



MEMO

To: Allegiance Companies' Clients

Date: May 14, 2010

Second Installment: Timelines of Key Provisions Affecting Employers Between Now and September 23, 2011

This is the second in a series of Allegiance articles concerning the recently enacted Patient Protection and Affordable Care Act (PPACA) ("the Act") of 2010.

This installment identifies when and to what extent the new rules will apply to plans between now and September 23, 2011.

As discussed in last week's client communication, a "grandfathered" plan is defined under the law as any group health plan or individual coverage that was in effect on March 23, 2010. New enrollees are intended to be included in a grandfathered plan.

The effective dates for certain provisions are delayed for grandfathered plans, and some provisions do not apply to grandfathered plans. However, the requirements discussed below apply to all plans, even those with grandfathered status.

Some of the new requirements, particularly the coverage mandates, become effective as of the first day of a specific

plan year. For example, the early market reforms take effect for plan years beginning six months after the date the new law was enacted (March 23, 2010). Thus, plans that are not based on a calendar year which begin in the fourth quarter will need to comply with certain requirements starting this year.

Many of the specifics for changes to plans and benefits are not spelled out in the new law. While some changes mandated by the new law appear to be somewhat straightforward, other provisions are missing crucial details, which must be clarified by the U.S. Department of Health and Human Services (HHS) in yet to be produced regulations.

2010 Provisions:

1) Retiree Health Benefit Subsidy.

This information supplements last week's installment. As previously described, the subsidy is a temporary reinsurance program, effective June 23, 2010, to help reduce the costs of healthcare coverage for certain early retirees, with a one time appropriation of \$5 billion. This program will reimburse participating employers for 80% of claims between \$15,000 and \$90,000 for retirees who are age 55 or older, but not yet eligible for Medicare ("Early Retirees"), their spouses, (or surviving spouses) and dependents. Funds are capped at \$5 billion, and the regulations make it clear that the program will end once those funds are depleted.

An application must be filed with HHS before a plan sponsor can submit claims for reimbursement. *Applications are first-come, first-served, and incomplete or inaccurate applications will be rejected.* The application for the program should be available by the end of June, 2010.

After the application is submitted and approved, HHS will "certify" the plan, allowing it to submit data regarding claims, once those claims are paid by the plan. The application itself needs to contain a projection (but not actual claims data) concerning the amount of claims that would be reimbursed under the program during the first two plan years. The application will need to state how the reimbursements will be used to (1) reduce premium contributions, co-pays, deductibles or other out-of-pocket expenditures for participants; (2) reduce health benefit costs or premium costs for the plan sponsor; or (3) reduce a combination of plan participant and sponsor costs. The application must also indicate how the plan sponsor will maintain its current level of contribution to the plan.

2) Adult Child Coverage Extension and Related Tax Treatment. This information supplements last week's installment as well.

The IRS has issued guidance, effective March 30, 2010, for tax treatment of health coverage and reimbursements for adult children. Effective that date, coverage and benefits are tax-free if they are employer-paid. Employer-paid adult child coverage is excepted from wages for payroll tax purposes.

Income tax exclusion for employer-provided medical care is extended to apply to coverage of an employee's child who has not yet reached age 27, even if the child is married. The exclusion applies up to the end of the tax year immediately prior to the tax year in which the child attains age 27. Employers may rely on employees' representations regarding children's ages.

The Act requires a plan to provide adult child coverage if it provides for any dependent coverage. *The requirement is effective for plan years beginning on or after September 23, 2010 (2011 for calendar year plans) regardless of a plan's grandfathered status.* Generally, all group health plan coverage (major medical, HRA, mini-medical) is subject to the coverage extension for children up to age 26. If the plan does not currently provide dependent coverage, it is the sponsor's choice as to whether to offer this coverage. However, if the plan currently provides dependent coverage, then it must provide adult child coverage as herein described. Note that the definition of adult child may be limited by plan terms and there is no requirement to cover any particular class of dependent children.

The federal Departments of Labor, Treasury and HHS recently released interim final rules for the coverage of dependents up to age 26. *Key provisions in the rules are as follows:*

- a) Open Enrollment Period
 - i) Group health plans with coverage that includes dependents or families must notify covered employees and individuals of a special 30-day open enrollment period on the first day of plan years beginning on or after September 23, 2010.
 - ii) During the open enrollment period, children who previously “aged out” of coverage or were not enrolled in coverage and who are not yet age 26 will be able to enroll under their parent’s coverage.
 - iii) Parents with a choice of coverage will be able to change their coverage option.
 - iv) Children under age 26 currently on COBRA after “aging out” may rejoin group coverage during open enrollment.
- b) Eligibility
 - i) Coverage is required only until the child attains age 26. There is no requirement to extend coverage to a spouse of a child, or a child’s child.
 - ii) Financial dependency, residency with a parent, student status, marital status, and employment may no longer be used to determine eligibility for coverage for any child.
 - iii) In grandfathered plans, for plan years beginning before January 1, 2014, children able to enroll in an employer-sponsored plan other than a parent’s plan, are not eligible for the extension under their parents’ coverage.
- c) Terms and Conditions of Coverage
 - i) Plan terms or health insurance coverage providing dependent coverage for children cannot vary by age (except for children age 26 or older), and surcharges are not allowed except where the surcharges apply regardless of the age of the child.
 - ii) Arrangements under which different premiums are charged based on how many family members are covered are allowed.
 - iii) For children under 26, benefits may not vary based on age.

NOTE: Plans whose plan years commence after *September 23, 2010 but before January 1, 2011* must comply with the above provisions in 2010. They must also comply with lifetime and annual benefit limitations; ban on pre-existing conditions for children; preventive care coverage, claims and external review processes; “highly compensated” nondiscrimination rules applicable to fully insured plans, and certain patient protections related to choice of primary care providers and selection of OB/GYN specialists. Details on these issues are described below.

2011 Provisions (these changes become effective on the first renewal date after September 23, 2010):

- 1) No Lifetime and Annual Benefit Limits. Any lifetime limit in a health plan on the value of “essential benefits” is prohibited. Any annual limit on the dollar value of essential benefits is permitted only if it qualifies as a “restricted annual limit.” The breadth of coverage in an “essential benefits” package and “restricted annual limits” are the subjects of yet to be written HHS regulations. The package will be further defined by HHS and must include, at a minimum, ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, including services recommended by the director of the Centers for Disease Control and Prevention; and chronic disease management. In addition, plans must cover pediatric services, including vision and oral care.
 - a) Annual limits will be prohibited entirely beginning in 2014.
 - b) The limits restriction applies to both “grandfathered” and non-grandfathered plans, starting in 2011.
- 2) Coverage of Adult Children. See above discussion and our earlier client communication.
- 3) Ban on Pre-Existing Conditions for Children. Plans can no longer impose pre-existing condition exclusions on children under age 19.
- 4) Nondiscrimination rules on highly compensated individuals will apply to fully insured employer-provided health insurance. This rule previously applied only to employer self-funded plans.
- 5) Value of Employer Benefits Reported on W-2 forms. Employers are required to disclose the value of benefits provided by the employer in 2011 for each employee’s health insurance coverage on the 2012 W-2 forms.

- 6) Increased Tax on Non-Medical Distributions from Health Savings Accounts (HSAs). The current tax on spending distributions from HSAs or Archer Medical Savings Accounts (MSAs) that are not used for qualified medical expenses is increased from 10% to 20% for HSAs and from 15% to 20% for Archer MSAs of the disbursed amount.
- 7) Over-the-Counter Drug Costs Reimbursement Restrictions in HRA, HSA, FSA plans. Over-the-counter drugs not prescribed by a doctor cannot be reimbursed through a health reimbursement arrangement or health flexible spending account. Such drugs cannot be reimbursed on a tax-free basis through an HSA or Archer MSA.

We hope you find this information helpful in guiding your compliance with health care reform.

Thank you!