National Health Care Reform Legislation - Review of Initial Guidance

We previously reported on the recently enacted health care reform legislation, under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (for purposes of this Alert, these Acts will be referred to collectively as "PPACA"), which, among other things, significantly altered employer responsibilities with respect to providing group health plan coverage to employees. A copy of our earlier Alert can be found at http://www.pbwt.com/resources/publications/navigating-health-care-reform/.

This Alert describes recent guidance that has been issued with respect to PPACA's provisions regarding extended coverage for adult children, an available small employer subsidy and a temporary reinsurance reimbursement program for early retirees.

At the time of the writing of this Alert interim final regulations were issued with respect to PPACA's rules regarding "grandfathered" plans, and some of the other changes made by PPACA. We anticipate issuing a follow-up Alert on those regulations, as well as one or more follow-up Alerts highlighting important PPACA provisions that become effective after 2011, including PPACA's provisions imposing penalties imposed on large employers who do not offer health coverage to full-time employees and the "Cadillac" tax.

I. Extended Coverage of Adult Children.

As we discussed in our prior Alert, the new PPACA rules regarding coverage of employees' adult children require group health plans to continue to make coverage available to adult children until the children attain age 26.[1] While group health plans are not required to offer extended coverage prior to plan years beginning on or after September 23, 2010, the Department of Labor has encouraged insurance companies to offer this extended coverage before the general effective date. Even if an insurer announces that it will allow policies to extend coverage to adult children prior to PPACA's effective date, however, employers are not legally required to offer the extension earlier than otherwise required under PPACA.

New guidance has recently been issued regarding PPACA's extended coverage provisions, although some questions still remain unanswered.

Plans Subject to Extended Coverage Requirement

The recent guidance indicates that plans that do not offer *any* dependent coverage are not required to open enrollment to adult children or other dependents. A plan will also not be required to cover the children of a covered adult child (i.e., the grandchildren of the group health plan participant) or the spouse of a covered adult child.

As discussed in our prior Alert, PPACA generally requires "grandfathered" plans to offer coverage to adult children. However, for plan years starting prior to January 1, 2014, grandfathered group health plans are only required to extend

[1] It should be noted that some states, like New York, had previously mandated extended coverage for adult children, and to the extent that a state requires a longer period of extended coverage than PPACA, employers must continue to comply with the applicable state law.

coverage to an otherwise eligible adult child if such child is not eligible to enroll in an eligible employer-sponsored health plan other than the grandfathered plan.

Coverage Provided to Adult Children

Young adults eligible for continued coverage must be offered the same plan benefits that are offered to similarly situated participants who did not lose coverage due to termination of dependent status. The new guidance clarifies that the eligible adult child, *and* the employee through whom the adult child would be eligible, must be offered all of the benefit packages offered to those participants who did not lose coverage due to termination of dependent status. Therefore, for example, if the adult child lost dependent status under the plan due to termination of his status as a student, and in light of that loss of coverage, the parent employee subsequently terminated participation in the plan, *both* adult child and parent must be offered the opportunity to re-enroll in the plan.

Additionally, the new regulations clarify that the adult child need not have been previously enrolled in the plan to be eligible to enroll under the new rules. Consequently, if an employee first becomes eligible for participation in a medical plan when her child is under 26 but older than the plan's age limit for dependents, provided the child is still under the age of 26 when the new rule becomes effective with respect to the plan, the adult child must be permitted to enroll.

Notably, the covered young adult cannot be required to pay more for his or her coverage than similarly situated individuals. However, it does appear that an employer may charge more for each additional person added to the plan, provided that the amount of increase does not vary depending on the child's age.

Finally, the guidance also clarifies the extent of a grandfathered plan's obligation when an employee's young adult child is also eligible to enroll in the employer-sponsored group health plan of the child's other parent. Because PPACA provided (as discussed above) that a grandfathered plan need not extend coverage to a young adult if the young adult is eligible to enroll in another eligible employer-sponsored group health plan, there was confusion regarding whether the child's eligibility to enroll in both parents' employer plans would mean that the employer plans would cancel each other out, leaving no plan required to extend coverage to the adult child. The guidance provides that a grandfathered plan must cover otherwise eligible young adult children of an employee even if the employer is aware that the young adult has coverage available through the non-employee parent; but the grandfathered plan need not offer the coverage if the young adult child is eligible for coverage in a plan of his or her own employer or any other employer (such as through a plan sponsored by employer of the adult child's spouse).

Enrollment of Adult Children

Employers must provide the adult children covered by this rule an enrollment period that continues for at least 30 days after the extension option first becomes available (generally required no later than the first day of the first plan year after September 23, 2010) and must also provide a written notice of this special enrollment period. The written notice may be provided to the parent employee on behalf of the eligible adult child. Notice of the enrollment period may be included in the plan's regular enrollment materials provided that it is "prominently" noted in the materials.

Tax Implications for Extended Dependent Coverage

Under PPACA, an employer's provision of health coverage for an adult child will be excluded from an employee's income for all tax years ending prior to the year the covered child turns age 27. This change is effective as of March 30, 2010, and the IRS recently announced that cafeteria plans would immediately be permitted to allow employees to make pre-tax contributions to pay for this benefit, even if the plan has not yet been amended. Cafeteria plan administrators will have until the end of 2010 to amend their plan language accordingly.

The IRS also clarified that the cafeteria plan regulations will be amended retroactively to include change in status events (which are required in order for a participant to change their elections under the plan mid-year) involving non-dependent children under age 27. These change in status events would include becoming newly eligible for coverage or eligible for a longer period than previously anticipated. Plan administrators will be permitted to rely on an employee's representation of the child's date of birth.

Recent guidance clarifies that the tax exclusion continues though the year the child attains age 26, even though the requirement is only through age 25, because the PPACA does not require a group health plan to terminate a child's health coverage when he or she attains age 26. Plan sponsors may choose to allow coverage through the end of the year in which the child attains age 26 because it is administratively easier than terminating coverage immediately upon a child's reaching his or her 26th birthday. By extending the tax exclusion until the end of the year the child attains age 26 (and beyond PPACA's required coverage period), where a group health plan chooses to continue the child's coverage until the end of the year in which the child attains age 26, the extended benefits will not be treated as taxable.

Open Issues

There are still some open issues with respect to these new requirements, including:

1. It is unclear whether the requirement applies to an employee's otherwise eligible adult step child, although it appears that an argument could be made that it should not.
2. It is also debatable whether an otherwise eligible young adult who was eligible for COBRA from his or her previous employer would be eligible for continuation coverage in a grandfathered plan prior to plan years starting on or after January 1, 2014 under the PPACA. Note, however, that under the PPACA an otherwise eligible adult child receiving COBRA under the parent's plan will be eligible to reenroll in that plan and, once reaching age 26 (or such later age at which participation under the plan will terminate) will be newly eligible for COBRA (and the term of that COBRA will not be reduced to reflect the previous COBRA received).

Plan Actions Required/Recommended

1. Most medical plans and cafeteria plans will require amendment to comply with these new requirements.
2. Plan administrators will need to confirm that their plan terms do not define dependent for purposes of eligibility of children under age 26 in terms of financial dependency on the parent employee, residence with the parent employee or on the child's status as a student.
3. Plans may also wish to revisit their pricing methodologies. Although a plan may not charge employees different premiums based on the age of the participants' dependents, the plan may charge employees different premiums based on the number of dependents covered with respect to a participant.

II. Small Employer Subsidy

As discussed in our prior Alert, PPACA introduces a new tax credit for certain small employers (for purposes of this Alert, the "small employer subsidy"), which is available for both taxable employers and tax-exempt employers. For 2010 through 2013, the small employer subsidy covers up to 35 percent (25 percent for eligible tax-exempt organizations) of an employer's premiums for health insurance coverage, and beginning in 2014, the maximum credit available will increase to 50 percent (35 percent for eligible tax-exempt organizations) of an employer's premiums paid for qualified health plan coverage. If an eligible small employer has more than 10 full-time equivalent employees and/or average annual wages in excess of $25,000, the credit will be proportionately reduced.

On May 17, 2010, the Internal Revenue Service issued guidance on the small employer subsidy in Notice 2010-44 (the "Notice"), addressing several issues that had previously been unclear and delineating the individual steps involved in

determining whether an employer is eligible for the small employer subsidy and how to calculate the amount of the subsidy. (The Notice is available at http://www.irs.gov/pub/irs-drop/n-10-44.pdf.) We discuss in this Alert the salient developments with respect to the small employer subsidy provided for in the Notice.

As discussed in our prior Alert, in order to qualify for the small employer subsidy, an employer must:

(i) have fewer than 25 "full-time equivalent employees"[2] for the applicable tax year;

(ii) pay average annual wages to its employees that are less than $50,000 per full-time equivalent employee per year;[3] and

(iii) pay a uniform percentage of at least 50 percent of the premium cost of single coverage in employer-sponsored health insurance coverage (beginning in 2014, health plan coverage must be in a qualified health plan offered through a state or federal government established "exchange"). However, as discussed below, transition relief has been provided for taxable years beginning in 2010 with respect to the requirement to pay a uniform percentage.

With respect to determining the number of "full-time equivalent employees," and as more fully discussed in our prior Alert, a determination of the total number of hours for which the employer pays wages to employees during the taxable year is required. Prior to the issuance of the Notice, it was unclear how to count hours for these purposes. The Notice clarifies that an employee's hours of service for a year include each hour that an employee is paid or is entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or is entitled to payment for a period of time in which no duties are performed due to holiday, vacation, illness, incapacity (including disability), layoff, jury duty, military leave or leave of absence (except that no more than 160 hours of service are required to be counted for an employee on account of any single continuous period during which an employee performs no duties). The Notice provides that in calculating the total number of hours of service that must be taken into account for an employee for the year, the employer may use any of the following methods: (a) determine actual hours of service from records of hours worked and hours for which payment it made or due (i.e., for vacation, holiday, illness, incapacity, etc.), (b) use a days-worked equivalency whereby the employee is credited with 8 hours of service for each day for which the employee would be required to be credited with at least one hour of service for the performance of duties or for periods in which no duties are performed, or (c) use a weeks-worked equivalency whereby the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service for the performance of duties or for periods in which no duties are performed.

With respect to the requirement that the employer pay a uniform percentage of at least 50 percent of the premium cost of single coverage in employer-sponsored health insurance coverage, the Notice clarifies the following:

- For years prior to 2014, "health insurance coverage" for purposes of the credit means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy, certificate or plan contract, or health maintenance organization contract offered by a health insurer. It *includes* limited scope dental or vision, long-term care, nursing home care, community-based care (or any combination thereof), coverage only for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, and Medicare supplemental health insurance and similar supplemental coverage provided under a group health plan. It excludes coverage only for accident, or disability income insurance (or any combination thereof), coverage issued as a supplement to liability insurance, liability insurance, including general

[2] For purposes of the credit, in general the number of "full-time equivalent employees" is calculated by dividing the total number of hours for which the employer pays wages to employees during the taxable year (up to a maximum of 2,080 hours for any employee) by 2,080 (rounded down if not a whole number), with special rules applying with respect to certain employees. It is possible that in some cases, an employer with 25 or more employees may qualify for the credit if some of its employees work part-time.

[3] In our prior Alert, consistent with the statutory language of the PPACA we indicated that eligible small employers included those with "no more than" 25 full-time equivalent employees and average annual wages that "do not exceed" $50,000. However, the Notice provides that in operation an employer with exactly 25 full-time equivalent employees or with average annual wages exactly equal to $50,000 will not be eligible for the credit.

liability insurance and automobile liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, and other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

- Different types of health insurance plans are not aggregated for purposes of meeting the 50% payment requirement described at (iii) above. Thus, if an employer offers a major medical insurance plan and a stand-alone dental plan, the employer must separately satisfy requirement (iii) with respect to each type of coverage. For example, if an eligible small employer offers a major medical plan and a dental plan, and pays 50% of the premium cost for single coverage for all employees enrolled in the medical plan, but only 40% of the premium cost for single coverage for all employees enrolled in the dental plan, for purposes of calculating the credit, the employer can take into account only the premiums it pays for the medical plan, and it cannot take into account the premiums it pays for the dental plan. Thus, in that example, a subsidy may be available for the medical coverage, even though it won't be available for the dental coverage.
- As we discussed in our prior Alert, the amount of an employer's premium payments that are taken into account for purposes of the credit may not exceed the average premium cost for the small group market in the state in which the employer offers coverage. The Notice clarifies that the average premium for the small group does not apply separately to each type of coverage (e.g., medical, dental, etc.), but rather provides an overall cap for all health insurance coverage provided by an eligible small employer.
- Only the employer portion of premiums for health insurance coverage provided to employees is taken into account for purposes of the credit, and amounts paid by employees (including any premiums paid on a pre-tax basis under an employer's cafeteria plan) are not taken into account for purposes of meeting the 50% payment requirement.
- The Notice also clarifies that if an employer is receiving a state tax credit for providing health insurance to their employees or is participating in certain premium subsidy programs, the premium payment made by the employer for purposes of the small employer tax credit is not reduced by the state credit or subsidy for purposes of determining whether the employer has satisfied requirement (iii) above. Additionally, the maximum amount of the small employer tax credit is generally not reduced by a state tax credit or by reason of payments by a state directly to the eligible small employer (but the amount of the small employer tax credit cannot exceed the amount of the employer's net premium payments).
- As expected, the Notice includes transition relief for tax years beginning in 2010 to make it easier for eligible employers to meet the requirements to qualify for the small employer subsidy. Specifically, the Notice provides that for tax years beginning in 2010, an employer will be deemed to satisfy the uniformity requirement for health insurance coverage if (a) the employer pays at least 50 percent of the premiums for single coverage for each employee receiving single coverage, and (b) if the employer offers coverage that is more expensive than single coverage (e.g., family or employee plus one coverage), 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 that the employee is actually receiving).

Although the Notice provides needed guidance on the small employer subsidy, unanswered questions still remain, including the following:

- How tax-exempt eligible small employers will claim the credit (as we noted in our prior Alert, taxable employers can claim the tax credit on their annual income tax return). The Notice indicates that the IRS will provide further information in this regard.
- Whether employers that exclude certain classes of employees (e.g., part-time employees) from eligibility for coverage under the employer-provided health plan can claim the small employer subsidy. Similarly, it is unclear

whether an employee that is otherwise eligible for an employer's group health plan but voluntarily chooses not to enroll (perhaps because s/he is enrolled in a spouse's or parent's coverage) would be counted in determining the number of an employer's full-time equivalent employees.

- It appears that the small employer subsidy may only be available to employers that sponsor fully-insured group health plans, and employers that maintain self-insured health plans are not eligible. While most small employers that provide health insurance coverage do so under fully-insured arrangements, this question is particularly relevant for church benefit programs that might otherwise be eligible for the small employer subsidy but are part of a self-insured health plan arrangement.

III. Temporary Reinsurance Reimbursement Program for Early Retirees

As discussed in our prior Alert, PPACA includes a temporary reimbursement program to reimburse employment-based plans for a portion of the cost involved in providing certain coverage to early retirees and their spouses, surviving spouses and dependents (the "Program"). For purposes of the Program, an individual is considered to be an "early retiree" if he or she is at least 55 years old, not yet eligible for Medicare and no longer an active employee of an employer maintaining or contributing to the plan or that has made substantial contributions to the plan.

Subject to availability of funds, the Program will reimburse approved plan sponsors for 80% of certain early retiree medical expenses amounting to between $15,000 and $90,000 (adjusted for inflation). PPACA appropriated $5 billion to the Program, which is due to expire on January 1, 2014. However, the Employee Benefit Research Institute has projected that, assuming all employers eligible to apply for the Program do so, the Program will run out of money within two years.

Recently, the Department of Health and Human Services ("HHS") issued guidance on the Program in the form of interim final regulations ("IFR"), Frequently Asked Questions ("FAQs"), Application Submission "Dos and Don'ts" and a Program application. HHS has recently attempted to quell concern about the IFR's "first-come first-served" review process for applications by indicating that HHS will not stop accepting applications unless it appears the Program funding will be insufficient to pay claims under new applications in light of reimbursements being paid out. While focus had initially been concentrated on submitting Program applications as soon as possible, because payment will only be made when claims are submitted, it now appears that timely submission of claim reimbursement requests is what is most critical.

Further IFR Program Details

The IFR provide further details on the operation of the Program. In particular, the IFR clarify the following issues:

1. **Entity Receiving the Reimbursement.** Under PPACA it was unclear whether the plan itself or the plan sponsor would receive the Program reimbursement. The IFR makes clear that the sponsor will receive the reimbursement.

2. **Eligible Plan Sponsor.** The IFR clarify that, among others, a VEBA or a sponsor of a self-insured plan may be an eligible Program plan sponsor. In addition, to be eligible, PPACA provides that an employment-based plan must have programs in place designed to generate cost-savings with respect to participants with "chronic and high-cost conditions." The IFR clarify that a condition is considered to be "chronic and high cost" if $15,000 or more in health benefit claims are likely to be incurred during a plan year by any one participant. The preamble to the IFR indicates that an example of a program designed to generate cost-savings is a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization. HHS also indicated in the preamble that it does not appear to be a problem if a plan provides more generous cost-sharing to a participant with a chronic and high cost condition than to other participants. A plan is not required to have a program in place to generate cost savings for all chronic and high cost conditions, however.

3. **Claims.** The IFR clarify several issues related to the calculation of claims submitted. First, for purposes of the $15,000 threshold and the $90,000 ceiling limit, an early retiree's claims will be aggregated. Second, with respect

to insured plans, the calculation of the claim eligible for reimbursement is based on what the insurer and participant pay for health benefits, not the premiums paid. Third, as described in PPACA, when calculating the amount of the claim, price concessions and discounts must be subtracted from the claim amount. The IFR provide that a plan sponsor must notify HHS if a price concession or discount is applied *after* the claim is submitted. Finally, the IFR further provide that a sponsor may only submit for reimbursement after the plan has paid for a claim.

4. **Claims Incurred Prior to June 1, 2010.** For plans with plan years beginning before June 1, 2010, the IFR provide that up to $15,000 in claims incurred during the plan year before June 1, 2010 will be counted toward the $15,000 - $90,000 claims thresholds. However, reimbursements will only be available for actual claims incurred and paid after June 1, 2010.

5. **Use of Reimbursements.** PPACA provides that a plan sponsor cannot use Program reimbursements as general revenue. Therefore, the IFR require a plan sponsor to maintain the level of its support for the plan. Recent FAQs issued by HHS interpret the IFR to prohibit a plan sponsor from reducing the dollar amount of its support, even if its support level (e.g., percentage of premiums paid) remains the same.

   Reimbursements, however, may be used to reduce employee premiums, copayments, deductibles, coinsurance, etc., as well as reducing or offsetting premium increases that the employer may otherwise be obligated to pay. The FAQs indicate that if a plan sponsor chooses to use some or all of the proceeds it receives under the Program to reduce plan participants' premiums, copayments, deductibles, co-insurance or other out-of-pocket costs, it must do so for all plan participants; not just for early retirees. The FAQs further clarify that reimbursements may not be used to pay for expenses that are created by participation in the Program and generally may not be used to pay increased administrative costs related to the administration of the plan.

6. **Vendor Agreements May Be Required.** The IFR recognizes that the information required to be released to HHS is protected health information, subject to HIPAA's privacy rules. Consistent with HIPAA, the IFR require a plan sponsor to have an agreement in place authorizing the plan or health insurer to disclose the requested information to HHS.s

7. **Recordkeeping Obligations.** Because the IFR provide that the Secretary of HHS may reopen and revise a reimbursement determination, the IFR provide that plan sponsors must maintain Program records for 6 years after the expiration of the plan year in which the costs were incurred (or longer, if required by law). In addition, the sponsor must require its health insurer or plan to maintain any Program required records. Recordkeeping is also important because PPACA directs the Secretary of HHS to conduct annual audits of claims data submitted by participating plans.

Submitting the Program Application

As described in our prior Alert, a plan sponsor must apply to, and be certified by, HHS before it can begin to request reimbursement from the Program. Although a sponsor with more than one plan will need to file one application per plan, annual application approval is not required. HHS recently issued the application for Program participation, which can be found at http://www.hhs.gov/ociio/Documents/official-errp-program-application_.pdf. In addition, HHS issued a list of "Application Submission Dos and Don'ts" regarding the application submission process, which can be found at http://www.hhs.gov/ociio/Documents/errp_dos_donts.pdf.

The application requires a plan sponsor to include a projection of the amount of Program reimbursements it expects to receive in each of two plan year cycles. In addition, among other things, sponsors must submit the following information in its application to HHS: a description of the programs and procedures in place to generate (or potentially generate) cost savings with respect to participants with chronic and high cost conditions; and a summary of how the organization will use the Program reimbursements and how it will maintain its current level of contribution to the plan.

The IFR provide that incomplete applications will be denied, and the new application will be processed based on when the new submission is received.

After Approval of the Application

When submitting claims for Program reimbursement, plan sponsors must submit claims records specifying, among other things: a list of early retirees for whom claims are being submitted; the health benefit provided; the provider or supplier, the date incurred, and the date and amount of payment, less any known negotiated price concession. HHS has indicated that it is still developing the infrastructure needed to accept claims data and reimbursement requests. The IFR require a plan sponsor to update HHS regarding data inaccuracies so that the reimbursement determination can be revised, based on updated information. Examples of data inaccuracies include post-point-of-sale concessions or claims that are reversed following submission of the application. Guidance regarding how to report data inaccuracies is still outstanding.

It should be noted that approval of an application does not guarantee that all claims will be reimbursed. Specifically, while PPACA authorizes HHS to stop accepting applications based on the availability of funds, the IFR clarify that a reimbursement request may also be denied due to Program fund limitations. Also, while applications to the Program will be reviewed on a "first-come, first-served basis," the director of the Office of Consumer Information and Insurance Oversight (the agency responsible for overseeing the Program) had said Program funds will not be distributed based on when a sponsor submits its application for approval. Rather, Program funds will paid out, gradually, as sponsors submit retiree claims.

Finally, the FAQs indicate that if HHS approves an application for the Early Retiree Program, a sponsor subsequently deciding not to request reimbursement or to stop receiving reimbursement, need not notify HHS. Its decision, however, will not relieve of any obligations under the Program, such as maintaining and furnishing records or reporting data inaccuracies.

Considerations in Determining Whether to Apply for Program Reimbursements

We recommend that a plan sponsor keep the following questions in mind when determining whether to apply for the Program:

1. How much does it expect to receive from the Program? Will the potential amount received offset the cost of participating in the Program (and keeping in mind that the Program reimbursement may not be used for the administrative costs of Program participation)? Depending on the amount involved, the administrative burdens may not be worth the amount received from the Program.
2. Does the plan sponsor have the administrative resources to complete the application? In the preamble to the IFR, HHS estimated that it will take 35 hours to complete one application package and 45 hours to assemble the necessary documentation of claims. Additional time will be required, moreover, for other related administrative obligations, such as obtaining required vendor agreements.
3. Does the plan have a program in place to manage the cost of chronic and high cost conditions? As described above, this is a condition of receiving Program reimbursement. ◆

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