult child to be determined differently than the premiums for any other covered child.

Specifically, the rules state that the terms of the plan, including the premiums charged, for dependent child coverage cannot vary based on the age of the child. According to this language, co-ops cannot charge employees any additional premium for the coverage of adult children. So, unless future guidance leads us to conclude otherwise, NRECA doesn't plan to create additional rating tiers as a result of this new coverage rule. **Added May 18, 2010**

**17. Can co-ops exclude adult children up to age 26 from coverage if they have their own employer-provided coverage?**

No. When a co-op offers coverage to dependents then all adult children up to age 26 are also eligible, at the election of the employee (parent), for coverage regardless of the availability of medical coverage from their own employer's plan. It's important to remember that NRECA already coordinates benefits where other coverage exists for a covered participant. In the event that an adult child covered under the co-op's plan also becomes covered under his or her own employer's medical plan, then the co-op's plan will generally become a secondary payor to that other employer's plan. As such, any potential costs attributable to the few adult children who might be eligible for coverage under another employer's plan should be minimal and largely offset by the reduced administrative burden and enforcement required by benefits administrators at your co-op. And, at the end of 2013, the ability of employers that cover dependents in their health plans to exclude these adult children expires. **Added July 13, 2010**

**18. Is it true that only the statement of dependency form and not adoption papers, divorce decrees or other documentation are now required when adding children who are not biological offspring, common law spouses or domestic partners to group benefits?**

It's true that NRECA will no longer require copies of adoption papers, divorce decrees, court orders or common law spouse affidavits along with the statement of dependency (SOD) form when adding children who are not biological offspring, common law spouses and domestic partners to benefits. **However, it's important that employees adding these dependents to benefits have these papers, as they will be requested later during routine eligibility audits.**

To verify that dependents being added into coverage meet eligibility requirements, NRECA will conduct routine eligibility audits. Supporting documents will be requested during an audit. If, during the course of an eligibility audit, it is determined that a dependent was not actually eligible for the coverage that was provided by virtue of the employee's attestation on the SOD, that coverage will be removed back to the effective date of coverage for that dependent and the employee will bear the responsibility for any financial impacts resulting from the loss of coverage, including adjustments to previously paid claims. **Added December 1, 2010**

**19. Are 125 Plan health flexible spending account reimbursements for over-the-counter medical supplies and medicines and drugs being eliminated?**

No, but there are some changes effective January 1, 2011. As of that date, 125 Plan health FSA participants may request reimbursement for over-the-counter (OTC) medical items and supplies and prescribed OTC medicines and drugs, which are defined as items used for medical care and not merely for an individual's general good health. To be eligible for reimbursement, an OTC item or supply or medicine or drug must meet all of the following requirements:

- used for the diagnosis, cure, mitigation, treatment or prevention of disease
- used by the participant, his or her spouse or the participant's eligible dependents
- purchased during the period of coverage

In addition, an OTC medicine or drug is eligible for reimbursement only if prescribed by a medical provider and the prescription accompanies the claim for reimbursement. This is the case even though the medicine or drug is available without a prescription. Insulin, however, remains eligible for reimbursement regardless of whether it has been prescribed by a doctor.

In determining whether an OTC item or supply, or medicine or drug is eligible for reimbursement under the 125 Plan, keep in mind these four categories:

- **Excluded items**—These items are never eligible for reimbursement and are primarily used for general health and well-being. Examples include cosmetics, toiletries, toothpaste, toothbrushes, face creams and multivitamins.

- **Medical-only items/supplies**—These items and supplies are generally eligible for reimbursement if primarily used to treat a medical condition. Examples include sunburn ointments, nicotine gum or patches for smoking cessation, Band-Aids and bandages, carpal tunnel wrist supports, diabetic supplies and pregnancy kits.

- **Medical-only medicines/drugs—**These medicines and drugs are generally eligible for reimbursement if primarily used to treat a medical condition and prescribed by a doctor. Examples include antacids, allergy medication, pain relievers, cold medications, eye drops, cough drops, antibiotic ointments and sleep aids.

- **Dual-purpose items/supplies—**These items could be used for general good health as well as medical purposes. Dual-purpose items could include sunscreen, nasal sprays for snoring, special shampoos, and special foods and beverages. In order for dual-purpose items to be reimbursed, CBA requires a doctor's certification stating the individual has a medical condition, the item is being used to treat the condition and the condition is not cosmetic in nature. **Updated September 20, 2010**

**20. When does the requirement to report employees' health benefit costs on W-2s go into effect?**

This requirement has been deferred one year, making it optional for the 2011 tax year, the IRS announced in mid-October 2010. The delay gives employers and group health plans more time to change their payroll systems or procedures to comply with the requirement. Reporting will be mandatory for all W-2s (see FAQ 21) issued in 2013 (for the 2012 tax year). Under current law, employees will not be taxed on the value of these benefits.

**Updated January 25, 2012**

**21. Are all employers subject to the requirement to report employees' health benefit costs on W-2s?**

No. The IRS issued interim guidance in March 2011 that provides transition relief for employers that are required to file fewer than 250 W-2s for the 2011 tax year. These employers are *not* subject to the W-2 reporting requirement for the 2012 tax year. Note that for related employers, this exception applies on a non-controlled group basis. This relief continues until further guidance is issued. Guidance can only apply prospectively and will not apply to any calendar year beginning within six months from the date guidance is issued.

Interim guidance issued in January 2012 clarifies that whether an employer is required to file fewer than 250 W-2s for a calendar year is based on the W-2s that the employer would be required to file if it filed W-2s to report all wages paid by it and without regard to the use of an agent to pay wages.

**Added January 25, 2012**

**22. For the requirement to report employees' health benefit costs on W-2s, which health benefits must be reported?**

In general, employers must report the aggregate cost of employer-sponsored health coverage under a group health plan that is excludable from employees' gross income.

The IRS issued interim guidance in March 2011 that clarifies the W-2 reporting requirement and provides transition relief for certain types of employer-sponsored plans. When the requirement goes into effect for the 2012 plan year, W-2s must contain both employer and employee costs for medical and prescription drug coverage, as well as for dental plans and non-VSP vision plans that are 100% employer-paid. Employer contributions, determined by a formula, to 125 Plan health flexible spending accounts (health FSA) also must be included. For more on calculating an employee's health benefits costs for his or her health FSA, see question 24.

Contributions to health savings accounts and employee salary deferrals to Health FSAs are excluded from this reporting rule. Employers also don't need to report contributions to health reimbursement arrangements until further guidance is issued.

Interim guidance issued in January 2012 states that the costs of employee assistance programs, wellness programs and on-site medical clinics need only be reported to the extent they are group health plans (*i.e.*, they provide medical care like counseling, flu shots

or screenings). However, an employer is *not* required to report these costs if it doesn't charge a COBRA premium for the medical care portions of these programs.

**Updated February 20, 2013**

**23. What methods can employers use to calculate the costs of employees' health benefits costs on W-2s and how should the costs be reported?**

The March 2011 IRS interim guidance provides that employers may calculate the health benefits costs in one of four ways, so long as the same method is used consistently for all employees receiving coverage under that plan. The four methods include:

- The amount the employer would otherwise charge for COBRA coverage
- For insured plans only: the premium charged by the insurer
- For employers that subsidize the cost of COBRA or determine the cost of COBRA for a year by applying the cost of COBRA in a prior year: a reasonable good faith estimate of the applicable COBRA premium
- For employers that charge employees the same premium for different types of coverage (*e.g.,* self-only versus family coverage): the rates charged for each class of employee. If the employer does not use the composite rate to determine COBRA premiums, it may use either the composite rate or the COBRA premium as the reportable cost of coverage.

If an employee begins coverage or terminates coverage during a year, the employer may use any reasonable method to calculate the reportable cost for that period. If an employee changes coverage during the year, the reportable cost must reflect any changes in cost.

The cost of each employee's health benefits is reported on the employee's W-2 in box 12, using code DD.

**Added January 25, 2012**

**24. How can employers calculate employer contributions to 125 Plan Health Flexible Spending Accounts (health FSA) to report them on a W-2?**

To calculate reportable employer contributions to 125 Plan health FSAs, use the following formula provided by the IRS:

(1) Take the value of the health FSA available on the 1st day of coverage for the plan year (health FSA employee + health FSA employer contributions on 1/1, for example).
(2) Subtract the total employee salary reduction election for *all* qualified benefits under the 125 Plan (i.e., the dependent care assistance program coverage, health FSA contributions and medical/dental/vision premiums, as applicable).
(3) If the result is 0 or negative (which may often be the case if the employee premiums for medical/dental/vision are considered), nothing is reported on the W-2 for the Health FSA. If the result is positive, then report step 1 minus step 2 on the W-2.

**Added February 20, 2013**

**25. How will NRECA help co-ops comply with the requirement to report employees' health benefit costs on W-2s?**

If your co-op participates in the NRECA Group Benefits Program and you need help compiling premium data to satisfy the W-2 reporting requirements, NRECA can identify the applicable premium amounts. NRECA developed a report that provides the premium amounts by employee for NRECA medical, prescription drug, dental and vision coverage. It was offered to co-ops that meet the 250-employee W-2 filing threshold, but it's available for all co-ops upon request. Contact us at 1.866.673.2299 if you need help or would like to see this report. **Updated February 20, 2013**

**26. What is long-term care insurance, or CLASS Act?**

In October 2011, the Obama administration suspended this program, saying that it had not found a way to implement it and that the financial structure was unsustainable. In January 2013, Congress repealed the CLASS Act as part of the American Taxpayer Relief Act of 2012 (the fiscal cliff avoidance legislation). **Updated February 20, 2013**

**27. What is the change to health savings accounts (HSAs) for 2011?**

The tax penalty for using HSA funds for non-qualified expenses will increase from 10% to 20%. There are no other changes to HSAs.

**28. What other changes were made to Medicare Part D?**

The following changes to Medicare Part D went into effect in 2011:

A. **Change in open enrollment period:** The annual open enrollment period for Medicare Part D has been held from November 15-December 31 every year. Starting in the fall of 2011, the open enrollment period moved to October 15-December 7. This gives Part D plans time to process all enrollments before the plan year begins on January 1.

B. **Medicare Advantage (MA) plan participants may switch to Medicare Part D Plans at the beginning of the year:** In the past, participants in MA plans could switch to Original Medicare (Part A and Part B) at the beginning of the year. However, they weren't allowed to switch to a Part D prescription drug plan and were left without prescription drug coverage until the next Part D open enrollment period.

   Starting in January 2011, MA plan participants are allowed to switch to a Part D plan during the first 45 days of the year (January 1 to February 14). This is called the Medicare Advantage Annual Disenrollment Period (ADP). It affects co-ops if they have individuals who are currently enrolled in a MA plan and who choose to enroll in one of NRECA's Part D Plans.

C. **Premium indexing (Part D-IRMAA):** Similar to Part B, Medicare charges higher Medicare Part D premiums as of 2011 for people who earn more than $85,000 and

couples earning more than $170,000 per year. These thresholds remain the same through 2019 (although the Part D-IRMAA dollar amount related to each threshold is adjusted annually based on the Consumer Price Index). Social Security determines whether or not a person is subject to this additional premium and notifies the individual. The additional premium is deducted from the individual's Social Security or Rail Road Retirement check and isn't paid to the Part D plan. If a person doesn't have adequate funds for Social Security or the Rail Road Retirement Board to deduct the additional premium, Medicare bills him or her directly.

**As of April 1, 2012**, Medicare notifies NRECA that it must terminate the Part D participation of anyone who hasn't paid his or her Part D-IRMAA premiums to Medicare. This termination occurs even if the co-op or the participant has paid the NRECA Medicare Part D Plan premium. The participant has 60 days to appeal this termination to Medicare. If an appeal is granted due to "good cause," the participant has 30 days to pay any Part D-IRMAA premium owed to Medicare.

**Updated January 25, 2012**

**29. Will out-of-network emergency room services be covered differently?**

Yes, claims for out-of-network emergency room services for true emergencies will be considered at the in-network benefit level. **Updated September 20, 2010**

## 2013 changes that affect co-ops in the NRECA Medical Plan

Unless otherwise noted, the changes addressed in the questions in this section take effect on January 1, 2013.

**30. What is the women's preventive services coverage requirement?**

The women's preventive services coverage requirement expands prevention coverage for women. In compliance with the regulation, NRECA's medical plans provide coverage for these services as follows:

- **For PPO plans,** women's preventive services provided by an in-network provider are covered at 100%—copayments and coinsurance don't apply. If these services are provided by an out-of-network provider, they are subject to the co-op's elected copayments and coinsurance percentage as well as reasonable and customary charges.
- **For indemnity plans,** these services are covered at 100% and subject to reasonable and customary charge limitations. **Added February 20, 2013**

**31. When did the requirement for women's preventive services coverage go into effect?**

It goes into effect for non-grandfathered plans for plan years that begin on or after August 1, 2012. For NRECA medical plans that renew on or after January 1, the effective date is January 1, 2013. **Added February 20, 2013**

**32. What women's preventive services are covered without cost-sharing?**

The law requires the following services to be covered with no cost-sharing when provided by an in-network provider (or in cases where there's no in-network provider or network coverage):

- Well-woman visits
- Screening for gestational diabetes
- Human papillomavirus DNA testing
- Counseling for sexually transmitted diseases
- Counseling and screening for human immune-deficiency virus
- FDA-approved contraceptive methods and counseling
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence issues

The NRECA Medical Plan already covered some of these preventive services without cost-sharing, such as well-woman visits, and began covering the other services without cost-sharing on January 1, 2013. More information on this coverage is in the summary plan description for NRECA medical plans. **Added February 20, 2013**

**33. How is cost-sharing for contraceptives covered by prescription drug benefits being handled?**

Generic oral contraceptives have no cost-sharing, while brand-name contraceptives are subject to the applicable copayment or coinsurance of the participant's prescription drug plan. Patches, injections and other contraceptives have no copayment or coinsurance, since in almost all cases, there are no generic versions available. **Added February 20, 2013**

**34. Can you explain the summary of benefits and coverage (formerly referred to as the uniform coverage explanation) that employers will be required to provide to new enrollees and at annual enrollment?**

In addition to the summary plan description, plan administrators must give a summary of benefits coverage (SBC) to all new enrollees at the time of first enrollment and to all employees, retirees, COBRA qualified beneficiaries and children covered by qualified medical child support orders before enrollment and re-enrollment. The SBC also is required within 60 days of a special enrollment event (e.g., marriage or birth of a child). An employee may request an SBC at any time, and it must be provided as soon as possible but no later than seven days after receipt of the request. The document can be no more than four pages long and address covered benefits, exclusions, cost sharing and continuation. A $1,000 penalty applies for each failure to provide the document. Plan administrators also will be required to provide a notice of material modifications to participants at least 60 days before the effective date of the changes. In the future, this may require co-ops to decide on plan changes several months before the date they become effective. The agencies were required to provide the standards to plan administrators by March 23, 2011. Initially, plan administrators were required to start issuing the new summaries by March 23, 2012.

The agencies issued proposed rules in August 2011. They discussed who should receive the Summary of Benefits and Coverage (SBC) and when, form and delivery, language, content, notice of material modifications and uniform glossary. With the rules, the agencies provided proposed templates, instructions, uniform glossary and other sample materials. On November 17, 2011 the agencies issued additional guidance that SBC compliance will not be required until the date specified in the final regulations. Co-ops received SBCs for the 2013 plan year in late October 2012. SBCs should have been distributed to employees by the earlier of when open enrollment materials were delivered or the first day of open enrollment, which was November 1, 2012.

For more on SBCs, see the SBC FAQ on the Employee Benefits website. Go to Document Library > Documents for Co-ops > Insurance Plans > Health Care Reform > SBC FAQ.

**Updated February 20, 2013**

**35. What is the cap on employee contributions to employees' 125 Plan health flexible spending accounts that goes into effect in 2013?**

As of January 1, 2013, the maximum employee contribution that can be deducted annually from salary and applied to a 125 Plan health FSA will be $2,500. Starting in 2014 and going forward, the cap will be indexed for inflation, rounded to the next lowest multiple of $50. This does not preclude an "employer match" or additional employer contributions made to a 125 Plan Health FSA.

The cap does not affect 125 Plan dependent care accounts or adoption assistance FSAs.

**Updated May 18, 2010**

**36. What is the Patient-Centered Outcomes Research Institute (PCORI)?**

The Patient-Centered Outcomes Research Institute (PCORI) is a national organization established in 2012 by the ACA to conduct research and provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options.

**Added June 5, 2013**

**37. What is the PCORI fee?**

The PCORI fee, formerly known as "comparative effectiveness research fee," will fund comparative effectiveness research, which evaluates and compares health outcomes and the clinical effectiveness, risks, and benefits of medical treatments or services. The fee is imposed on certain self-insured plans annually, beginning with the 2012 plan year and phasing out with the 2018 plan year.

For more information on the PCORI fee, see the IRS questions and answers and chart summary. You also can check the final rules and regulations.

**Added June 5, 2013**

**38. How much will the PCORI fee be?**

The fee is equal to the average number of covered lives (including dependents) for the plan year times the applicable dollar amount below:

- For plan years ending on or after Oct. 1, 2012 and before Oct. 1, 2013, the dollar amount is $1 per covered life.
- For plan years ending on or after Oct. 1, 2013 and before Oct. 1, 2014, the dollar amount is $2 per covered life.
- For plan years ending after Oct. 1, 2014, the dollar amount per covered life is the prior year's dollar amount plus an adjustment for medical inflation as determined by HHS.

**Added June 5, 2013**

**39. What plans are subject to the PCORI fee and who is responsible for paying them?**

The following plans are subject to the PCORI fee:

- group medical and prescription drug plans
- group dental and vision plans that are not HIPAA-excepted
- health reimbursement arrangement (HRA) plans

Health savings accounts (HSA) and most health flexible spending accounts (health FSA) (such as the HFSAs administered by CBA) are exempt from the fee. Employee assistance programs (EAPs) and wellness programs that do not provide significant medical benefits also are exempt. Retiree-only plans are not exempt from the fee.

Plan sponsors are responsible for paying the fee. For the NRECA plans, NRECA is the plan sponsor and will pay the fee.

**Note:** For HRA plans administered by CBA, co-ops are the plans sponsors and are responsible for paying the applicable PCORI fee.

**Added June 5, 2013**

**40. If my co-op sponsors an HRA plan, how do we calculate the PCORI fee owed?**

A plan sponsor may use any reasonable method to determine the average number of covered lives for the 2012 plan year. For future plan years, a plan sponsor may use one of the following methods:

- Actual count method—Add the number of covered lives for each day of the plan year and then divide by the number of days in the plan year.
- Snapshot method—On the same date in each quarter (or more frequently), determine the number of covered lives and then divide by the number of dates on which the count was made.
- Form 5500 method—For a plan providing only self-only coverage, add the Form 5500-reported total participants at the beginning and end of the plan year, and divide by two. For a plan not limited to self-only coverage, add the Form 5500-reported total participants at the beginning and end of the plan year.

If your co-op participates in the NRECA Medical Plan (and sponsors no other medical plan), you count all employees who participate in the HRA for the PCORI fee. You don't need to include spouses and dependents in the count. If your co-op doesn't participate in the NRECA Medical Plan, it could treat its medical plan(s) and the HRA plan (assuming the plans had the same plan year) as a single plan to calculate the fee. In this case, you would count all covered spouses and dependents, and the co-op would be responsible for the PCORI fee for both its non-NRECA medical plan(s) and HRA plan. **Added June 5, 2013**

**41. How will PCORI fees be collected?**

The PCORI fee is reported and paid annually using IRS Form 720 *Quarterly Federal Excise Tax Return.* The fee is due each July 31 for any plan year ending during the preceding calendar year.

**Note:** Since the PCORI fee was effective for the 2012 plan year, the first filing to pay the fee is due July 31, 2013. **Added June 5, 2013**

**42. Will my co-op have to provide a notice of state insurance exchange to our employees?**

Yes. Employers must provide the notice about the state insurance exchanges, which will become operational January 1, 2014, to current employees by October 1, 2013, when open enrollment for the exchanges begins. Employees hired on or after the effective date must receive the notice within 14 days of their start date. **Updated June 5, 2013**

**43. How must my co-op provide the notice of the state insurance exchange to our employees?**

Employers must provide the notice automatically, free of charge, and it must be provided by first-class mail. It also may be provided electronically per the DOL electronic distribution rules. The notice much be provided to each employee, regardless of plan enrollment status (if applicable) and regardless of part-time or full-time status. Notices don't need to be provided to non-employees or separately to dependents of employees. See Question 46 below for the link to the DOL's model notice. **Added June 5, 2013**

**44. What are the state insurance exchanges?**

Exchanges, known as the Health Insurance Marketplace, are state-based online marketplaces that will use online portals, websites and calculators, as well as toll-free hotlines, to help individuals and small employers shop for, select and enroll in government-regulated and standardized health plans. They also will help eligible individuals to receive premium tax credits or coverage through other federal or state health care programs. **Updated June 5, 2013**

**45. What should the exchange notice include?**

The notice must inform employees of the existence of the exchange, describe its services and how employees can contact the exchange for assistance. It also must inform employees that they may be eligible for a premium tax credit through the exchange in certain circumstances. Lastly, the notice must inform employees of the consequences of purchasing

a qualified health plan through the exchange, such as losing the employer contribution (if any) to any employer plan. **Updated June 5, 2013**

**46. How will NRECA help co-ops comply with the exchange notice requirement?**

Since distributing the notice is an employer requirement, NRECA cannot distribute notices on behalf of co-ops. Co-ops must distribute them to employees.

The DOL provides model notices that can be used for distribution. The model notice for employers that offer a health plan to some or all employees can be found at www.dol.gov/ebsa/pdf/FLSAwithplans.pdf. This notice requires employers to complete page 2 (page 3 is optional), including whether the plan meets the minimum value standard and is "affordable." The model notice for employers that don't offer health plans can be found at www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf. **Updated June 5, 2013**

**47. Is it true that high-income taxpayers will be taxed more for Medicare? What are the thresholds, and how does it work?**

Yes. High-income taxpayers will be taxed more for Medicare as follows: Medicare taxes will increase 0.9% to 2.35% on W-2 wages only above $200,000 annually for individuals and $250,000 annually for married couples. There also will be a new, separate tax of 3.8% on the ***lesser of***:

- net "unearned" investment income (including dividends, rent and royalties, but ***excluding*** W-2 and retirement distributions); or
- the excess of $200,000 for individuals or $250,000 for married couples of modified adjusted gross income (***including*** W-2 wages and retirement distributions)

**48. There's been a lot in the news about the negative financial impact to employers from making the 28% Medicare Part D Retiree Drug Subsidy (RDS) taxable to employers. How will this affect co-ops in the NRECA Medicare Part D Plan?**

Fortunately, this change will have no impact on the NRECA Medicare Part D Prescription Drug Plan (PDP). NRECA is one of only a few remaining employer-based Medicare PDP plans in the nation. All other employers that provide retiree drug coverage for retirees are eligible for this 28% RDS. Although this 28% RDS will not be taxable until 2013, SEC Rules require this tax liability to be reflected on company financial statements immediately. As a result, many companies are contemplating dropping their retiree drug coverage and shifting these retirees into government-run PDP programs. Between 1.5 and 2 million retirees could face a change in drug coverage. But again, this change has no impact on the NRECA Medicare Part D PDP.

**49. Will the excise tax on medical equipment manufacturers and fees on pharmaceutical companies have an impact on health care users and medical plans?**

Yes, we believe some or all of these billions of dollars in new taxes and fees may be passed along to health care consumers, raising the cost of health care for everyone.

## 2014 changes that affect co-ops in the NRECA Medical Plan

Unless otherwise noted, the changes addressed in the questions in this section take effect on January 1, 2014.

**50. Will the new "Annual Fee" on health insurance providers impact co-ops that participate in NRECA health plans?**

No. NRECA worked to ensure this new "annual fee" on insurance companies does not apply to self-insured plans like the NRECA Group Benefits Program. Instead, this new tax only applies to fully-insured plans like those offered by commercial insurance carriers, based on market share. Like the new taxes and fees on medical device manufacturers and pharmaceutical companies, we believe all of these billions in new "annual fees" will be passed along to health care consumers, raising health care costs for everyone in those plans.

**51. Can you explain how the employer shared responsibility penalty assessment (a.k.a. "the play or pay penalty") on employers with 50 or more employees will work?**

Employers with 50 or more full-time equivalent employees will be subject to a penalty for each month in which any such employee is covered under a state Health Exchange and receives a premium tax credit to subsidize his or her coverage, and either (1) the employer fails to offer its full-time employees (and their dependents) "minimum essential coverage" under an employer-sponsored plan, or (2) the employer offers its full-time employees (and their dependents) "minimum essential coverage" that—with respect to employee with the premium tax credit—is either "unaffordable" or "fails to provide minimum value."

Individuals are eligible for the premium tax credit only if their household income is under 400% of the federal poverty level ($88,200 in 2010 for a family of 4), and if they are not eligible for other "minimum essential coverage," which generally includes employer-sponsored coverage. The Affordable Care Act did not define "minimum essential coverage." Coverage is considered "unaffordable" for an employee if his or her portion of the premium for self-only coverage exceeds 9.5% of his or her household income. Coverage "fails to provide minimum value" if it does not pay at least 60% of the total allowed costs. Good news: All co-ops currently in the Group Benefits Trust meet the 60% actuarial value test.

If any full-time employees receive an income-based premium tax credit to buy insurance through the Health Exchange, there are penalties for employers that do not offer qualifying coverage:

- If at least one full-time employee receives a premium tax credit and the employer does not offer minimum essential health coverage, the annual penalty (calculated monthly) is $2,000 x total number of full-time employees minus the first 30 full-time employees.
- If an employee receives the premium tax credit because he or she has a household income up to 400% of the federal poverty level, and (1) the plan does not meet the 60% actuarial value test *or* (2) the premium the employee pays is greater than 9.5% of his or her income, then the annual penalty (calculated monthly) is the *lesser of*
    - $2,000 x total number of full-time employees, or

- $3,000 x number of employees receiving the tax credit

**Note:** Full-time employees are those who work an average of 30 hours or more per week during a month. Part-time employees who work less than 30 hours a week are included in determining the number of full-time equivalents.

**In a May 2011 notice [IRS Notice 2011-36]**, the IRS indicated that it was considering different approaches to determining full-time employee status, noting that a month-to-month determination may be difficult as a practical matter. Among the approaches considered include using a look-back period to determine full-time employees. In addition, it is thought that proposed regulations will provide (1) that 130 hours worked in a calendar month will be the equivalent of 30 hours per week and (2) that an employer offering coverage to all, or substantially all, of its full-time employees would not be subject to the penalty.

**In a September 2011 notice [IRS Notice 2011-73]**, the IRS proposed a safe harbor for determining the affordability of coverage that takes into account the employee's W-2 wages rather than household income. The IRS recognized the practical difficulties of determining household income that includes family members' incomes in addition to the employee's.

**In a February 2012 technical release [DOL Technical Release 2012-01]**, the DOL confirmed that the IRS intends to issue proposed guidance that permits employers to use an employee's W-2 wages as a safe harbor for determining the affordability of employer coverage and that addresses how the penalty provisions and the 90-day waiting period limitation are coordinated. The guidance also will provide that an employer, for the first 3 months from an employee's date of hire, will not be subject to the penalty for failing to offer coverage during that 3-month period and will allow employers to use a "look-back/stability period safe harbor" method (not exceeding 12 months) to determine whether an employee (other than a newly-hired one) is a full-time employee. The will address too whether a newly-hired employee is a full-time employee.

**In an August 2012 notice [IRS Notice 2012-58]**, the IRS expanded upon previous notices that described safe harbor methods for determining whether variable hour employees and seasonal employees are full-time employees for purposes of the penalty.

**In December 2012, the IRS issued proposed regulations and an FAQ document** (with 23 Q&As) that incorporated many of the provisions of the notices above, and provided a number of clarifications and new rules on the "play or pay penalty." A few of these rules include: An employer will satisfy its obligation to offer "minimum essential coverage" to its full-time employees (and dependents) if it offers such coverage to 95% of its full-time employees, and employers must offer the coverage to dependent children up to age 26 to avoid the penalty. Affordability of a full-time employee's coverage is based on the employee's cost for self-only coverage. Companies with a common owner or that are otherwise related are combined for purposes of determining whether they employ at least 50 full-time employees, but the penalty applies on a company-by-company basis. The proposed rules provide a W-2 safe harbor, a rate of pay safe harbor and a federal poverty line safe harbor for measuring the affordability of employee coverage. The proposed rules

also addressed break in service and employment status/position changes for purposes of applying the measurement and stability period rules for determining full-time employee status. There are also several transition rules. Here's a link to the Federal Register with the proposed regulations: www.gpo.gov/fdsys/pkg/FR-2013-01-02/html/2012-31269.htm

**In February 2013, the IRS issued final regulations** on the acceptable methods for determining whether or not the total allowed costs of benefits provided by a plan are less than 60%. These methods are:

1. *Minimum value calculator*. The minimum value (MV) calculator permits an employer-sponsored plan to enter information about the plan's benefits, coverage of services and cost-sharing terms to determine whether the plan provides MV. The data used by the MV calculator is claims data reflecting typical self-insured employer plans. If the plan chooses to use the MV calculator but offers benefits outside of the parameters of the calculator, an actuary is permitted to determine the value of the benefit and adjust the result derived from the calculator to reflect that value.
2. *Design-based safe harbors in the form of checklists*. The checklists are intended to give a plan the ability to compare its design against the checklists to determine whether MV is met, without using a calculator or an actuary. Each checklist will describe the cost-sharing attributes of a plan (e.g., deductibles, copays, coinsurance and maximum out-of-pocket costs) that apply to the four core categories of benefits (physician and mid-level practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services).
3. *Actuarial certification.* For plans with nonstandard features that preclude the use of the MV calculator without adjustments, a plan may rely on a certification by a certified actuary, in accordance with prescribed continuance tables, recognized actuarial standards and "other conditions that may be prescribed in administrative guidance," to determine that the plan provides MV.

**Note:** NRECA will determine whether NRECA plans satisfy the MV standard.

**Updated June 5, 2013**

**52. How do the "free choice vouchers" for employers with over 50 employees work?**

This provision was repealed in April 2011. **Updated January 25, 2012**

**53. What is the reinsurance fee that I've been hearing about?**

The reinsurance fee is a fee imposed on all fully-insured and self-insured plans. The fee funds the transitional reinsurance program that the ACA requires each state to establish beginning in 2014. The transitional reinsurance program is intended to help stabilize premiums in the individual market during the first three years (2014-2016) that the state-based insurance exchanges (see FAQ 43) are in effect. If a state chooses not to establish a transitional reinsurance program or a risk adjustment program, the Department of Health and Human Services (HHS) will do so on the state's behalf. **Added June 5, 2013**

**54. How much is the reinsurance fee?**

The fee for 2014 is $63 per covered life (or $5.25 per month).

The total amount of fees to be collected over the three-year period is $25 billion—$12 billion in 2014, $8 billion in 2015 and $5 billion in 2016. Of that amount, $20 billion will fund the reinsurance program, and $5 billion will go to the U.S. Treasury to cover the amount appropriated by the ACA for the Early Retiree Reinsurance Program (ERRP) [see FAQ 9].

**Added June 5, 2013**

**55. Who must pay the reinsurance fee?**

The ACA requires all fully-insured and self-insured plans, known as "contributing entities," to contribute to the reinsurance program. HIPAA-excepted dental and vision plans are exempt from this requirement. For fully-insured plans, the fee will be paid by the health insurance carrier. NRECA will pay the reinsurance fee NRECA plans. Self-funded plans may use their third-party administrator (TPA) to transmit the fee. **Added June 5, 2013**

**56. Are tax-advantaged side accounts subject to the reinsurance fee?**

HSAs and Health FSAs aren't subject to reinsurance fees. HRA plans are excluded from the reinsurance fee only if they are integrated with the major medical coverage.

**Added June 5, 2013**

**57. How will the reinsurance fee be collected?**

HHS will collect the reinsurance fees annually. By November 15 of each year, the contributing entity must submit the number of covered lives (employees, retirees, spouses and dependents) subject to the fee for that calendar year. HHS will notify the contributing entity of the total fee to be paid by the later of 30 days after the submission or December 15. The contributing entity must then submit its payment to HHS within 30 days of receiving notice of the amount due. HHS will provide details on the payment process in future guidance. **Added June 5, 2013**

**58. Will waiting periods for health benefits be limited? What are the details?**

The period of continuous employment required before an employee becomes eligible to participate in health benefits—the waiting period—will be limited to a maximum of 90 days. The good news: over 80% of co-ops in the NRECA Medical Plan already comply.

In a February 2012 technical release, the DOL confirmed that the 90-day waiting period limit doesn't require employers to offer coverage to part-time employees or other classes of employees. The 90-day waiting period begins when an employee is otherwise eligible for coverage. So, if full-time employees are eligible for coverage without satisfying any other condition, the waiting period, if any, begins on their date of hire and cannot exceed 90 days. Other conditions for eligibility are generally permissible (unless the condition is designed to avoid compliance with the 90-day limit). Upcoming guidance is expected to address situations involving hours of service requirements for eligibility.

In an October 2012 notice, the IRS provided temporary guidance on variable-hour employees effective "at least through the end of 2014," stating that any other guidance on this issue for periods after 2014 will provide sufficient time to comply with "any additional or modified requirements." If a plan conditions eligibility on an employee working a specified number of hours per period (or working full time), and it cannot be determined that a newly-hired employee is reasonably expected to work that number of hours per period (or work full time), the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition, which may include a measurement period that is consistent with the timeframe permitted for purposes of determining whether an employee is a full-time employee under the employer shared responsibility (pay or play) rules. The temporary guidance provides several examples of the application of the 90-day limit to variable-hour employees where a specified number of hours of service per period is a plan eligibility condition. Lastly, the IRS warns that an employee is not eligible for minimum essential coverage (and therefore may be eligible for a premium tax credit or cost-sharing reductions for state insurance exchange coverage if they meet all other conditions) during any period when coverage is not offered, "including any measurement period or administrative period before coverage takes effect."

**Updated February 20, 2013**

**59. Are dental and vision plans subject to the excessive waiting period prohibition?**

Yes, if they aren't HIPAA excepted benefits. HIPAA excepted benefits include fully-insured dental and vision plans (like VSP vision plans) as well as dental and vision plans with a participant opt-out or employee contributions. So, the NRECA dental and vision plans subject to the prohibition include the NRECA dental and self-insured vision plans that are 100% employer-paid with respect to any tier of coverage or covered group. Currently, 74% of co-ops participating in the NRECA Dental Plan are in compliance. Currently, 66% of co-ops participating in the NRECA Vision Plan are in compliance. **Added February 20, 2013**

**60. Are collectively-bargained (union) plans exempt from the excessive waiting period limit?**

No. The only union plans that are exempt from certain ACA mandates were ones that existed on March 23, 2010 and were fully-insured plans. Even these plans will be subject to the excessive waiting period prohibition effective January 1, 2014. **Added February 20, 2013**

**61. What about employees who are in a waiting period before the effective 1/1/2014 date?**

The waiting period cannot exceed 90 days even for employees who are in an already existing waiting period once the rule goes into effect on January 1, 2014. For example, an employer would need to offer coverage on January 1, 2014 to an employee who was subject to a 6-month waiting period beginning on his start date of October 1, 2013. **Added June 5, 2013**

**62. How do you count days for a 90-day waiting period?**

The ACA requires that all calendar days be counted beginning on the first day of the waiting period, including weekends and holidays. If the 91$^{st}$ day is a weekend or a holiday, the plan may permit coverage to become effective earlier than the 91$^{st}$ day but no later than the 91$^{st}$ day.

**Note:** The agencies declined to provide a *de minimis* exception for the difference between 90 days and 3 months. Waiting periods can be no longer than 90 calendar days.

**Added June 5, 2013**

**63. Which waiting periods will no longer be available as of January 1, 2014 for NRECA benefit plans?**

The following waiting period options will no longer be available for annual renewals beginning on 1/1/2014:

- 3 months
- First of the month after 3 months
- 4 months
- 6 months
- 1 year

**Added June 5, 2013**

**64. If my co-op has more than 200 employees, how will automatic enrollment affect us?**

Employers with 200 or more full-time employees must automatically enroll all new hires in health coverage. Currently, it is unclear which plan an employee must be enrolled in if there is more than one option (*e.g.,* HMO, PPO, employee-only, employee + spouse, etc.). A permissible waiting period of no more than 90 days can be applied, and employees can opt out of automatic enrollment. There is some uncertainty about the effective date of this provision, though all other provisions in this section of the law—Health Exchange, Employer Mandate, etc.—begin January 1, 2014.*

The Department of Labor (DOL) confirmed, in FAQs issued in December 2010, that employers are not required to comply with the automatic enrollment provision until the DOL issues regulations, which it intends to do by 2014.

*In a February 2012 technical release, the DOL stated that its automatic enrollment guidance will *not* be ready to take effect by 2014, citing "the need for coordinated guidance and a smooth implementation process." Again, employers are not required to comply until regulations are issued and become effective.

**Updated February 20, 2013**

**65. What are the new wellness program incentive rules that will go into effect?**

Wellness regulations under the Health Insurance Portability and Accountability Act (HIPAA) currently permit wellness incentives of up to 20% of the total premium, provided that the program meets certain conditions. The new law will increase this amount up to 30% of the premium. Regulators may be able to increase that amount up to as high as 50% after they have studied the effect of wellness programs.

**Note:** In November 2012, HHS, DOL and the Treasury Department issued proposed regulations for nondiscriminatory wellness programs under the ACA. Specifically, the proposed rules address the maximum permissible reward under a "health-contingent"

wellness program offered in connection with a group health plan (GHP), including self-insured plans, and any related health insurance coverage as well as plan design and reasonable alternatives. In a health-contingent wellness program participants must maintain or achieve a certain health outcome to receive a reward (*e.g.*, blood pressure within a certain range).

Effective for plan years beginning on or after January 1, 2014, the proposed rules replace the current ones for health-contingent wellness programs. The new rules continue to permit rewards in the form of a discount or rebate of a premium or contribution, a waiver of all or part of cost-sharing (*e.g.*, deductibles, copayments or coinsurance), the absence of a surcharge, the value of a benefit that otherwise wouldn't be provided under the plan, or other financial or nonfinancial incentives or disincentives.

Under the new rules, health-contingent wellness programs are allowed only if they satisfy certain requirements. For example, the total reward can't exceed 30% (increased from 20%) of the total cost of coverage of employee-only coverage (including both employee and employer contributions toward the cost of coverage) under the GHP. The rules though don't define "cost of coverage." (The limit increases to 50% for programs preventing or reducing tobacco use. The agencies are seeking comments on the definition of "tobacco use." Premium incentives for tobacco use must be applied to the portion of premium attributed to each family member.)

The EEOC hasn't yet issued definitive guidance on when an incentive may be so high as to make a wellness program "involuntary" under the ADA. Also, in 2012 the Eleventh Circuit affirmed a lower court's ruling that a wellness program that provided a $20 per pay period decrease in the participant share of medical coverage premiums to participants who completed a health risk assessment didn't violate the ADA; however, the ruling didn't address the "voluntary" issue. So, there's still no clear guidance on this issue.

**Updated February 20, 2013**

**66. Will HIPAA certificates be required after 2014?**

No. Effective December 31, 2014, plans will no longer be required to issue HIPAA certificates of creditable coverage. **Added June 5, 2013**

## 2018 changes that affect co-ops in the NRECA Medical Plan

Unless otherwise noted, the changes addressed in the questions in this section take effect on January 1, 2018.

**67. What impact will the 40% excise, or "Cadillac tax," on high-cost plans have on co-ops in the NRECA Medical Plan?**

A 40-percent tax will be imposed on the value of coverage over $10,200 (single) and $27,500 (family), indexed to the Consumer Price Index plus one percent in 2019. After that it is simply indexed to CPI. The valuation includes premiums paid (by employer and employee) for medical and prescription drug, as well as contributions to health FSAs, health

reimbursement arrangements and health savings accounts. Stand-alone dental and vision benefits are excluded.

The good news is we succeeded in getting plans with electric line workers classified as high risk, raising the thresholds for taxation to $11,850 (single) and $30,950 (family). It is important to note that these thresholds are in 2018 dollars. Even with these higher thresholds, most co-op plans will likely exceed these thresholds in 2018 or a subsequent year.

**68. I've already heard a lot of speculation as to whether or not this "Cadillac tax" will happen. Will it happen?**

The other good news is that this tax does not take effect until 2018, a legislative lifetime away. As such, we will continue to work with policymakers to protect the interest of co-ops by working to eliminate this tax altogether. We believe this tax is unfair for a not-for-profit, self-insured/self-administered trust fund, like the NRECA Group Benefits Program, that operates "at-cost" just like co-ops, and works to manage costs as best it can.

## Health Care Reform Acronyms

There are a lot of acronyms related to health care reform. The following helpful question and answer is from the Employee Benefits Institute of America's weekly e-newsletter, *EBIA Weekly* (October 7, 2010).

**69. I have been hearing a lot of new acronyms lately relating to health care reform. Do you have a list of common health care reform acronyms and what they stand for?**

A lot of health care reform acronyms are being used these days—some are new while others have been around for years. Here's a list of some key acronyms we are seeing in the health care reform context, along with a brief description of what they stand for:

- ACA—The "Affordable Care Act" is sometimes used as a shorthand name for PPACA or for both PPACA and HCERA (see below).
- CDC—The "Centers for Disease Control and Prevention," a division of HHS that is involved with certain aspects of health care reform.
- CO-OP—The "Consumer Operated and Oriented Plan" program is a federal program created under health care reform to assist in the establishment and operation of qualified nonprofit, member-run health insurance issuers in the individual and small-group markets.
- ERRP—The "Early Retiree Reinsurance Program" is a temporary program established under health care reform to reimburse employment-based plans for a portion of the costs they incur providing health coverage to early retirees.
- FLSA—The "Federal Fair Labor Standards Act," which was amended by PPACA to incorporate certain health care reform provisions.

- HCERA—The federal "Health Care and Education Reconciliation Act of 2010" (also referred to as the "Reconciliation Bill"), which was enacted on March 30, 2010 to amend and supplement PPACA.

- HCR—A shorthand for "health care reform."

- HHS—The United States Department of "Health and Human Services."

- IRO—An "independent review organization" is an entity that performs independent external reviews of adverse benefit determinations under state or federal external review procedures.

- MLR—"Medical loss ratio," which refers to the claims costs and amounts expended on health care quality improvement as a percentage of total premiums (excluding taxes, fees and allocable adjustments for risk adjustments, risk corridors and reinsurance).

- NAIC—The "National Association of Insurance Commissioners."

- OCIIO—The "Office of Consumer Information and Insurance Oversight," a division of HHS that is responsible for implementing many health care reform provisions.

- PCE—A “preexisting condition exclusion" is a plan provision imposing an exclusion on benefits relating to a preexisting condition.

- PCIP—The "Pre-Existing Condition Insurance Plan" program is a temporary high-risk health insurance pool program established by HHS to provide health insurance coverage for eligible individuals until 2014.

- PCORI—The federal “Patient-Centered Outcomes Research Institute funds research that provides evidence-based information to help patients, caregivers and clinicians make better-informed health care decisions.

- PHSA—The federal "Public Health Service Act," which was amended to include many of the health care reform provisions. The PHSA applies directly to insurers and governmental plans, but amendments were also made to the Code and ERISA to apply the health care reform provisions more broadly to employer-sponsored plans (including self-insured plans).

- PPACA—The federal "Patient Protection and Affordable Care Act," which was enacted on March 23, 2010 and is the primary health care reform law.

- QHP—A "qualified health plan" is an Exchange-certified health plan that provides an essential health benefits package and is offered by a licensed health insurer.

- SHOP Exchange—The "Small Business Health Options Program" is a program that each Exchange must create to assist eligible small employers in enrolling their employees in qualified health plans offered in the small group market.

**Updated February 20, 2013**

**END**