Health Care Reform Advisory: FAQs: Health Care Reform and Employee Benefits

4/14/2010

Employers who participated in our April 7th webcast, "Health Care Reform: What's Happened and What's Next," asked many penetrating questions about the implications of health care reform on employee benefits. As promised, here are our answers.

To review The Patient Protection and Affordable Care Act of 2010, together with the Health Care and Education Tax Credits Reconciliation Act of 2010 (collectively referred to herein as the "Act"), please visit the Health Care Reform: Legislative Resources page on mintz.com.

1. **Please explain the new rule regarding "dependent" coverage. Does it end at age 26 or 27? Are married children and non-students eligible?**

   The new "child coverage" provision works as follows. All plans (including insured, self-funded, grandfathered and non-grandfathered plans) that provide dependent coverage must continue to make the dependent coverage available for a child (whether or not married) until the child turns 26. Coverage need not be made available to the child's child(ren). The child need not be a student.

   The provision is effective for plan years beginning on or after September 23, 2010.

   For plan years beginning before January 1, 2014, grandfathered plans that are group health plans need not offer this coverage to children who are covered under another employer's plan.

   The "age 27" rule applies to the taxation of the coverage. The Act amends Section 105(b) of the Internal Revenue Code to provide that medical reimbursements made to an employee are not taxable with respect to any child of the taxpayer who as of the end of the taxable year has not attained age 27. This provision is effective March 30, 2010.

   The Treasury Department and the IRS will need to revise the regulations under Code Section 106 to ensure that premium contributions by the employer to accident and health plans are not taxable to the employee.

2. **If over-the-counter (OTC) items are not allowed to be reimbursed under a Flexible Spending Account (FSA) in 2011 (unless there is a prescription), then what about employees who estimated their annual election for, say, 2/1/10-1/31/11 and included OTC items they plan on purchasing in January 2011? The obvious solution would be to instruct those employees to run out to CVS or Target, or wherever, in**

December 2010. But I am wondering if I am misunderstanding the 2011 date. Will this only impact plans with a renewal date or a plan year commencing date in 2011?

The Act states that the amendment shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010. Because individuals are taxed on a calendar year, it does seem that OTC expenses would need to be incurred prior to January 1, 2011 in order to be reimbursed under a FSA, even if the FSA does not operate on a calendar year.

It does seem that a more sensible (and fair) rule would be one that allows OTC drugs to be reimbursed with respect to any election in effect as the date of enactment, or for any plan year beginning before January 1, 2011. We would also like to know if the elimination of OTC drugs could be adequate justification for a change in election. Hopefully, future guidance will clarify these points.

3. **This question is about the real effective date of the $2500 cap for 2013. If the plan year runs 5/1/12-4/30/13, I would assume we have our client limit the max to $2500 at that renewal. I am not as concerned about this one as we have time to plan and prepare and I am sure the answer will be clarified by then.**

   Similar to the new OTC limitation, the Act states that this provision shall apply to taxable years beginning after December 31, 2012. Because the employee's taxable year is the calendar year, it seems that the rule would apply to any plan year that falls partially in 2013, even if the plan year began in 2012.

   A more sensible rule would be to apply the $2500 limitation starting in plan years beginning on or after December 31, 2012, and perhaps this is the intention.

   Another note of interest: the Act states that the limit is applied to employee salary reductions "if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement." This seems to be saying that no cap is applied so long as the FSA is funded solely through salary reduction. The committee reports indicate otherwise. Additional guidance would be welcome.

4. **Please tell us more about "grandfathered" plans. We heard from a broker that it could mean as long as your plan doesn`t change; once we make a change, it is no longer the same plan and would therefore be considered a new plan and we`d have to follow all of these new regulations. Can you please confirm the definition of "grandfathered," and if what I mention above is accurate, what type of change would be significant enough to have the plan considered new?**

   The sentiment behind grandfathering is that an individual cannot be required to terminate coverage under any plan in which he or she was enrolled on March 23, 2010. Any plan covering any such individual as of March 23, 2010 is referred to as a "grandfathered plan." While it seems that this provision was intended to placate individuals who feared

losing access to their doctors of choice, it is likely to be used by plans to avoid adopting new mandates and features.

Currently, there are far more questions than answers with respect to "grandfathered" plans. We do know that, under the Act, grandfathered plans and policies will be required to make the following coverage changes along with everyone else:

- Limit waiting periods to 90 days (effective for plan years beginning on or after January 1, 2014)
- No lifetime limits (effective for plan years beginning on or after September 23, 2010)
- No rescissions of coverage once enrolled (effective for plan years beginning on or after September 23, 2010)
- Extend coverage to adult children (effective for plan years beginning on or after September 23, 2010), although a grandfathered plan may exclude children who have coverage from another employer for plan years beginning before January 1, 2014.

In addition, the following coverage changes apply to grandfathered plans:

- No annual limits (effective for plan years beginning on or after January 1, 2014)
- No pre-existing condition exclusions (effective for plan years beginning on or after September 23, 2010 for those under 19, January 1, 2014 for everyone else).

Many questions, however, remain open. In particular, what will end the grandfathering? Could grandfathering status last indefinitely? We anticipate that future guidance will help us answer these questions.

5. **Can you clarify what "employer does not offer to pay at least 60% of benefits" means? Does that mean there must be a 60/40 premium cost-share or does it not have anything to do with the premium?**

   In order to be eligible for a premium or cost-sharing subsidy, an individual who has access to an employer plan must demonstrate, among other things, that the "plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs." While the Act is not entirely clear, we understand from our informal discussions with IRS and Treasury representatives that this calls for an actuarial calculation that starts with the anticipated costs for *all* benefits without regard to any co-pays, deductibles and coinsurance. This is the "100%" (i.e., the "total allowed costs of benefits") that is multiplied by 60% to establish the employer contribution amount. We will know more about the particulars once regulations are issued.

6. **Which of the new insurance law regulations will apply to self-funded ERISA plans? For example, will they be required to include dependents up to age 26? To comply with essential benefits packages? To comply with age rating bands?**

   As long as a self-funded ERISA plan is grandfathered, it will be exempt from many of the Act's provisions (see above).

   If a self-funded ERISA plan is not grandfathered, or loses its grandfathered status, the plan is subject to all of the Act's rules applicable to "group health plans." This includes all of the provisions applicable to "grandfathered" plans (see above), as well as:

   - Coverage of preventive health services
   - Annual reports to the government required
   - Cost-sharing limitations
   - Rules re: internal and external claims procedures
   - Plan may not limit choice of primary care provider
   - Coverage of certain emergency services
   - Access to pediatric care
   - Access to ob/gyn care
   - Coverage for individuals participating in clinical trials.

   However, the Act does have some areas which do not appear to apply to self funded ERISA plans, even if the plan does not benefit from grandfathering:

   - The plan need not offer the long menu of benefits set forth as the "essential health benefits package," including the related cost-sharing limits. This mandate is limited to insured plans (1) in the small and individual group markets and (2) that wish to be "qualified health plans" offered on an exchange.
   - The new non-discrimination rules will not apply (however, Code Section 105(h) will continue to apply).
   - New participant disclosure requirements are not required.
   - These plans are not subject to the "risk adjustment" payments—payable if the plan's experience is above average, receivable if the plan's experience is below average.
   - Cost reports to the government are not required.

7. **When the Act says that something is effective in 2014, would that mean 7/1/14 for an employer with a July 1 renewal or do they expect to see these changes on a calendar year going forward?**

   In the Act, effective dates are generally stated in terms of the first plan year beginning on or after a date. However this is not always the case (see above with respect to flexible spending accounts).

8. **Does the Act allow any exemptions for employers managing benefits under a collective bargaining agreement?**

   Very few of the Act's provisions specifically address collective bargaining and multiemployer plans. Two provisions, however, are worth noting:

   - **Potentially delayed effective date.** The Act's insurance provisions will not apply to health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, until the last of the collective bargaining agreements relating to the coverage terminates. It is not clear if this delayed effective date also applies to self-insured plans.
   - **Tax on high-cost health plans.** A multiemployer plan sponsor is required to calculate and report the value of coverage for purposes of the tax on high-cost health plans. It is unclear, however, whether the union or each participating employer is ultimately responsible for the payment of the tax.

9. **What is the definition of "preventive care" which must be provided as first dollar coverage? Is there a list of specific coverage items?**

   The Act mandates dollar-one coverage for these specific preventive services:

   - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
   - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved
   - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
   - With respect to women, certain additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

10. **An employer with 50 or more employees is subject to the "employer responsibility" mandate, and all employees in the employer's "controlled group" must be counted. Does this mean that my company must count employees of wholly-owned non-U.S. subsidiaries?**

    Possibly. The Act does not specifically address this issue, and federal regulations have taken a variety of approaches on the matter. For example, under COBRA, employees of non-U.S. controlled group members are counted towards the 20-employee threshold; alternatively, the regulations under Code Section 409A give plan sponsors the right to choose to include or exclude non-U.S. employees. So it remains to be seen which approach the regulators will choose.

11. **The maximum small business tax credit is 35% in 2010, but increases to 50% in 2014, when the state exchanges become effective. If an eligible small business purchases coverage on an existing state exchange prior to 2014, is the business eligible for the 50% credit?**

    No. Prior to 2014, the maximum small business tax credit is 35%, regardless of whether the employer purchases coverage in the open market or through a state exchange.

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For up-to-date information regarding health care reform, please visit our Health Care Reform: Analysis & Perspectives page.

Please click here to learn more about our health care reform practice.

For further information regarding this or any issue related to Health Care Reform, please contact one of the professionals listed below or the Mintz Levin attorney who ordinarily handles your legal affairs.

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