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# Benefits Bulletin

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## Regulations Issued on Grandfathered Plans

The health care reform law passed earlier this year brings many changes to employers and health plans. The extent of the impact will depend, in part, on whether you maintained a health care plan on March 23, 2010, the date the primary legislation was enacted. If your company sponsored a plan on that date, it is considered a "grandfathered" plan. Grandfathered plans are exempt from certain health care reform requirements, such as no cost-sharing for preventive care and other patient protections.

On June 14, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury issued regulations regarding grandfathered plans. Importantly, these regulations clarify what types of changes can be made to existing plans that will allow them to retain their "grandfathered" status.

### Summary

The regulations essentially state that plans will lose their grandfathered status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers. Losing grandfathered status means that a plan would have to comply with additional health care reform requirements, such as first-dollar coverage of recommended prevention services and patient protections such as guaranteed access to OB-GYNs and pediatricians.

### Permitted Changes

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

### Prohibited Changes

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. Specifically, making the following changes would cause a plan to lose its grandfathered status:

- *Significantly Cutting or Reducing Benefits.* For example, if a plan decides to no longer cover care for

people with diabetes, cystic fibrosis or HIV/AIDS.

- *Raising Co-Insurance Charges.* Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- *Significantly Raising Co-Payment Charges.* Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next two years, it will lose its grandfathered status.
- *Significantly Raising Deductibles.* Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000 or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-5 percent so this formula would allow deductibles to

go up, for example, by 19-20 percent between 2010 and 2011, or by 23-25 percent between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.

- **Significantly Reducing Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- **Adding or Tightening an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- **Cannot Change Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

### **Additional Requirements for Grandfathered Plans**

The regulations also contain additional requirements to keep health plans from using the grandfather rule to avoid providing important consumer protections.

To promote transparency, the regulations require a plan to disclose to consumers, every time it distributes materials, whether the plan believes that it is a grandfathered plan and therefore is not subject to some of the additional consumer protections of the health care reform law. This allows consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed.

The regulations also provide that a plan's grandfathered status may be revoked if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections. Grandfathered status may also be revoked if a plan is bought by or merges with another plan simply to avoid complying with the law.

## **Interim Final Rules on Dependent Coverage of Children up to Age 26**

The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (the Reconciliation Act), provides that health plans and issuers that offer dependent coverage to children on their parents' plans must make the coverage available until the adult child reaches the age of 26. The Departments of Health and Human Services (HHS), Labor and Treasury have issued interim final rules relating to this requirement.

- The interim final rules clarify that qualified dependents must be offered the same coverage that is available to similarly situated individuals and cannot be required to pay more. They also provide a special enrollment opportunity for qualified dependents not currently covered.
- Note that the requirement to extend coverage applies only to plans that offer dependent coverage in the first place. Most insurers and employer-sponsored plans offer dependent coverage, but there is no legal requirement to do so.
- The interim final rules complement guidance issued by the Treasury Department on April 27, 2010, on the tax benefits for dependent coverage. Under a new tax provision in the Reconciliation Act, the value of employer-provided health coverage for an employee's child is excluded from income through the end of the taxable year in which the child turns 26, effective March 30, 2010.

### **General Rule**

The interim final rules incorporate PPACA's requirement that health plans and issuers that make available dependent coverage of children, must make the coverage available for children until they reach 26 years of age.

### **Restrictions on Plan Definition of Dependent**

The interim final rules also address a plan's definition of the term "dependent." They state that a plan or issuer may not define dependent for purposes of eligibility "other than in terms of a relationship between a child and the participant." This means that coverage may not be denied for a child who is under age 26 based on the following factors (or any combination of them):

- The presence or absence of the child's financial dependency (upon the participant or any other person);
- Residency with the participant or with any other person;
- Student status;
- Employment; or
- Eligibility for other coverage (unless the plan is a grandfathered plan and the child is eligible for other employer-sponsored coverage before January 1, 2014).

The rules specifically state that plans and issuers are not required to make coverage available for the child of a dependent receiving coverage.

### **Uniformity in Plan Terms**

PPACA did not specifically address benefit packages or the cost of benefits available to dependents that are eligible for coverage under the new law. However, the interim final rules specifically state that the terms of the coverage cannot vary based on age (except for children who are age 26 or older). This means that qualified dependents must be offered all of the benefit packages available to similarly situated individuals who did not lose coverage because of cessation of dependent status. Also, these dependents cannot be required to pay more for coverage than those similarly situated individuals.

### **Special Enrollment Opportunities for Dependents**

Dependents that are eligible for coverage under their parent's plan because of the new rules are entitled to a special enrollment opportunity. Plans must provide these dependents with a 30-day special enrollment opportunity, along with written notice of the opportunity. The opportunity must begin no later than the first day of the first plan year beginning on or after September 23, 2010. This rule applies regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur.

The written notice of the special enrollment opportunity must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before age 26, are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child and may be included with other enrollment materials.

The coverage for dependents that enroll through a special enrollment opportunity must take effect no later than the first day of the first plan year beginning on or after September 23, 2010. Also, these dependents must be treated as special enrollees (as under HIPAA).

### **Applicability Dates**

The coverage requirement for children up until age 26 is effective for plan years beginning on or after September 23, 2010. However, for plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under PPACA, and makes dependent coverage of children available, may exclude an adult child under age 26 from coverage if the adult child is eligible to enroll in an employer-sponsored health plan, other than a group health plan of a parent.

### **IRS Issues Guidance on Tax-Free Coverage for Children Under Age 27**

As a result of changes made by the recently enacted Affordable Care Act, health coverage provided for an

employee's children under 27 years of age is now generally tax-free to the employee, **effective March 30, 2010.**

The Internal Revenue Service announced on April 27, 2010 that these changes immediately allow employers with cafeteria plans – plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits – to permit employees to begin making pretax contributions to pay for this expanded benefit.

[IRS Notice 2010-38](#) explains these changes and provides further guidance to employers, employees, health insurers and other interested taxpayers.

### **Who is Eligible for the Tax Benefit?**

Employees who have children who will not have reached age 27 by the end of the year are eligible for the new tax benefit from March 30, 2010, forward, if the children are already covered under the employer's plan or are added to the employer's plan at any time. For this purpose, a child includes a son, daughter, stepchild, adopted child or eligible foster child. This new age 27 standard replaces the lower age limits that applied under prior tax law, as well as the requirement that a child generally qualify as a dependent for tax purposes.

### **Pretax Contributions Permitted Immediately, Plan Amendment Required Later**

The notice says that employers with cafeteria plans may permit employees to immediately make pretax salary reduction contributions to provide coverage for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. Plan sponsors then have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

In addition to changing the tax rules as described above, the Affordable Care Act also requires plans that provide dependent coverage of children to continue to make the coverage available for an adult child **until the child turns age 26.** The extended coverage must be provided no later than **plan years beginning on or after Sept. 23, 2010.** The favorable tax treatment described in the notice applies to that extended coverage.

## **Health Care Reform Changes to Health Accounts**

The health care reform law, which consists of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), makes some significant changes to accounts such as health flexible spending accounts (health FSAs) and health savings accounts (HSAs). These include:

### **Limits on Reimbursement of Over-the-Counter Medications**

Under the health care reform law, health FSAs and HRAs will not be able to reimburse the cost of over-the-counter medications that do not have a prescription (except for insulin). Also, distributions from Archer MSAs and HSAs used to pay for over-the-counter medications without a prescription (except for insulin) will be taxable and subject to penalties. However, amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses. The limits on over-the-counter medications for health FSAs and HRAs are effective for expenses incurred with respect to **taxable years beginning after December 31, 2010**. For HSAs and Archer MSAs, the limits are effective for amounts paid with respect to **taxable years beginning after December 31, 2010**.

#### **Limits on Health FSA Contributions**

Many employers choose to limit the amount that employees may contribute to a health FSA each year, but there is no federal limit on contributions. However, beginning in 2013, a health FSA offered through a cafeteria plan will have to limit the amount of salary reduction contributions that employees can make. Effective for **taxable years beginning after December 31, 2012**, employees may not elect to contribute more than **\$2,500 per year** to a health FSA. This amount will increase in future years to reflect cost-of-living increases.

#### **Increased Tax on Withdrawals from HSAs and Archer MSAs**

Participants in HSAs and Archer MSAs may withdraw funds from those accounts either to pay for qualified medical expenses or to use for other purposes. However, only withdrawals used to pay for qualified medical expenses are tax-free. If the funds are used for other purposes, the withdrawal becomes taxable and subject to penalties.

The health care reform law increases the additional tax on HSA distributions prior to age 65 that are not used for qualified medical expenses from 10 to **20 percent**. The additional tax for Archer MSA distributions not used for qualified medical expenses increases from 15 to **20 percent**. The increased taxes apply to distributions from these accounts made after **December 31, 2010**.

#### **Health Care Reform Implications on Wellness Programs**

Under the recently passed health care reform legislation, employers can offer increased incentives to employees for participating in a workplace wellness program or meeting certain health status targets starting in 2014. Grants will be made available for small businesses who implement comprehensive workplace wellness programs starting in 2011, and technical assistance will be made available to companies of any size.

#### **Wellness Incentive Increases**

Existing wellness regulations under HIPAA permit wellness incentives of up to 20 percent of the total premium, as long as the program meets certain conditions. Under the new legislation, the potential incentive increases to 30 percent of the premium in 2014 for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. Following a governmental study on wellness programs, the incentive may be increased to as much as 50 percent.

#### **Small Employer Grants**

Under the new legislation, there will be a five-year, \$200 billion program for implementing comprehensive workplace wellness initiatives starting in 2011. Grants will be available to eligible employers who provide their employees with access to a new workplace wellness program. Eligible employers include businesses that employ fewer than 100 employees who work 25 hours or more per week and did not have a workplace wellness program as of March 23, 2010. To be eligible for the grants, wellness programs must be made available to all employees and include:

- criteria related to health awareness including health education, preventive screenings and health risk assessments;
- efforts to maximize employee engagement;
- initiatives to change unhealthy behaviors and lifestyle choices; and
- a supportive environment at the workplace including workplace policies to promote healthy eating, increased physical activity and improved mental health.

#### **IRS Guidance on the Small Employer Health Care Tax Credit**

The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (the Reconciliation Act), provides a tax credit to certain small employers that provide health care coverage to their employees, effective with tax years beginning in 2010.

On May 17, 2010, the Internal Revenue Service (IRS) issued Notice 2010-44 (the Notice), which provides guidance on the credit applicable to tax years beginning before January 1, 2014.

#### **Eligible Small Employers**

The following requirements must be met in order for an employer to be eligible for the tax credit:

- The employer must have fewer than 25 full-time equivalent employees (FTEs) for the taxable year;
- The average annual wages of its employees for the year must be less than \$50,000 per FTE; and
- The employer must maintain a "qualifying arrangement."

A qualifying arrangement is one under which the employer pays premiums for each employee enrolled in the employer's health insurance coverage, in a uniform percentage that is at least 50 percent of the premium cost of the coverage. However, as discussed below, the Notice also provides transition relief with respect to the requirements for a qualifying arrangement.

The Notice sets out specific steps for determining whether an employer is eligible for the tax credit.

**Step 1: Determine the employees who are taken into account for purposes of the credit.**

**Step 2: Determine the number of hours of service performed by those employees.**

**Step 3: Calculate the number of the employer's FTEs.**

**Step 4: Determine the average annual wages paid per FTE.**

**Step 5: Determine the premiums paid by the employer that are taken into account for purposes of the credit.**

#### **Calculating the Credit**

The Notice also contains the following specific steps illustrating how to calculate the amount of the tax credit.

**Step 1: Calculate the maximum amount of the credit.**

**Step 2: Reduce the maximum credit according to the phase out rule.**

**Step 3: For employers receiving a state credit or subsidy for health insurance, determine the employer's actual premium payment.**

#### **Claiming the Credit**

For taxable employers, the credit is claimed on the employer's annual income tax return. For tax-exempt employers, the IRS will provide further information on how to claim the credit.

For taxable employers, the credit is a general business credit that offsets an employer's actual tax liability for the year. For a tax-exempt eligible small employer, the credit is a refundable credit, so that even if the employer has no taxable income, the employer may receive a refund, as long as it does not exceed the tax-exempt eligible small employer's total income tax withholding and Medicare tax liability for the year.

#### **Transition Relief for Taxable Years Beginning in 2010**

Generally, in order to be eligible for the tax credit, an employer must provide health coverage to employees through a "qualifying arrangement." However, employers that provide coverage that is not through a qualifying arrangement can still be eligible for the

credit for the 2010 tax year, if certain requirements are met.

An employer that meets the conditions for the transition relief is considered to satisfy the requirement that the employer pay a uniform percentage (of at least 50 percent) of the premium cost of the health insurance coverage for each employee (the uniformity requirement). Specifically, for 2010 tax years, an employer that pays an amount equal to at least 50 percent of the premium for single (employee-only) coverage for each employee enrolled in coverage is deemed to satisfy the uniformity requirement for a qualifying arrangement, even if the employer does not pay the same percentage of the premium for each such employee.

This means that an employer will be deemed to satisfy the uniformity requirement for a qualifying arrangement:

- if it pays at least 50 percent of the premium for single coverage for each employee receiving single coverage; and
- if the employer offers coverage that is more expensive than single coverage (such as family or self-plus-one coverage), if it pays an amount for each employee receiving that more expensive coverage that is at least 50 percent of the premium for single coverage for that employee (even if it is less than 50 percent of the premium for the more expensive coverage the employee is actually receiving).

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