

To: Clients and Friends
From: Smith & Downey
Date: September 10, 2010
Re: Health Reform Tasks for Employers

Now that the summer has ended, many of our clients are intensifying their efforts to comply with the first set of changes to take effect under the health reform law, and to strategize about their possible responses to the changes that will take effect at later dates.

The first major set of changes is effective on the first day of the first health plan year beginning after September 22, 2010 (for example, on the first of next month for October 1 plans, on January 1, 2011 for calendar year plans, etc.), so it is very important for employers to confirm that they have compliant procedures and documents in place soon. (Compliance requires plan document amendments, SPD amendments, new and revised employee notices, and the like.)

The following is a list of some of the more pressing health reform tasks facing employers.

1. Apply for Retiree Subsidy. If the employer maintains a retiree health benefit that covers individuals ages 55 to 64 and determines that the "limited time" federal subsidy available to employers that provide these benefits is available and worth the effort, apply as soon as possible for the subsidy.
2. Identify Grandfathered Plans. Determine which health plans of the employer that were in existence on March 23, 2010 have not been modified since that date in one of the ways described in the regulators' grandfathering guidance that became effective June 14, 2010, and therefore are "grandfathered" health plans, which have a simpler, and more chronologically relaxed, compliance burden under the reform legislation. (We provided a summary of the grandfathering guidance in a prior e-Alert.)
3. Maintain Grandfathered Status. Create internal systems, and consult with all health plan vendors, concerning the on-going steps specified in the June 14, 2010 guidance that must be taken by the employer's grandfathered plans in order to maintain their grandfathered status.
4. Required Notice for Grandfathered Plans. Amend grandfathered plans' SPDs and other documents provided to participants, before the first day of the first plan year beginning after September 22, to contain the grandfathering statement contained in the June 14, 2010 regulatory guidance.
5. Identify Non-Grandfathered Plans. Determine which health plans of the employer either: (a) were not in existence on March 23, 2010; or (b) were in existence on March 23, 2010 but have been modified since that date in one of the ways causing a loss of grandfathered status described in the regulators' June 14, 2010 guidance. These are the employer's "non-grandfathered" health plans, which have a more complex, and more chronologically challenging, compliance burden under the reform legislation.

6. Identify "Grace Period" Plans. Determine which health plans of the employer were in existence on March 23, 2010 but were modified after that date and before June 14, 2010 in one of the ways causing a loss of grandfathered status that the employer would like to amend, on or before the first day of the first plan year beginning after September 22, to remove, going forward from that first day of that first plan year, the "offending" provision(s) that caused the loss of grandfathering.

(Such an amendment has the effect of "washing away" the plan's prior loss of grandfathering, resulting in it being treated as a grandfathered plan continuously since March 23, 2010.)

7. Required Grace Period Plan Amendments and Notices. If applicable and desired, before the first day of the first plan year beginning after September 22, adopt and communicate to participants the "cleansing" amendment(s) necessary to restore grandfathered status to a plan described above.

8. Required Non-Grandfathered Plan Amendments and Notices. If the employer maintains any non-grandfathered plans, before the first day of the first plan year beginning after September 22, adopt and communicate to participants the required "first year" amendments to comply with health reform. Specifically, non-grandfathered plans must be amended by that date to:

- a. Eliminate any lifetime coverage maximums on essential benefits.
- b. Eliminate any annual coverage maximums on essential benefits that do not qualify as "restricted annual limits" under the recent guidance. Specifically, eliminate annual maximums on essential benefits under \$750,000 for the first plan year beginning after September 22, 2010, \$1.25 M for the second, and \$2M for the third. (Plans must eliminate all annual maximums beginning with the first plan year beginning after September 22, 2013.)
- c. Eliminate any rescission provisions (except for fraud or misrepresentation).
- d. Eliminate pre-ex limitations for children under age 19.
- e. Provide for coverage for children until age 26. (See the item below about the required special election period.)
- f. Eliminate cost-sharing for preventive care.
- g. Apply new nondiscrimination rules to insured coverages (similar, but not identical, to Code Section 105(h) rules).
- h. Permit selection of any primary care provider.
- i. Permit children to select a pediatrician as a primary care provider.
- j. Eliminate pre-authorization for emergency care.

k. Eliminate pre-authorization or referral for ob-gyn care.

l. Provide required internal and external appeals mechanisms.

9. Required Grandfathered Plan Amendments and Notices. If the employer maintains any grandfathered plans, before the first day of the first plan year beginning after September 22, adopt and communicate to participants the required "first year" amendments to comply with health reform. Specifically, grandfathered plans must be amended by that date to:

a. Eliminate any lifetime coverage maximums on essential benefits.

b. Eliminate any annual coverage maximums on essential benefits that do not qualify as "restricted annual limits" under the recent guidance. Specifically, eliminate annual maximums on essential benefits under \$750,000 for the first plan year beginning after September 22, 2010, \$1.25 M for the second, and \$2M for the third. (Plans must eliminate all annual maximums beginning with the first plan year beginning after September 22, 2013.)

c. Eliminate any rescission provisions (except for fraud or misrepresentation).

d. Eliminate pre-ex limitations for children under age 19.

e. Provide for coverage for children until age 26, or just to children under age 26 who do not have other "employment-based" health coverage available to them. (See the item below about the required special election period.)

10. Continual Review of Proposed Grandfathered Plan Changes. If any grandfathered plans (including "cleansed" plans as described above) are maintained by the employer, design and initiate an on-going procedure to review, in advance of adoption, every proposed change to each grandfathered plan to determine if that change is a change on the regulators' list of changes (that is, the June 14, 2010 list plus any additions to that list made by the regulators after June 14, 2010) that will cause a plan to lose grandfathered status. If the proposed change would cause the plan to lose its grandfathered status, weigh the benefits of the proposed change against the projected economic costs of a loss of grandfathered status.

11. Simple Section 125 Plans. If the employer has fewer than 100 full time equivalent employees ("FTEs"), before the first day of the first plan year beginning after September 22, consider whether to adopt a "Simple Section 125 Plan" that is exempt from Section 125 non-discrimination testing if it meets specified minimum eligibility and employer contribution requirements.

12. Employer Tax Credit. If the employer is a Qualified Small Employer (generally, an employer with fewer than 26 FTEs with those FTEs having average wages of \$50,000 or less), before the first day of the first plan year beginning after September 22, consult with the employer's tax preparer to ensure that Qualified Small Employer Health Plan credit is taken by the employer.

13. Track Health Plan Value Information for W-2s. Form W-2s for 2011 will need to reflect, in an "informational" reporting box, the value (generally, the COBRA cost, less the 2% administrative charge) of each employee's health coverage enjoyed during that year. Therefore, employers should initiate a system, beginning January 1, 2011, to track in their payroll systems the value of that coverage.

14. Amend HFSAs, HRAs and HSAs to Eliminate OTC Coverage. If the employer maintains a health flexible spending account, a health reimbursement arrangement or a health savings account that reimburses for over-the-counter drugs, effective for expenses incurred after 2010, the employer must amend the program to eliminate that feature (except for OTC drugs provided under a valid prescription).

[Note: Required Special Election Period Concerning Age 26 Rule. The law requires that employees be given a special 30-day enrollment opportunity during which they can add dependents who are under age 26 and who were previously dropped from the plan or denied coverage, and this new special enrollment period cannot start until after a specified notice is given.

Therefore, as part of their annual enrollment for the first plan year beginning after September 22, 2010, employers must distribute this new special enrollment notice. In addition, before preparing the notice and amending their plan documents and Summary Plan Descriptions, employers need to determine what dependent definition will be used going forward. For example, employers need to determine whether their plans' existing definition of dependent will be used going forward, amended to reflect the various aspects of the age 26 rule, or whether a new definition (again reflecting the various aspects of the age 26 rule) will replace the prior definition. (For grandfathered plans employers also need to determine whether the definition will include the permissible exclusion for older dependents with other employer-sponsored coverage available.)

Employers also must determine whether their selected dependent definition will apply just to their health plan or to others of their welfare benefits. Of course, insured plans are limited by what their insurers will sell, so any decisions on the definition of dependent must be coordinated with the insurers. Similarly, self funded plans will need to acquire from their stop loss carriers a sign-off of their new dependent definition.

Finally, for those plans that might have "early adopted" the age 26 rule in 2010, employers should confirm that they understand the specifics of the dependent definition used in 2010, determine whether they want (or are required) to change that definition going forward, and determine whether the required special enrollment notice still needs to be provided as part of open enrollment materials for the first plan year beginning after September 22, 2010.]

Please contact us if we can provide assistance with your health reform compliance efforts.