HealthPlans
A HARVARD PILGRIM COMPANY

Compliance Bulletin
June 2, 2010

Federal Health Care Reform
Implementation of Regulations
Issue Number 1

This is the first in a series of Compliance *Bulletins* and *Alerts* that **Health Plans** will issue over the next several years as the provisions of federal health care reform are implemented.

The series is designed to help you learn about health care reform, about the actions that are required and about the steps that **Health Plans** will take to help you keep your plan in compliance.

To keep these *Bulletins* and *Alerts* easy to read and understand, we may refer you to the *Compliance Guide* that accompanied this *Bulletin* for a more in-depth discussion of certain topics.

This issue addresses

- Extension of coverage for adult children
- Tax treatment of coverage and reimbursements for children under age 27
- Early retiree reinsurance program *(applicable only to groups offering medical coverage to retirees ages 55-64)*

Extension of Coverage for Adult Children

Quick summary

On May 10, 2010, the Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health & Human Services (HHS) issued interim final regulations governing the requirements for plans to extend coverage for children until age 26. For plan years beginning before January 1, 2014, "grandfathered plans" must extend coverage unless the adult child is eligible to enroll in another employer-sponsored health plan (i.e., through their own employer). Beginning with plan years that start on or after January 1, 2014, all adult children under age 26 must be permitted to enroll, regardless of the availability of other coverage. *Please see the* Compliance Guide *for a detailed discussion of the grandfathering provisions*.

Although this provision does not apply to "stand-alone" dental and vision plans, we expect employers to adopt the extension for such plans, thereby maintaining consistent eligibility criteria across plans. A plan is considered stand-alone if: 1. participants have the right to elect NOT to receive coverage; and 2. if a participant elects coverage, he/she must pay an additional premium or contribution.

Dependents covered

- Plans are not required to provide dependent coverage. The extension of coverage applies only if the plan already offers dependent child coverage.
- Grandchildren are not required to be covered.
- Except for the restriction allowed until January 1, 2014 (noted above), no limitations except the requirement for the child to be under age 26 will apply. This means a child does ***not*** need to:
  - ◊ Live with the parent
  - ◊ Be a dependent on the parent's tax return
  - ◊ Be a student
  - ◊ Be unmarried (although the child's spouse and children do not qualify for coverage)
- If an adult child is eligible for coverage under the employer sponsored plans of both parents, the child must be permitted to enroll in either plan.

Enrollment requirements

- Eligible children who lost coverage, were denied coverage, or were not eligible for coverage due to the inability to meet the dependent child status requirements under a plan, must be given the opportunity to enroll and be provided a 30-day enrollment period with coverage effective by the first day of the first plan year beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year.
- Plans must provide written notice to employees explaining the new eligibility rules and special enrollment period.
- If a parent is not enrolled in the plan but is otherwise eligible and a child qualifies for the new enrollment opportunity, the plan must allow the parent to enroll in addition to the child.
- The child must be allowed to enroll in any benefit package option for which he or she is otherwise eligible; thereby allowing the parent to switch benefit package options.
- A child who qualifies for the new enrollment opportunity and is currently covered under COBRA must be allowed to enroll as a dependent of an active employee.
- Children enrolling under this provision must be treated as HIPAA special enrollees and be offered the same benefit package options for the same cost as those currently covered under the plan.

Implementation

Important: As encouraged by the Secretary of HHS and as permitted by the IRS, **Health Plans**, along with numerous health insurers and group health plans, will automatically amend all of our clients' plans to continue providing coverage to currently covered dependents under age 26. The amendments will permit adult children who would otherwise lose and then regain eligibility for coverage under the new law to remain on the plan without interruption (e.g., graduating students under age 26 will not lose their coverage).

Employer's actions

Uninterrupted coverage for adult children

- Distribute notices regarding continued dependent eligibility to all employees currently participating in your plan *(See below: **Health Plans** will draft these notices for you)*

Effective for first plan year that begins on or after September 23, 2010

- Distribute notices regarding special open enrollment period for newly eligible dependents to all employees eligible to participate in your plan *(See below: **Health Plans** will draft these notices for you)*
- Hold required 30-day open enrollment period for newly eligible individuals

Health Plans' actions

Uninterrupted coverage for adult children

- Draft notice templates announcing continued dependent eligibility for distribution by clients
- Draft plan amendments to permit currently enrolled adult children under age 26 to remain on plan unless the child has coverage available through their own employer (Note: if **Health Plans** administers a stand-alone dental and/or vision plan, we will also amend these plans assuming that you will maintain consistent eligibility criteria across plans)
- Eliminate any existing dependent verification procedures (e.g., verifying status as full-time student or federal tax dependent) since notices and plan amendments will specify the restriction that the child cannot have coverage available through their own employer and that the employee is responsible to notify the plan if the child's status changes

Effective for first plan year that begins on or after September 23, 2010

- Draft notice templates announcing special open enrollment period for newly eligible dependents for distribution to clients
- Draft plan amendments to permit newly eligible dependents under age 26 to enroll in the plan unless they have coverage available through their own employers (Note: we will also amend stand-alone dental and vision plans as noted above)
- Continue to administer plans without dependent verifications as noted above

Tax Treatment of Coverage for Children Under Age 27

Quick summary

Recently issued IRS guidance announced that the value of coverage for adult children under age 27 will no longer be imputed as taxable income to the employee. (In the past, employees could have been taxed on the value of the coverage for children who did not qualify as federal tax dependents.) In addition, employees may now request reimbursement of eligible medical expenses for children under age 27 from their FSA and HRA plans, even if the children are not federal tax dependents. These changes require amendments to an employer's cafeteria, FSA and/or HRA plan.

Note: This change does not affect the tax treatment of coverage for other individuals who are not children, such as same-sex spouses, domestic partners, civil union partners, or dependents who are age 27 or older, unless these individuals otherwise qualify as federal tax dependents under the Internal Revenue Code. The value of coverage for these individuals who are not federal tax dependents must still be treated as income imputed to the employee.

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IRS guidance

Effective March 30, 2010, the Internal Revenue Code was amended to extend the general exclusion from gross income for employer-provided medical care to any employee's child who has not "attained age 27 as of the end of the employee's taxable year." A "child" is broadly defined to include a son, daughter, stepson, stepdaughter, legally adopted child, or foster child placed with the parent by judgment or decree.

On April 27, 2010, the IRS issued Notice 2010-38 which provides additional guidance. The key provisions of the rule follow:

- Coverage provided under an employer's group health plan as well as reimbursements for medical care provided to an employee's child who is under age 27 as of the end of the taxable year are excluded from the employee's gross income.
- Coverage for a child under age 27 may be paid on a pre-tax basis under a Section 125 cafeteria plan, and participants may make pre-tax contributions to health flexible spending account (FSA) arrangements that can be used to reimburse medical expenses incurred by a child under age 27.
- Coverage and reimbursements for adult children are not considered wages for FICA or FUTA purposes.
- Expenses incurred by a child under age 27 may be reimbursed from a health reimbursement arrangement (HRA) or health savings account (HSA).
- The IRS "change in status" rules will be amended retroactive to March 30, 2010 to provide that becoming eligible or remaining eligible for coverage beyond the date the child would have otherwise lost coverage will permit participants to change their pre-tax elections coverage and contribution elections.
- Cafeteria plans may be amended retroactively to the first date in 2010 that employees are permitted to make pre-tax contributions to cover adult children (but not earlier than March 30, 2010), provided that the amendment is adopted no later than December 31, 2010.

Implementation

Employer's actions

- Determine when to amend cafeteria plan to permit tax-free coverage for children under age 27; amendments may be retroactive to March 30, 2010 if they are adopted by December 31, 2010
- Determine whether to amend FSA and/or HRA plans to permit reimbursements for children under age 27; amendments may be retroactive to March 30, 2010 if they are adopted by December 31, 2010 *(Note: employers are not required to amend plans to reimburse expenses for adult children under age 27, but may choose to do so)*
- Arrange to amend cafeteria plan and FSA/HRA plans not administered by **Health Plans**
- Stop imputing income based on adult child coverage
- Work with payroll vendor regarding tax treatment of employee contributions already collected
- Hold open enrollment period to permit new FSA elections if FSA plan amended

Health Plans' Actions

- Upon notice from employer**,** draft amendments for FSA/HRA plans administered by **Health Plans**

Early Retiree Reinsurance Program

NOTE: This provision of health care reform affects only plans that provide medical coverage to retirees ages 55-64.

Quick summary

On May 5, 2010, HHS issued interim final regulations establishing the early retiree reinsurance program **effective June 1, 2010**. The program is intended to provide financial assistance to help employers provide coverage to early retirees by reimbursing employers 80% of costs between $15,000 and $90,000 that are paid for each retiree. The program is temporary and will run until January 1, 2014 when early retirees will be able to obtain health coverage through the Health Insurance Exchanges *(Please see the Compliance Guide for information on the Exchanges.)*

To be eligible, employers must apply to participate and must implement programs and procedures to generate cost savings with respect to participants with chronic and high-cost conditions. Any reimbursements received must be used to lower plan costs. Applications will be available by the end of June and the process will be similar to that used by the Medicare Part D Retiree Drug Subsidy program.

Program eligibility

In order to participate in the Program, an employer must:

- Sponsor a plan that provides health benefits to "early retirees"- defined as an individual who is at least age 55, not eligible for Medicare, and is not an active employee of the employer;
- Implement programs and procedures to generate cost savings with respect to participants with chronic and high-cost conditions - defined as a condition for which $15,000 or more in health benefit claims is likely to be incurred;
- Provide documentation of the actual cost of medical claims involved;
- Submit an application to HHS containing required information including:
  - ◊ Identification of the programs and procedures in place or to be implemented to generate cost savings for chronic and high cost conditions;
  - ◊ Explanation of how the plan expects to use reimbursements under the program to reduce plan costs;
  - ◊ Projection of reimbursement amounts for the first two plan-year cycles;
  - ◊ Attestation that the plan has fraud, waste and abuse policies and procedures in place; and
- Be certified by the Secretary of HHS.

Eligible claims

- Claims submitted for reimbursement must be based upon the actual costs paid by the plan within the plan year for health benefits provided to the early retiree, spouse, surviving spouse or dependent.
- The actual costs paid must take into account negotiated price concessions (e.g. discounts, direct or indirect subsidies, rebates, and direct or indirect remuneration) received by the plan. In addition, the costs paid by the early retiree, spouse, surviving spouse or dependent in the form of deductibles, co-payments, or coinsurance must be included in the amounts paid.

Eligible claims (cont'd)

- For approved claims, the plan will be reimbursed up to 80% of the claims costs between $15,000 and $90,000. Claims incurred between the start of the plan year and June 1, 2010 (the effective date of the Program) are credited towards the $15,000 threshold. However, only claims incurred after June 1st are eligible for reimbursement. (Example: If an individual incurs costs of $25,000 between the start of the plan year and June 1, and incurs $50,000 after June 1, only the $50,000 is reimbursable, which are the costs incurred above the $15,000 threshold after June 1.)

Claim reimbursements

- Reimbursement paid to the plan must be used to lower costs for the plan such as reducing employer premium costs, or reducing participant premium contributions, co-payments, co-insurance, deductibles, or other out-of-pocket costs.
- Reimbursements cannot be used as general revenues by the employer.
- Reimbursements cannot be used to reduce the employer's level of support for the plan.
- HHS will develop a mechanism to monitor the appropriate use of reimbursements.

Other administrative processes

- HHS will establish an appeals process to permit plans to appeal a determination with respect to a claims reimbursement.
- HHS will conduct annual audits of claims data submitted by plans to ensure that plans are in compliance.
- Based on the availability of funding, HHS has the authority to stop taking applications for participation in the Program and to stop accepting claim submissions. Applications and claim submissions are on a first come-first served basis. Although the program is slated to continue until January 1, 2014, the $5 billion appropriated could run out before then.

Implementation

If you are an employer who provides health benefits to early retirees under your plan(s), you will need to determine whether you meet the above requirements and apply to participate in the early retiree program. Please contact your **Health Plans** Account Manager for information on how we can assist you with implementation.