Health Care Reform Quarterly is devoted to developments surrounding the implementation of health care reform. This edition features an update to the major health care reform legal challenges, a summary of publications that can help you better understand and implement required provisions, significant health care reform news over the past quarter and a response to a frequently asked question regarding essential health benefits and grandfathering.

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continued >>>>
FEATURED STORY

Fourth Circuit Decision Adds to Uncertainty

On Sept. 8, 2011, the Fourth Circuit Court of Appeals in Virginia threw out two legal challenges on procedural grounds. The first decision overruled the Virginia judge who was the first to declare the health care law unconstitutional, and threw out the suit brought by Virginia Attorney General Kenneth Cuccinelli on the grounds that he had no standing to sue.

In the second decision, Chief Judge Diana Gribbon Motz threw out the suit brought by Liberty University based on the Anti-Injunction Act, which forbids taxpayers from challenging taxes in court prior to paying the tax. The court found that the individual mandate penalty was in fact a tax.

The Fourth Circuit was the first court to give the tax argument merit. Prior courts rejected the tax argument, pointing to congressional assertion that the penalty for noncompliance was not a tax. U.S. District Judge Roger Vinson, of Pensacola, FL, claimed in his ruling against the law that Congress called it a penalty and not a tax because taxes are unpopular and many politicians pledged to not raise taxes. If the penalty had been called a tax, it would have made it more difficult to secure the necessary votes for passage of health reform.

The Eleventh Circuit, in a suit filed by 26 states and the National Federation of Independent Business, held that the statute was unconstitutional; the Sixth Circuit, in Thomas More Law Center, et al. v. Obama, et al., held that it was constitutional; and the Fourth Circuit ruled that it lacks jurisdiction to figure out whether it’s constitutional or not. Three different courts of appeals issued three different rulings on three different bases. The issue is ripe for review by the U.S. Supreme Court.

The Supreme Court has already received an appeal from Thomas More Law Center, which lost in the Sixth Circuit Court of Appeals. The federal government, which lost the case in the Eleventh Circuit, confirmed that it will not ask the full Eleventh Circuit Court of Appeals to review the case again (en banc review), and, on Sept. 28, 2011, filed a petition for review requesting that the Supreme Court consider the case.

Because the federal government filed the petition for review promptly, most legal observers expect the court to hear arguments during the term that begins in October, and rule in the summer of 2012. However, the Fourth Circuit ruling could complicate the matter by raising doubt as to whether any judges, including those on the Supreme Court, have jurisdiction until the tax (penalty) takes effect in three years.

NEW AND UPDATED PUBLICATIONS AND TOOLS

Ask your advisor for a copy of the publications.

IRS Notice 2011-28 Provides Guidance on PPACA W-2 Reporting Requirement

This white paper focuses on the upcoming W-2 reporting requirement that applies to employers. As background, under PPACA most employers must report the aggregate cost of employer-sponsored group health plan coverage on each employee’s Form W-2. The requirement is optional for 2011 and mandatory for 2012, meaning the first required reporting will be in January 2013, when 2012 Forms W-2 are issued by employers. The IRS has issued Notice 2011-28, which provides guidance on the W-2 reporting requirement. The new white paper discusses the details of both the requirement and Notice 2011-28, and also includes frequently asked questions and links to government resources on the issue. The white paper is a valuable resource for employers seeking to understand and comply with the new requirement.

How Will Health Reform Affect Employers Through 2012?

PPACA will transform the current model for employer-sponsored health coverage, with certain provisions having an impact on employers each year through 2012. This document provides a review of each item employers should be aware of through 2012, as well as a detailed list of model notices that may need to be provided by the plan.
PPACA Requires Fully Insured Plans to Comply with Nondiscrimination Rules of IRC Section 105(h)

In the past, fully insured group health plan administrators had great liberty to design benefit availability and eligibility as they desired, so long as such plans did not run afoul of the Title VII-type discrimination rules (i.e., discrimination based on age, gender, disability, pregnancy, etc.) and the cafeteria plan rules under Section 125. For example, plans generally could discriminate outside of the cafeteria plan rules by allowing an employer to offer particular benefits only to highly compensated individuals (HCIs) or contribute a higher percentage of premiums for owners, officers, shareholders or the top 25 percent of its HCIs. Such liberty, however, has been greatly restricted by PPACA. The act requires fully insured group health plans to comply with IRC Section 105(h), which generally prohibits discrimination in favor of HCIs. This paper describes the recent changes under the law, and provides a summary of the applicable tests under Section 105(h), examples and frequently asked questions.

IN THE NEWS

Federal District Court Judge Declares PPACA’s Individual Mandate Unconstitutional

On Sept. 13, 2011, a federal district court judge in Pennsylvania ruled that PPACA’s individual mandate is unconstitutional. That means so far three district courts that have ruled on the merits of cases have found the individual mandate unconstitutional. Four district courts have upheld the law. More than two dozen suits filed against the law are making their way through federal district courts around the nation. Many cases have been dismissed for procedural reasons. In addition, three federal appeals courts have already ruled on the health care law’s constitutionality. Thus, this district court decision has limited impact, but the opinion includes unique views.

In this case, Judge Christopher Conner took a new approach to the issue of severability, which determines whether the rest of the law can be left intact if the individual mandate is found to be unconstitutional. Upon determining that the individual mandate was unconstitutional, Conner also struck down the guarantee-issue and pre-existing condition prohibition provisions. Conner noted that the two provisions are dependent on the individual mandate because the individual mandate serves to get healthy people into the risk pool, offsetting the cost of covering sick people. Although he struck down the individual mandate, Conner made a point of disagreeing with the activity vs. inactivity rhetoric.

Instead, he focused on the fact that Congress does not have the power to regulate an activity in anticipation of a future event: “Congress may lawfully regulate the interstate market for health insurance and health services, but Congress cannot require individuals who choose not to purchase health insurance or individuals who are not currently seeking or receiving services in the health care market to purchase health insurance in order to stabilize the health insurance market. Congress cannot mandate or regulate in anticipation of conduct that may or may not occur in the future.”


Treasury and IRS Request Comment on Affordability Safe Harbor Under PPACA

In IRS Notice 2011-73, the U.S. Department of the Treasury and the IRS requested public comments on a proposed affordability safe harbor for employers under the shared responsibility provisions included in PPACA, also known as the “employer mandate,” which are applicable to certain employers starting in 2014.

As background, under PPACA, employers with 50 or more full-time employees that do not offer “affordable” health coverage to their full-time employees may be subject to an employer mandate penalty. Notice 2011-73, posted on www.IRS.gov, solicits public input and comment on a proposed safe harbor designed to make it easier for employers to determine whether the health coverage they offer is “affordable.” Coverage under an employer-sponsored plan is considered “affordable” to a particular employee if the employee’s required contribution to the plan does not exceed 9.5 percent of the employee’s household income for the taxable year. The proposed safe harbor would set the affordability standard at 9.5 percent of wages, instead of 9.5 percent of household income. An employer also could use the safe harbor prospectively, at the beginning of the year, by structuring its plan and operations to set the employee contribution at a level not to exceed 9.5 percent of that
employee's W-2 wages for that year. This safe harbor would only apply for purposes of the employer mandate, and would not affect the employees’ eligibility for health insurance premium tax credits.

In particular, the IRS seeks comments on the following issues:

- Whether or how wages and employee contribution amounts would need to be determined for employees who are employed for less than a full year, employees who move between full-time and part-time status, situations in which the plan year is not a calendar year, and other special circumstances

- Whether there are other possible safe harbor methods for determining the affordability of coverage under an employer sponsored plan for purposes of calculating an employer’s potential assessable payment under IRC § 4980H(b)

- How to coordinate any affordability safe harbor with the full-time employee look-back/stability safe harbor described in IRS Notice 2011-36

The deadline for comments is Dec. 13, 2011.


HHS Offers Insurance Marketplace Partnership Option for States

On Sept. 19, 2011, HHS provided more guidance relating to states and the proposed partnership model. The partnership model describes exchanges where both HHS and a state work together to operate different functions of the exchange, offering states a way to transition to fully operating their own exchanges. States may use exchange grant funding to support the exchange-related functions they choose to operate under the partnership.

The options include:

- Having states tailor the health plan choices for their exchange by running plan management functions, including the collection and analysis of plan information, plan monitoring and oversight, and data collection and analysis. Under this option, HHS would coordinate with the state regarding plan oversight, such as consumer complaints and enrollment, and help to ensure that exchanges meet all of the required standards;

- Having states assist consumers’ access to exchange plans by overseeing in-person consumer assistance, managing the Navigator program that will provide direct assistance to help people sign up for insurance, and conducting outreach and education. HHS would run more centralized consumer assistance functions, such as call center operations, the consumer website and written correspondence with consumers; or

- Having states run both the plan management and consumer assistance functions.

States and other stakeholders were able to comment on the partnership model as part of public comments to the July 15, 2011, Notice of Proposed Rule on Exchange Establishment and Qualified Health Plans, for which comment closed on Sept. 28, 2011.

CMS Issues Changes to ERRP Claims Submissions

CMS has announced several changes to streamline the process of submitting claims data for Early Retiree Reinsurance Program (ERRP) reimbursement requests. Beginning on Oct. 3, 2011, a new automated review system will give detailed feedback on claim lists, helping plan sponsors submit error-free claim lists. CMS has also extended the deadline for submitting detailed claim lists for prior reimbursements. Given the feedback from the automated system, all claim lists submitted on or after Oct. 3 must be error-free in order for the plan sponsor to be able to submit a reimbursement request, and then be approved for payment. If a claim list is determined to be invalid as a result of the automated review and cancelled from the system, the sponsor may resubmit a corrected claim list. Similarly, before the automated processing system becomes effective in October 2011, claim lists and reimbursement requests that have errors will be cancelled from the system, and plan sponsors may resubmit them. Plan sponsors with questions should contact the ERRP Center by visiting the link below.


ERRP Center Contact Information: http://www.errp.gov/contact_us.shtml.

Fourth Circuit Dismisses Legal Challenges to PPACA

On Sept. 8, 2011, the U.S. Court of Appeals for the Fourth Circuit Court dismissed two lawsuits challenging the constitutionality of the individual mandate in PPACA, effective as of 2014, which requires individuals to purchase health insurance or face penalties. This marks the third federal appellate court to rule on this issue. In the first opinion, Com. of Vir. ex rel. Cuccinelli v. Sebelius, 11-1057, 2011 WL 3925617 (4th Cir. Sept. 8, 2011), the Fourth Circuit considered a state lawsuit where Virginia Attorney General Ken Cuccinelli argued that the individual mandate is unconstitutional and conflicts with a state law that protects state residents from such federal insurance mandates. In the lower court’s ruling, U.S. District Court Judge Henry Hudson agreed with this argument, holding that the mandate is unconstitutional as exceeding Congress’ power to regulate interstate commerce. However, in a unanimous decision, the Fourth Circuit held that the commonwealth of Virginia does not have legal standing for the lawsuit because the state lacks “a personal stake” in the lawsuit.

In the second opinion, Liberty Univ., Inc. v. Geithner, 10-2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011), the court considered a lawsuit filed by Liberty University and several individuals arguing that Congress exceeded its constitutional authority in enacting the individual mandate as well as the employer mandate. The employer mandate imposes an “assessable payment,” effective in 2014, on “any applicable large employer” if a health exchange notifies the employer that at least one “full-time employee” obtains an “applicable premium tax credit or cost-sharing reduction.” U.S. District Court Judge Norman Moon, in a November 2010 ruling, dismissed the university’s lawsuit and upheld the constitutionality of the law. The Fourth Circuit, in a 2-1 decision, held that the plaintiffs do not have standing to challenge either mandate because the financial penalties amount to a tax. The court indicated that another federal law, the Anti-Injunction Act, requires U.S. residents to wait to oppose a tax until after it is collected.

There are still a number of pending federal lawsuits seeking to overturn the mandate in PPACA. Due to two prior conflicting appellate court decisions, with the Sixth Circuit upholding the individual mandate in late June and the Eleventh Circuit subsequently ruling that the mandate is unconstitutional only six weeks later, legal experts are speculating that the Supreme Court may hear the challenge as early as the next term, which starts in October. This means a decision could potentially be issued by next June. We will keep you updated as additional developments occur.

CBO Predicts Delay in Start of CLASS Act Program
According to a recently released Congressional Budget Office (CBO) report, the CBO anticipates a one-year delay in implementation of the Community Living Assistance Services and Supports (CLASS) Act. The CLASS Act program is a voluntary long-term care insurance program with premiums paid through a payroll deduction from wages or self-employment income. In its latest periodic update to Congress on the federal budget, the CBO notes that based on the pace of implementation of the CLASS program so far, the program will start collecting premiums in fiscal year 2013, not fiscal year 2012 as previously estimated.


DOL and HHS Issue Proposed Rules for PPACA’s Summary of Benefits and Coverage Requirements
On Aug. 22, 2011, the DOL, HHS and U.S. Department of the Treasury released proposed rules for the Summary of Benefits and Coverage required under PPACA. Starting in 2012, health insurers and group health plans will have to provide a new plan document, the Summary of Benefits and Coverage, along with a uniform glossary of terms, to employees before enrollment. The Summary of Benefits and Coverage will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year and within seven days of requesting a copy from their health insurance issuer or group health plan. This Summary of Benefits and Coverage will include a health plan comparison tool for consumers, known as “Coverage Examples,” which will illustrate what proportion of care expenses a health insurance policy or plan would cover for three common benefits scenarios: having a baby, treating breast cancer and managing diabetes. Health plans and issuers will be required to provide 60 days’ prior notice before any material modification is made in the plan or coverage that is not set forth in the most recent Summary of Benefits provided to the enrollees.

The proposed rules are open to public comments until Oct. 21, 2011. As these are merely proposed rules, employers do not have to take any action immediately. Nonetheless, employers and plan sponsors should be aware of the upcoming requirements when developing a long-term compliance strategy.


CCIIO Issues Guidance on HRAs and Restricted Annual Limit Waiver Process
On Aug. 19, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) introduced supplemental regulatory guidance regarding the annual limit waiver application process. Specifically, the guidance clarifies that sponsors of stand-alone HRAs will not be required to seek waivers from PPACA rules that restrict annual dollar limits on the coverage of essential benefits.

As background, PPACA Section 2711 generally prohibits group health plans and issuers from offering coverage that imposes lifetime or annual limits on the dollar value of “essential health benefits,” but PPACA allows restricted annual limits with respect to essential health benefits for plan years beginning before Jan. 1, 2014. The waiver program is an application process permitted under PPACA whereby the secretary of HHS is permitted to temporarily waive the restricted annual limits for limited benefit or mini-med plans if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. For plan years beginning on or after Jan. 1, 2014, all group health plans may not impose annual dollar limits on essential health benefits.
Prior regulations provided that HRAs that were integrated with group health coverage were exempt as long as the other group health coverage complied with the restricted annual limit requirements, meaning a waiver would not be needed. In those prior regulations, the CCIIO also requested comments on the process that should be imposed with respect to stand-alone HRAs.

The new guidance recognizes that “all HRAs set limits on the amount that can be spent” and that the limits would always be less than the applicable restricted annual limit amounts, which would ultimately result in a “significant decrease in access to HRA benefits.” Therefore, the guidance “exempts as a class all HRAs that are subject to the requirements of Section 2711 and that were in effect prior to Sept. 23, 2010, from having to apply individually for an annual limit waiver for plan years beginning on or after Sept. 23, 2010, but before Jan. 1, 2014.” This means that HRAs established prior to Sept. 23, 2010, which were otherwise subject to the restricted annual limit requirements, such as stand-alone HRAs, have been granted a waiver from the requirements without the need to actually request a waiver.

Significantly, while stand-alone HRAs are now exempt from the restricted annual limit waiver process, they still must comply with the record retention and annual notice requirements contained in the “Technical Instructions for the Waiver Extension and Waiver Application Process,” available below. Finally, if an employer that maintains an HRA also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must meet the annual limit requirements or obtain a waiver. All waiver and waiver extension applications must have been received by Sept. 22, 2011, as set forth in the previous guidance issued on June 17, 2011.


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CMS Clarifies ERRP Guidance
On Aug. 19, 2011, CMS revised “Guidance on Complying with the Prohibition on Using Early Retiree Reinsurance Program Reimbursements as General Revenue,” originally published on July 20, 2011, to clarify a key point with respect to the maintenance of contribution requirements discussed in such guidance. The revision clarifies that plan sponsors participating in the Early Retiree Reinsurance Program (ERRP) must meet a maintenance of contribution requirement if they use program reimbursements to offset increases in their costs for plan benefits. Specifically, the revision clarifies that in all instances in the guidance that discuss the amount a plan sponsor would have to allocate or spend in any given plan year for which the maintenance of contribution requirement applies, either in terms of dollars or percentages, the amount is net of any ERRP reimbursement received that the sponsor uses toward that contribution.

This guidance is intended to give plan sponsors some flexibility in applying the maintenance of contribution requirement, while also helping to ensure that sponsors do not violate the prohibition against using ERRP reimbursement as general revenue. To the extent that a plan sponsor is unable to use the maintenance of contribution approaches set forth in this guidance, the sponsor may demonstrate compliance with this requirement in other ways. In such situations, the sponsor may be required, upon audit, to demonstrate how its approach is consistent with the statutory and regulatory requirements.

A recent training webinar also gives sponsors and their vendors information on compiling detailed claim lists for submission to the ERRP secure website.

FREQUENTLY ASKED QUESTION

We have a self-insured grandfathered plan that has a $25,000 annual limit and a $100,000 lifetime limit on morbid obesity surgical treatments. Considering PPACA, what are our options with respect to the annual and lifetime limits going forward, particularly if we want to remain grandfathered?

Before exploring the options, a preliminary question must be answered, which is whether morbid obesity surgical treatments are considered “essential health benefits” under PPACA. As background, effective Sept. 23, 2010, PPACA prohibits group health insurance plans (including grandfathered plans) from imposing lifetime limits on essential health benefits. For the plan year that begins in 2014, PPACA also prohibits plans from imposing annual limits on essential health benefits. Prior to 2014, the annual dollar limits on essential health benefits can be no less than the following amounts:

- $750,000 for the plan year beginning on or after Sept. 23, 2010, and before Sept. 23, 2011
- $1.25 million for the plan year beginning on or after Sept. 23, 2011, and before Sept. 23, 2012
- $2 million for the plan year beginning on or after Sept. 23, 2012, and before Jan. 1, 2014

Essential benefits are currently defined only in broad categories, including the following:

- 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

Unfortunately, in terms of definitively determining essential health benefits, an exact determination cannot yet be made, because HHS has not issued final guidance on the definition of “essential health benefits.” Until additional guidance is released, group health plans are subject to a “good faith” compliance standard. According to HHS, this standard means that HHS will take into account a plan’s good faith efforts to comply with a reasonable interpretation of essential health benefits, so long as the plan applies this definition consistently.

Thus, there is no definitive answer as to whether surgical treatment for morbid obesity (or other similar treatments) would be considered an essential health benefit subject to PPACA's annual and lifetime limit provisions. A strong argument could be made that a reasonable interpretation of the “preventive and wellness services and chronic disease management” category would include surgical treatment for obesity, since obesity is likely a chronic disease and services relating to obesity would constitute either chronic disease management or preventive services. Then again, an argument may be made that a reasonable interpretation of any of the above essential health benefit categories would not include surgical treatment for morbid obesity.

The plan sponsor should strongly consider whether the morbid obesity surgical treatment (or treatments for other medical conditions) reasonably fits into one of the above categories. After making such a determination, the plan sponsor would have to apply the determination consistently.

With respect to grandfathered status, it is important to remember that PPACA’s annual and lifetime limit provisions apply to a grandfathered plan. In addition, the elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan to lose its grandfathered status. For this purpose, elimination of any element necessary to diagnose or treat the condition is considered elimination of all or substantially all of the benefits for that condition. Thus, if the plan eliminates coverage for surgical morbid obesity treatments, the plan will lose its grandfathered status.
There are basically three options available for a self-insured plan:

- Eliminating the obesity treatment. This option would eliminate any issues relating to “essential health benefits,” since the annual and lifetime limits would no longer be applicable. However, eliminating the obesity treatment will cause the plan to lose grandfathered status, which would subject the plan to those PPACA provisions that apply to non-grandfathered plans.

- Continuing the obesity treatment, but removing the annual limit. This is probably the most conservative option, since there would be no issue regarding whether the obesity treatment falls under the definition of “essential benefits.” In addition, there may be a reasonable argument that morbid obesity treatment falls under the essential health benefits category of either a preventive and wellness service or chronic disease management. However, this approach is also the most expensive for a self-insured employer, since it would be the employer who would bear the cost associated with the elimination of the annual limit. This approach will not cause a loss of grandfathered status (since making a change to comply with a provision of PPACA does not cause the plan to lose grandfathered status).

- Continuing the obesity treatment and continuing the annual and lifetime limits. This option would not cause a loss of grandfathered status, since the plan has not made a change that would cause a loss of grandfathered status. However, because it’s not entirely clear whether the obesity treatment falls under one of the above categories of essential health benefits, it’s not clear whether the annual limit is allowed. As stated above, there are probably arguments on both sides: that the obesity treatment falls under one of the categories or that it does not. If the employer feels that a reasonable interpretation of the categories does not include morbid obesity surgical treatments, and the employer consistently applies that interpretation, then the plan could continue the annual and lifetime limits. However, the employer should proceed with caution, since HHS (or other federal agencies) may challenge the reasonableness of the determination.

Based on the above, the conservative approach would be to conclude that a treatment for morbid obesity reasonably falls under one of the above categories. The result would be that the plan would have to comply with the annual limits restrictions and lifetime limit prohibitions described above, meaning that the plan would have to remove the lifetime limit and comply with the transition rules for the annual limits. This also means that the plan would lose grandfathered status, meaning that the plan would be subject to other PPACA provisions that apply to non-grandfathered plans. Lastly, this means that the plan, as a self-insured plan, would bear the additional costs associated with the removal of the annual and lifetime limits. While this seems like a harsh result, it is the safest option from a compliance standpoint, since the plan would not be inviting a challenge (and the related penalties) from the DOL on the reasonableness of its interpretation of the definition of essential health benefits.

The issue may be clarified once HHS issues guidance on the specifics of the definition of essential health benefits. Until then, the plan sponsor must make a good faith and reasonable interpretation of the annual and lifetime provisions of PPACA, apply that interpretation on a consistent basis and be prepared to defend its interpretation should a DOL inquiry arise.
# ACRONYMS GLOSSARY

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