

# BENEFITS ALERT

Rose & Kiernan, Inc.

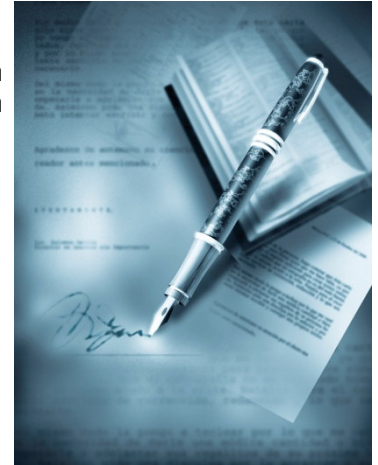
December, 2010



## Year End Summary 2010

As we approach year end, there are several issues associated with PPACA as well as some not associated with PPACA that should be reviewed. This Alert highlights areas in which we've received significant client inquiries. We felt this to be a better approach than just providing a list of the 2011 changes, as we so often have seen in other emails. The items we'll be reviewing are:

1. Grandfathered status changes
2. Annual plan limit waivers as they apply to Health Reimbursement Accounts
3. Non Discrimination Testing
4. CHIPRA Special Open Enrollment
5. New ERRP Application
6. W-2 reporting delay



**Grandfathered Status:** On November 15<sup>th</sup>, the three agencies responsible for PPACA; Treasury, Labor and Health and Human Services, announced amendments to the Interim Final Regulations (IFR) that had been issued earlier in 2010.

- A. The first amendment allow an employer to change insurers without losing grandfathered status as long as no other changes are made to the plans that trigger loss of status (change in copays, reduction in employer contributions, etc). However, the change of insurers must occur on or after November 17, 2010 in order to avoid losing grandfathered status. Any change made prior to November 17, 2010 will cause a plan to lose grandfathered status.
- B. The second amendment is more of a clarification than a change. Employers may change the funding of their medical plan from self funded to insured without losing grandfathered status. As with (A), the change must occur on or after November 17, 2010 and not involve any other changes that trigger loss of status. The issue of switching from insured to self funded is still open as to whether this will impact grandfathered status
- C. The final amendment requires health insurers to obtain documentation of the prior plan's terms from the new policyholder so the new carrier can determine whether the change in policies will result in a reduction of benefits or employer contribution which would trigger a loss of grandfather status. The responsibility falls on the insurer to obtain the documentation. The responsibility of the policy holder is to provide the documentation. For self funded plans the employer (or Trust if a multiple employer plan) needs to maintain the documentation. The documentation must include benefits, cost sharing information, employer contributions and annual limits.

Still to be decided are whether a change in prescription formularies or change in provider network will trigger a loss of status.

**Annual Plan Limits:** This issue was highlighted in an RK Alert we sent out on September 27, 2010 but considering the number of inquiries received, it bears review one more time. This requirement applies to Health Reimbursement Accounts (HRA) in which the employer deposits a specified amount of money for the employee to use in purchasing medical services covered under IRC Section 213(d). That constitutes an annual limit in a medical plan.

If the HRA is designed specifically to cover deductibles, copays, etc. that are in the medical plan, then our opinion is that these HRA's do not require a waiver since they are "integrated with a larger medical plan that does not contain annual limits". A reminder: applications for a waiver of annual limits need to be submitted 30 days prior to the effective date of the plan.

**FSA and HRA coverage includes children to age 26:** Although this topic has been beat to death, there is confusion in how the expanded definition of a dependent will apply to Flexible Spending Accounts and Health Reimbursement Accounts. Most are aware that health plans are required or will be required to cover children to age 26 as of the first renewal after September 23, 2010. Also, the Health Care Reconciliation Act extended the tax free status of employee contributions under a Section 125 plan to these children as well, avoiding a very messy imputed income calculation. We have received many calls asking if Section 125 Flexible Spending Account funds could be used for these same children. The answer is yes they can as well as Health Reimbursement Account funds. Make sure you've changed the eligibility definition in both plans to correspond to your health plan.

No corresponding change has been made in the definition of eligible dependent for purposes of health savings accounts (HSA) so in order to qualify for tax free reimbursement, the child must either qualify as a dependent, be younger than 19 or 24, if a full time student.

**Non-Discrimination Testing:** For the past 6 weeks, this has been the leading reason for inquiries on health reform. The PPACA prohibits all new and non-grandfathered plans from discriminating in favor of highly compensated employees in terms of benefits and eligibility. Self funded plans have always been subject to non-discrimination testing but this is new to insured plans that have always been governed by State Insurance regulation or statute. Part of the confusion comes from the fact that although the PPACA incorporates the "substantive non-discrimination requirements of Code section 105(h)", the impact on insured plans is not identical to the requirements on self funded plans. For example if a self funded group fails to comply with 105(h), the penalty is a taxable benefit for the highly compensated individual. If an insured group fails to comply, the plan is subject to civil action to compel it to comply plus the plan or plan sponsor is subject to an excise tax or civil money penalty of \$100 per day per individual discriminated against. Many are also looking for similarities with the non-discrimination testing required of their qualified pension plans but there are differences both in the testing used to determine compliance and the definition of highly compensated individuals. For an insured plan that is new or non-grandfathered, the plan must pass both an eligibility test and a benefits test. The eligibility test is to determine whether acceptable percentages of employees are participating in the plan. The benefits test is to determine whether all benefits (it is our opinion that employer contribution will be defined as a benefit) available to highly compensated are available to non-highly compensated. This essentially means that more generous employer contributions to highly compensated individuals will be determined as discriminatory when further guidance is released. It also means the end of insured executive reimbursement plans provided only to senior staff.

IRS issued Release 2010-63 to explain the statute but there are still a lot of unanswered questions. A separate RK Alert will be issued when further guidance is released.

**CHIPRA Special Open Enrollment:** The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created a new open enrollment opportunity and a new qualifying event for an employee to join an employer's health plan. Effective April 1, 2009, employees who are eligible for but not enrolled in your health plan must be permitted to enroll upon:

- Losing eligibility for coverage under a State Medicaid or CHIP plan or,
- Becoming eligible for State premium assistance under a State Medicaid or CHIP plan.

Employer notification was required by the later of the first day of the first plan year after February 4, 2010 or May 1, 2010, as we notified you in an earlier RK Alert. We also notified our clients that this created a new open enrollment opportunity which would trigger the HIPAA requirement that a notice go out to all employees. The HIPAA requirement meant a notice had to go out prior to the dates in the CHIPRA legislation so many of you, correctly provided the notice twice; once to comply with HIPAA and once to comply with CHIPRA.

The only change is that HHS has updated the model notice on their website indicating those states with premium waiver programs. New York and Vermont have only a Medicaid waiver, New Jersey and Massachusetts have both Medicaid and CHIP waivers, and Connecticut has neither a Medicaid nor a CHIP waiver program.

We recommend that this be part of your annual open enrollment notification and included in your new employee orientation kit.

**New ERRP Application:** For those of you who have yet to file your application for the Early Retiree Reinsurance Program (ERRP), you still have time. However, any application postmarked on or after November 9, 2010, must use the new updated (and easier) application. Many of our clients have been granted approval.

**W-2 Reporting delayed:** As reported last month the requirement for reporting the aggregate amount of health insurance on your employees 2011 W-2 has been delayed until, we assume, 2012. Therefore, for the most part, the W-2 you provide to your employees in January 2013 will be the first one to have the health insurance information included.

*This Summary is provided to you for general information purposes only and does not include references to other legal resources (e.g., supporting regulations, or formal or informal opinions) unless specifically noted. Please seek qualified and appropriate counsel for further information and/or advice regarding the application of the topics discussed herein to your employee benefits plan.*

*December 6, 2010*