ALLEGIANCE

MEMO

To: Allegiance Companies' Clients

Date: May 7, 2010

Re: First Installment: Patient Protection and Affordable Care Act (PPACA) Federal Health Care Reform

This is the first of several installments that the Allegiance Companies will be presenting regarding the Patient Protection and Affordable Care Act (PPACA), more widely known as federal health care reform. This first installment will be a discussion of three topics under that health care reform which have somewhat immediate applicability. Those three topics are: 1) "Grandfathered" plans; 2) Tax treatment for health care benefits for children under age 27; 3) The Early Retiree Reinsurance Program (ERRP).

"GRANDFATHERED" PLANS

An item of much discussion and debate under the new health care reform laws is the concept of "grandfathered" health plans. First, a definition is necessary. A "grandfathered" health plan is defined under the new law as any group health plan or individual coverage that was in effect on March 23, 2010.

The next question is how long the "grandfathering" status is in effect. The answer to this question is far less clear. The new law is somewhat clear that a plan with grandfathered status will remain grandfathered even if it renews, even if eligibility requirements are changed, and even if dependents or other family members are added or dropped from the plan. In addition, specifically with regard to collectively bargained plans, they will continue to have grandfathered status until the date after March 23, 2010 upon which the collectively bargained agreement expires. It is unclear, for either collectively bargained plans or other group health plans, whether changes in plan design or benefit design will affect the grandfathered status. The specific language of the statute simply indicates that grandfathered plans are not subject to the new health care reform law. However, the Reconciliation Bill and other

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corrections have made it clear that that is not entirely the case. At this point, in the absence of further regulation, it is impossible to state with any certainty whether plan design changes will cause the loss of grandfathered status.

The next question is what is the effect of having a plan with grandfathered status? As it applies to group health plans, there are actually only a few provisions of the new law which grandfathered plans are not required to comply with at the same time as any other plan. These provisions are in two categories.

The first category is federal health plan mandates for which new plans will be required to comply immediately, but for which grandfathered plans will not be required to comply until the first plan year following January 1, 2014. There are four of these mandates. They are:

1) Grandfathered plans will not be required to cover adult children up to age 26, *even if the child has coverage available through his or her own employment*. Note: even grandfathered plans will be required to cover some adult children up to age 26 on the first plan year following September 23, 2010, but only for children who do not have coverage available through their own employment.
2) Grandfathered plans will not be required to eliminate waiting periods in excess of ninety (90) days.
3) Grandfathered plans will not be required to immediately eliminate pre-existing condition exclusions for individuals over 19 years of age. Note that all plans, grandfathered or not, will be required to eliminate pre-existing condition exclusions for dependent children 19 years of age and under effective the first plan year after September 23, 2010.
4) Grandfathered plans will not be required to eliminate annual limits on certain essential benefits, although the exact scope of this grandfathered provision is not clear, and will have to wait for further regulation and guidance for clarification.

There are four other provisions with which, at least arguably, grandfathered plans will never have to comply. Those four mandates are:

1) For fully insured group health plans, grandfathered plans will not have to comply with the non-discrimination rules under §105(h) of the Internal Revenue Code;
2) Grandfathered plans will not have to comply with new rules regarding external appeal review requirements;
3) Grandfathered plans will not be required to follow the mandate that requires women to be permitted to select in OB/GYN of their choice; and
4) Grandfathered plans will not be required to comply with certain preventive care mandates for immunizations and preventive care treatments.

There are additional provisions regarding certain tax issues which may also not apply to grandfathered plans, and the discussion is not meant to be exhaustive. Rather, this discussion is meant to summarize and highlight some of the more common and high interest provisions regarding grandfathered health plans.

TAX TREATMENT OF HEALTH BENEFITS WITH RESPECT TO CHILDREN UNDER AGE 27

As has been discussed for several years with regard to prior state mandates, as a general rule, the Internal Revenue Code did not consider a child 24 years of age or older to be a dependent child for any purpose, including tax free coverage under an employee's group benefit plan. As a result, for a number of years, coverage for dependents over that age required employers to impute income for the value of the coverage for each such dependent to the employee as part of wages and salary. Because the new federal mandates will require coverage of dependent children up to age 26, and some state mandates already in place require coverage of children up to age 27, the Internal Revenue Service and the Department of Treasury issued interim guidance to correct this gap between coverage and the tax status of the dependent. The guidance issued was effective March 30, 2010. In essence, the guidance simply states that effective March 30, 2010, and specifically with regard to coverage under a group health plan and group health insurance, such coverage for adult children of employees up to the age of 27 years may be covered without creating an issue of imputed income. No income for children falling within this category is required after that date to be imputed to the employee.

Specifically with regard to the age issues, the imputed income issue will not apply to an adult child "who has not

attained age 27 as of the end of the employee's taxable year". The full text of this guidance is published in Treasury Notice 2010-38 which can be found on the IRS website. Please note this guidance applies only with regard to issues regarding imputed income for adult children on health plans, and as stated to Flex plans and HRAs. It does not change the definition of a dependent for income tax purposes under §152 of the federal Internal Revenue Code.

EARLY RETIREE REINSURANCE PROGRAM (ERRP)

Another aspect of the heath care reform that becomes effective nearly immediately is the so-called "Early Retiree Reinsurance Program" (ERRP). That portion of health care reform becomes effective June 1, 2010. However, it applies only to group health plans that provide retiree coverage for retirees who are less than 65 years of age. The purpose of this program is to assist employers with the cost of providing retiree coverage to individuals who retire before they reach age 65 and become eligible for Medicare coverage. The broad terms of the program are quite simple. The ERRP provisions apply to any retiree covered under an employer-sponsored group health program who is 55 years or age or older, but less than 65 years of age. For each such retiree, the United States government has set aside an appropriation of $5 billion, to be spent over the next 3 years, on a first-come first-served basis, to reimburse employers for portions of the cla ims incurred by such individuals. More specifically, this fund will reimburse 80% of claims paid for any such individual under an employer-sponsored group health plan for claims paid that exceed $15,000 in any plan year, but are less than $90,000 in any plan year. In other words, each employer will be eligible for a maximum reimbursement for any retiree on its plan who meets the definition above of $60,000 per retiree per plan year.

Although the concept above seems simple, regulations regarding the implementation of this program were issued on May 4, 2010. Unfortunately, the regulations appear to change this from a fairly simple concept to a somewhat more complicated program, mostly in regard to the application and registration requirements.

The newly issued regulations set out a very significant application process requiring each employer applying to provide a large amount of data to the U.S. Department of Health & Human Services. They do not, however, provide a model application form. As was expected, the application will be required to contain the employer's name, address and tax identification number, employer contact name and telephone number and email address, and a signed agreement by the employer authorizing the federal government to obtain and receive health care information regarding all retirees on the employer's plan, and also authorizing the U.S. Department of Health & Human Services to audit the plan at its discretion at any time.

The application will also require that the employer assure the U.S. Department of Health & Human Services that the employer has policies and procedures in place to detect and reduce fraud, waste and abuse under the group health plan, and will require a description of those policies and procedures. Further, the application will require that the employer acknowledge that the information in the application is being provided to obtain federal funds and is therefore subject to all federal laws that apply to a grant of federal funds. The application will require that the employer describe how the employer will use any reimbursement it receives, and specifically requires that the reimbursement be used to either reduce premium contributions, copayments, deductibles, coinsurance or other out of pocket costs for retiree plan participants or to reduce health benefit or other health premium costs for the plan sponsor or the plan participants or any combination of the above. The regulations will also require, as part of the application, that the employer describe procedures and programs it has in place to generate potential cost savings to plan participants with chronic and high cost conditions and the employer will be required to project or estimate the amount of reimbursement it thinks it will receive under this program on a yearly basis for the first two plan years subsequent to the application. Once the application is submitted, an employer will not be eligible for the reinsurance subsidy until the application is actually approved in writing by the Secretary of Health & Human Services. For all details regarding this program, the newly published regulations can be found at 45 Code of Federal Regulations (CFR) §149.1, et seq.

We at Allegiance hope you find the information above to be helpful to you as the sponsor of an employee group health plan. Please watch for further weekly installments regarding health care reform. The next installment, which will be published approximately May 13th or 14th, will describe the requirements of the new health care reform laws that will apply to your plan between now and January 1, 2012.

Thank you!