

# Health Care Reform Quarterly

## Q4 2011

*Health Care Reform Quarterly* is devoted to developments surrounding the implementation of health care reform. This edition features an update on what's in store in 2012, 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 the timeline for compliance with the automatic enrollment provision required under PPACA.

## Table of Contents

### Featured Story

Health Care Reform: What's Coming in 2012?

### New and Updated Publications and Tools

#### In the News

Health Care Reform Litigation Update

Initial HHS Proposal Gives States Flexibility to Define Essential Health Benefits

HHS Issues CO-OP Program Regulations

End Date Announced for Claims Under Early Retiree Reinsurance Program

Final MLR Regulations Released

HHS Releases FAQs Concerning Implementation of Exchanges

FAQ Issued on Health Care Reform's SBC Requirement

HHS Suspends PPACA's CLASS Program

Institute of Medicine Releases Criteria for HHS to Develop Essential Benefits Package Under PPACA

### Frequently Asked Question

When do employers have to comply with the new automatic enrollment requirements imposed under PPACA?

### Acronyms Glossary

## FEATURED STORY

**Health Care Reform: What's Coming in 2012?**

Much has happened in the health care reform landscape, and there is more to come in 2012. Here's a look at where we are and what to expect in 2012.

As of Sept. 23, 2010, nearly all plans are required to provide coverage for adult children to age 26, are prohibited from having lifetime limits on the dollar value of "essential health benefits" (annual limits on the dollar value of essential benefits were first restricted in 2010 and are prohibited in 2014), are prohibited from rescinding coverage except in the case of fraud or intentional misstatement of material fact, and are prohibited from imposing pre-existing condition limitations for coverage of children under age 19. Additionally, for plan years beginning on or after Sept. 23, 2010, certain preventive coverage must be provided with no cost sharing, although grandfathered plans are exempt from this requirement.

In terms of what to expect in 2012, let's first take a look at what has been eliminated. When PPACA was first enacted, the Secretary of HHS was required to create procedures and protocols for the Community Living Assistance Services and Supports (CLASS) Act, which was designed to establish a national, voluntary long-term care insurance program for purchasing community living assistance services and supports. Procedures for the CLASS program were expected to be released in 2012; however, on Oct. 14, 2011, HHS announced that, due to actuarial and solvency challenges, it would halt implementation of the CLASS Act.

Beginning in 2012, most employers that provide "applicable employer sponsored coverage" must begin reporting information concerning an employee's insurance benefits on the employee's Form W-2 issued in early 2013. Some coverage, such as disability insurance and long-term care coverage, does not have to be reported. (Ask your advisor for a copy of the NFP white paper on the W-2 reporting requirement for additional information). There is also a small employer exception for employers who filed fewer than 250 Forms W-2 for 2011. Unless changed by future guidance, those employers who file fewer than 250 Forms W-2 for one calendar year will be exempt for the next calendar year.

PPACA also requires plans to provide a new four-page summary of benefits and coverage to all enrollees who meet specified criteria, with an applicability date of March 23, 2012, initially proposed. Because final regulations on this requirement have not yet been issued, recent guidance provides that plans and issuers are not yet required to comply, noting that the final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.

Further, starting with policies having a plan year ending after Sept. 30, 2012, a fee of \$2 per the number of lives covered under a plan will be assessed for insurers of specified health insurance policies and by sponsors of applicable self-insured health plans. This fee will fund comparative effectiveness research, and the fee will not apply to any policy year ending after Sept. 30, 2019.

Employers who sponsor FSAs should also prepare to comply with the new annual limit on health FSAs, capping the maximum contribution amount at \$2,500, which goes into effect Jan. 1, 2013. For plans that currently permit health FSA salary reductions in excess of \$2,500, plan amendments and changes to employee communications will be required before the January 1, 2013, effective date. Additionally, to simplify the administration of the new FSA limit, sponsors of non-calendar-year plans (those that straddle two calendar years) should consider implementing the \$2,500 maximum as of the first day of the plan year that starts in 2012.

Finally, in 2012, the Supreme Court is expected hear oral arguments for three days beginning on March 26, 2012, and ending on March 28, 2012, on the constitutionality of PPACA's individual mandate, among a handful of other issues, described below. The court is expected to issue a decision by late June, in the middle of the presidential election year. Importantly, despite the uncertainty in this area due to the pending litigation, employers should be moving forward with implementation.

## NEW AND UPDATED PUBLICATIONS AND TOOLS

- Impact on Employees, Revised January 2012
- Patient Protection and Affordable Care Act Brandable White Paper, Revised December 2011
- Patient Protection and Affordable Care Act Brandable FAQs, Revised November 2011
- Grandfathered Health Plans Test Model, Revised November 2011
- Interim Final Rules for Grandfathered Health Plans, Revised October 2011

Ask your advisor for a copy of these publications.

## IN THE NEWS

**Health Care Reform Litigation Update**

There have been two recent developments regarding health care reform litigation. More information about these developments is detailed below.

**Supreme Court**

On Monday, Nov. 14, 2011, the Supreme Court agreed to review three of the five separate appeals challenging the constitutionality of PPACA. Within the three appeals, the court selected for review only those issues tied to the overall question of how governmental power is divided between national and state governments. The court will not review, at this time, the cases involving the Thomas More Law Center and Liberty University, and the issue involving the employer mandate. Additionally, the *Seven-Sky v. Holder* decision, discussed in more detail below, is not one that the Supreme Court agreed to review.

The court announced on Dec. 19, 2011, that it will hear oral arguments on these issues for three days, beginning on March 26, 2012, and ending on March 28, 2012, totaling 5 1/2 hours of actual argument. The court is expected to issue a decision by late June, in the middle of the presidential election year.

The issues chosen by the court for review are:

**The Individual Mandate** — This provision of PPACA has been the centerpiece of the constitutionality challenges. It requires all individuals to maintain a minimum level of health insurance or pay a penalty. Opponents claim it is a federal intrusion into a private matter that is beyond the scope of Congress' reach, and that there must be a limit on the federal government's powers. Specifically, this is Question 1 in the government case *U.S. Department of Health and Human Services v. Florida, et al.*, and it has been granted two hours of oral argument.

**Severability** — The issue of severability asks what other provisions of PPACA, if any, are so closely intertwined with the individual mandate that they rise and fall together. When Congress debated the health care reform law, it justified the necessity of the individual mandate due to the implementation of insurance market reforms. The thought is that the individual mandate will diminish the effects of adverse selection when reforms are implemented, such as guarantee issue, the prohibition on pre-existing condition provisions and rating mandates. The court will have to determine if Congress wanted those market reforms – and others – if the individual mandate was not included. Specifically, this is the only question in *National Federation of Independent Business v. Sebelius* and Question 3 in *Florida, et al., v. U.S. Department of Health and Human Services*. The cases have been consolidated for 90 minutes of oral argument.

**Jurisdiction** — The court will review whether the Anti-Injunction Act bars the lawsuit (assuming the penalty is characterized as a federal tax) before the tax is actually enforced. This act requires the taxpayer to pay the tax and then pursue a challenge, which would mean that the individual mandate issue would not be heard by the court at this time, because the mandate is not in effect until 2014. Specifically, the act declares that “no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any Court by any person,” and was intended to keep the government's revenues flowing even while a taxpayer objects to paying a certain tax. There is a separate question within this argument of whether the act applies to states as challengers. Specifically, this is an added question in the government case *U.S. Department of Health and Human Services v. Florida, et al.*, and it has been granted one hour of oral argument.

**Medicaid Expansion** — The states have also raised the issue of the broad expansion of the Medicaid law. Simplified, this questions to what extent Congress can apply a heavy hand to conditions states must agree to before accepting federal funding. Specifically, this is Question 1 in the *Florida, et al., v. U.S. Department of Health and Human Services* case, and it has been granted one hour of oral argument.

**Seven-Sky v. Holder**

On Nov. 8, 2011, in *Seven-Sky v. Holder*, the D.C. Circuit Court of Appeals upheld a lower court decision, ruling that PPACA's individual mandate is constitutional. Judge Laurence Silberman, who was nominated by President Ronald Reagan, wrote the 2-1 opinion, and is now the second conservative judge to uphold the mandate.

While plaintiffs in many of the health care reform suits have argued that Congress exceeded its authority in enacting the mandate, the plaintiffs in this case presented a slightly different argument, arguing that the mandate violates the religious freedom of those who choose not to have insurance because they rely on God to protect them from harm.

The D.C. Circuit is now the second appeals court to uphold the constitutionality of the individual mandate. This means that two appellate courts upheld the mandate, one ruled against it and one declined to reach a decision, citing procedural legal issues. The Supreme Court will not review this case, which means, in practice, the ruling may have little

impact. Nevertheless, the ruling does improve PPACA's record in federal appellate courts, and the reasoning of the D.C. Circuit Court judges may ultimately prove to be persuasive to the Supreme Court.

Benefits Compliance will continue to monitor the status of the health care reform litigation and keep you informed.

*Supreme Court PPACA Briefs* (<http://www.supremecourt.gov/docket/PPAACA.aspx>)

*Seven-Sky v. Holder* ([https://internal.nfp.com/webfiles/public/Benefits/ComplianceCorner/documents/Seven-Sky\\_vs\\_Holder.pdf](https://internal.nfp.com/webfiles/public/Benefits/ComplianceCorner/documents/Seven-Sky_vs_Holder.pdf))

*Supreme Court Argument Calendar* ([http://www.supremecourt.gov/oral\\_arguments/argument\\_calendars/MonthlyArgumentCalMAR2012.pdf](http://www.supremecourt.gov/oral_arguments/argument_calendars/MonthlyArgumentCalMAR2012.pdf))

---

## Initial HHS Proposal Gives States Flexibility to Define Essential Health Benefits

On Dec. 16, 2011, HHS released a “pre-rule” bulletin to provide information and solicit comments on the regulatory approach that HHS plans to propose to define essential health benefits (EHB) under PPACA § 1302(b). Non-grandfathered plans in the individual and small group markets inside and outside of the exchanges must cover EHB beginning in 2014. Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Under HHS' intended approach as announced in the bulletin, states would have the flexibility to select an existing health plan to set the benchmark for the items and services included in the EHB package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state
- One of the three largest state employee health plans
- One of the three largest federal employee health plan options
- The largest HMO plan offered in the state's commercial market

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are “substantially equal” to the benchmark plan selected by the state and modified as necessary to reflect the 10 coverage categories.

The bulletin addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments and coinsurance, which will be addressed in future bulletins. Final rules are expected to be issued sometime next year. HHS is accepting comments on the proposal, which are due by Jan 31, 2012, and may be sent to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov).

*Essential Health Benefits Bulletin* ([http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf))

*Fact Sheet* (<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>)

---

## HHS Issues CO-OP Program Regulations

On Dec. 13, 2011, HHS issued final regulations implementing the Consumer Operated and Oriented Plan (CO-OP) program, which provides loans to encourage the establishment of consumer-governed, private, nonprofit health insurers (referred to as CO-OPs). CO-OPs are designed to offer individuals and small businesses additional affordable, consumer-friendly and high-quality health insurance options. Starting Jan. 1, 2014, CO-OPs will offer health plans through the new, competitive health care marketplaces in each state, called the Affordable Insurance Exchanges. In addition to offering health plans through an exchange, CO-OPs may offer health plans outside of an exchange.

Two types of loans are available under the program: startup loans for costs associated with establishing a CO-OP, and solvency loans to help CO-OPs satisfy state solvency and reserve requirements. The final regulations address eligibility standards for the CO-OP program, establish terms for loans and provide certain basic standards that organizations must meet to participate in the program and become CO-OPs. The regulations are effective Feb. 13, 2012, and finalize proposed regulations that were issued in July 2011.

*Regulations* (<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>)

*Fact Sheet* ([http://cciio.cms.gov/resources/factsheets/coop\\_final\\_rule.html](http://cciio.cms.gov/resources/factsheets/coop_final_rule.html))

---

## End Date Announced for Claims Under Early Retiree Reinsurance Program

Congress appropriated \$5 billion for the Early Retiree Reinsurance Program (ERRP), established under PPACA, and directed the Secretary of HHS to set up the program within 90 days of enactment. By law, ERRP is scheduled to end when its resources have been used to pay claims. Due to the significantly high response from employers, the program stopped taking applications as of May 6, 2011.

On Dec. 9, 2011, CMS notified plan sponsors that \$4.5 billion had been paid and issued further guidance informing plan sponsors that claims incurred after Dec. 31, 2011, will not be accepted. HHS has also announced that any claim list that includes a claim incurred after that date will be rejected in its entirety. Claims incurred on or before Dec. 31, 2011, but paid after that date may still be submitted, but not until the claim has been paid.

Reimbursement requests received after the \$5 billion has been fully exhausted will be held in the order of receipt, pending availability of funds. Sponsors with reimbursement requests on hold can expect to:

- Receive an email notifying them that their reimbursement requests have been placed on hold pending availability of funds;
- Have access to information about the position of their requests in the list of held reimbursement requests; and
- Be paid in the order in which reimbursement requests were received, if additional funds become available. In such cases, reimbursement requests will be honored until there are not sufficient funds to pay a reimbursement request in its entirety, at which time, that request will be partially paid and the balance will be paid if and when additional funds become available. Each time a partial payment is processed, the plan sponsor will receive an email notification regarding the specific amount paid and the balance remaining to be paid.

In addition to the news release and notice, HHS issued an updated state-by-state list of amounts paid to approved sponsors.

*Notice* (<http://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31920.pdf>)

*News Release* (<http://www.errp.gov/newspages/20111209-updated-payment-processing-new-incurred-date.shtml>)

*Update* ([http://cciio.cms.gov/resources/files/Files2/12092011/errp\\_disbursement\\_12\\_02\\_2011\\_508.pdf](http://cciio.cms.gov/resources/files/Files2/12092011/errp_disbursement_12_02_2011_508.pdf))

---

## Final MLR Regulations Released

HHS released a final rule on Dec. 2, 2011, relating to the medical loss ratio (MLR) requirements enacted as a part of PPACA § 2718, which does not exempt agent and broker commissions from the final MLR calculation. The final rule does not explicitly address commissions, instead leaving the calculation of administrative costs unchanged from the original draft. Thus, the fundamental structure of the MLR policy is not changing.

Beginning in 2011, the law required insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies that do not meet the MLR standard will be required to provide rebates to their consumers. Insurers will make the first round of rebates to consumers in 2012. Rebates must be paid by Aug. 1 each year.

The changes in this final rule largely address technical issues involved in the way issuers calculate and report their MLR and the mechanism for distributing rebates to enrollees in group health plans. The regulations clarify that any MLR rebates paid out to consumers are tax-free. Under an earlier rule, rebates to employers would have been taxable, so the final rule says any rebates given for group policies should be in the form of lower premiums or “in other ways that are not taxable.” This process will vary by plan type, but policy holders must ensure that the rebates are used for the benefit of subscribers.

Under the final rule, plans must send their customers a notice about the MLR even if they meet the requirements and do not have to offer rebates. The notice will explain how the policy works, what the plan’s loss ratio was, and how it changed because of the health care law. Also, HHS agreed to phase out allowances for the administrative expenses of so-called mini-med plans that offer limited benefits to individuals or small groups.

*HHS Fact Sheet* (<http://cciio.cms.gov/resources/factsheets/mlrfinalrule.html>)

*Final Rule* (<http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/html/2011-31289.htm>)

---

## HHS Releases FAQs Concerning Implementation of Exchanges

On Nov. 29, 2011, HHS released 13 FAQs addressing implementation issues for states and federally facilitated exchanges. The FAQs cover a range of topics, including funding responsibility and resources, information exchanges through federally managed data “hubs,” and shared eligibility verification services. Among them are FAQs focused on issues raised by federally facilitated exchanges.

*FAQs* ([http://cciio.cms.gov/resources/files/Files2/11282011/exchange\\_q\\_and\\_a.pdf.pdf](http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf))

*News Release* (<http://www.hhs.gov/news/press/2011pres/11/20111129a.html>)

---

## FAQ Issued on Health Care Reform’s SBC Requirement

The DOL, HHS and IRS issued a new set of FAQs on Nov. 20, 2011, addressing PPACA’s summary of benefits and coverage (SBC) requirement. The first section of the FAQs addresses the timing of the application of the SBC requirement, since an applicability date beginning March 23, 2012, was initially proposed, but final regulations on the SBC requirement have not yet been issued. The FAQ clarifies that since final regulations have not yet been issued on the SBC requirements, plans and issuers are not yet required to comply. The FAQ notes that it is anticipated that the departments’ final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.

*FAQs* (<http://www.dol.gov/ebsa/faqs/faq-aca7.html>)

---

## HHS Suspends PPACA’s CLASS Program

On Oct. 14, 2011, HHS announced that it would halt implementation of the Community Living Assistance Services and Supports (CLASS) Act under PPACA. Under the CLASS program, the Secretary of HHS was supposed to create procedures and protocols establishing a national voluntary long-term care insurance program for purchasing community living assistance services. To implement the program (which was to be done by Oct. 1, 2012), HHS was required to develop at least three “actuarially sound” benefit plans that would remain solvent for 75 years. HHS cited actuarial and solvency challenges as the reasons it had “not identified a way to make CLASS work at this time.”

*HHS’ Report to Congress* (<http://aspe.hhs.gov/daltcp/reports/2011/class/index.shtml>)

*HHS Secretary’s Cover Letter* (<http://www.hhs.gov/secretary/letter10142011.html>)

---

## Institute of Medicine Releases Criteria for HHS to Develop Essential Benefits Package Under PPACA

On Oct. 6, 2011, the Institute of Medicine (IOM), a federal advisory panel, released a 297-page report that set forth the criteria that HHS should use in drafting the requirements relating to PPACA's essential benefits package. HHS will follow, with final regulations outlining the specific essential benefits requirements likely to be released next spring.

The IOM said HHS must consider both cost and effectiveness of the package, making affordability a key tool in the decision-making process. The report laid out broad goals:

“The (package) must be affordable, maximize the number of people with insurance, protect the most vulnerable individuals, promote better care, ensure stewardship of limited financial resources by focusing on high value services of proven effectiveness, promote shared responsibility for improving our health, and address the medical concerns of greatest importance to us all.”

When deciding on benefits, the panel said, HHS should take into account whether they would result in “meaningful improvement in outcomes” and are “supported by a sufficient evidence base.”

The IOM stated that the packages should be defined initially by what is typical in the small employer market, and that only medically necessary services should be covered. The IOM noted a strong preference for evidence-based medicine, excluding experimental treatments. The IOM also recommended that the methodology include an initial determination of the cost target followed by a determination of what services could be purchased within those cost constraints.

The rules will apply to all policies sold to individuals and small businesses within the state exchanges and the private market. We are still waiting to see whether larger employers will be affected by the list of essential benefits in the form of minimum essential coverage. The IOM said that the federal government should allow states that administer their own exchanges to make changes to the list of essential benefits as long as those variations are consistent with PPACA and are as comprehensive as the required benefits list. Under PPACA, states can continue to impose coverage requirements not included in the essential benefits package — but they would be responsible for paying insurers the additional costs for those benefits in policies sold through state exchanges.

The IOM recommended using a structured public process to identify priorities. HHS Secretary Kathleen Sebelius said she will seek public comment before making any decisions.

*IOM Report* (<http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>)

## FREQUENTLY ASKED QUESTION

### **When do employers have to comply with the new automatic enrollment requirements imposed under PPACA?**

PPACA amends the FLSA to require certain large employers to:

- Automatically enroll new full-time employees in one of the employer's health benefit plans (subject to any waiting period authorized by law);
- Continue the enrollment of current employees

Employers subject to the rule are those who 1) are subject to the FLSA, 2) have more than 200 full-time employees and 3) have one or more health benefit plans. Adequate notice must be provided, and employees who are automatically enrolled must be given an opportunity to opt out of coverage.

PPACA does not specify an effective date for the automatic enrollment requirement. In sub-regulatory guidance though, the DOL has indicated that employers are not required to comply with this requirement until regulations are issued, with rulemaking expected to be completed by 2014.

EBSA issued a request for information in May 2011, and the rule is currently in the pre-rule stage. The DOL and the U.S. Department of the Treasury will coordinate to develop the rules that apply in determining full-time employee status for purposes of implementing the requirement. For more information, see “FAQs About Affordable Care Act Implementation Part V,” Q/A-3, found at [www.dol.gov/ebsa/faqs/faq-aca5.html](http://www.dol.gov/ebsa/faqs/faq-aca5.html).

In the meantime, employers and administrators will need to assess the impact that automatic enrollment will have on cafeteria plan elections and election change procedures.

For additional health-reform-related FAQs, ask your advisor for a copy of NFP's “Patient Protection and Affordable Care Act FAQs.”

## ACRONYMS GLOSSARY

<b>ADA</b>	Americans with Disabilities Act
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act
<b>DOL</b>	U.S. Department of Labor
<b>EBSA</b>	Employee Benefits Security Administration
<b>EEOC</b>	Equal Employment Opportunity Commission
<b>ERISA</b>	Employee Retirement Income Security Act
<b>FLSA</b>	Fair Labor Standards Act
<b>FMLA</b>	Family and Medical Leave Act
<b>FSA</b>	Flexible Spending Arrangement
<b>HHS</b>	U.S. Department of Health and Human Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HRA</b>	Health Reimbursement Arrangement
<b>HSA</b>	Health Savings Account
<b>IRC</b>	Internal Revenue Code
<b>IRS</b>	Internal Revenue Service
<b>OTC</b>	Over-the-counter Item or Drug
<b>PPACA</b>	Patient Protection and Affordable Care Act (aka Health Care Reform)

For traditional insurance products only; may not be used with variable life policies. Riders are available for an additional cost. Any guarantees offered by life insurance products are subject to the claims-paying ability of the issuing insurance company. There are considerable issues that need to be considered before replacing life insurance such as, but not limited to: commissions, fees, expenses, surrender charges, premiums and new contestability period. There may also be unfavorable tax consequences caused by surrendering an existing policy, such as a potential tax on outstanding policy loans. Please discuss your situation with your financial advisor.

This material was created by NFP (National Financial Partners Corp.), its subsidiaries or affiliates for distribution by their registered representatives, investment advisor representatives and/or agents. This material was created to provide accurate and reliable information on the subjects covered but should not be regarded as a complete analysis of these subjects. It is not intended to provide specific legal, tax or other professional advice. The services of an appropriate professional should be sought regarding your individual situation. Neither NFP nor its subsidiaries or affiliates offer tax or legal advice.

Securities and Investment Advisory Services may be offered through NFP Securities, Inc., member FINRA/SIPC. NFP Securities, Inc. and the firm branded on this document are affiliated.