

HEALTH REFORM IMPACT

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Departments Issue Additional Guidance Under Healthcare Reform

November 3, 2010

Recently, the Departments of Labor, Treasury and Health and Human Services (collectively, the “Departments”) jointly issued a series of frequently asked questions (“FAQs”) which provide useful guidance on healthcare reform. Additionally, the Internal Revenue Service recently issued Notice 2010-69 which suspends the W-2 reporting requirement regarding the costs of employer-provided healthcare until 2012. These developments are welcome news for employers struggling to implement the numerous new requirements mandated by healthcare reform. The following is a brief overview of the key guidance that directly relates to employer-sponsored health plans.

Enforcement: The FAQs provide that the Departments will work with employers, issuers and other stakeholders to help ensure compliance with healthcare reform. The Departments emphasized that their approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and comply with the new law. This approach will include transition relief, grace periods, safe harbors and other policies intended to simplify transition and minimize disruptions for existing plans.

Grandfathered Plans: The FAQs provide that the Departments expect to issue additional guidance to address the circumstances under which grandfathered group health plans may change carriers without losing grandfathered status. This guidance may be encouraging for employers as it would help level the playing field for employers who are attempting to maintain the grandfathered status of their plans and are currently limited to negotiating with their current insurers.

In addition, the FAQs clarify two important factors regarding an employer’s ability to maintain the grandfathered status of its health plan. First, the FAQs state that the following six requirements are the only changes that would cause a plan to lose its grandfathered status under a continuing policy.¹ Any other changes implemented by the employer will not affect this status.

1. The elimination of all or substantially all benefits to diagnose or treat a particular condition.
2. An increase in a percentage cost-sharing requirement (e.g., an increase of a plan’s coinsurance percentage).

¹ As discussed above, the Departments are also considering issuing guidance which would permit an employer to switch insurers and maintain grandfathered status.

3. An increase in a plan's deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15%.
4. An increase in a copayment requirement in an amount that exceeds medical inflation plus 15% (or, if greater, \$5 plus medical inflation).
5. A decrease in an employer's contribution rate towards the cost of coverage by more than 5%.
6. The imposition of annual limits on the dollar value of all benefits below specified amounts.

Second, the FAQs make it clear that the grandfathered analysis applies on a benefit-by-benefit basis. As a result, if one benefit package loses its grandfathered status, this will not affect the other packages. For example, if an employer offers three benefit packages, an HMO, a PPO and a POS arrangement, and the HMO loses grandfathered status, this will not affect the POS or PPO arrangements. These clarifications are useful for employers who are still in the process of determining whether to maintain their plan's grandfathered status.

The FAQs also clarify how the grandfather rules apply to situations where an employer modifies the tiers of coverage offered under the plan. For example, if on March 23, 2010 the employer offered self-only coverage and family coverage with an employer contribution rate of 50% for family coverage and the employer modifies its tiers of coverage to self-only, self-plus-one, self-plus-two, etc., then the employer contribution rate for the new tiers would be compared to the rate for family coverage prior to the modification. In this example, the rates for self-plus-one, self-plus-two, etc, must be within 5% of the cost of the prior family coverage rate (45%). However, the FAQs clarify that if the employer had previously only offered self-only coverage to its employees and now desires to add family coverage, then the rate of the employer contribution for family coverage may be set without regard to the self-only coverage tier without losing grandfather status. In addition, the FAQs caution employers that (i) a change in any cost sharing provision for a benefit (as opposed to a benefit by benefit analysis) which exceeds the permitted level under the interim regulations will cause a plan to lose its grandfathered status regardless of whether the plan's other cost sharing provisions remain the same and (ii) the penalties under a wellness program (such as premium surcharges) could implicate a plan's grandfathered status.

Claims, Internal Appeals and External Reviews: The FAQs provide a useful overview of the safe harbor established under Technical Release 2010-01 (please [click here](#) for an overview of the safe harbor requirements) regarding the claims procedures for non-grandfathered plans. In addition, the FAQs clarify that plans that fail to strictly comply with the safe harbor will be reviewed on a case-by-case basis under a facts and circumstances analysis. This clarification is welcome relief as it provides that a plan which fails to satisfy all the safe harbor requirements may in some circumstances nevertheless be considered to be in compliance with the law. In addition, the FAQs clarify that a plan may contract with an "independent review organization" directly or through its third party administrator and still meet the requirements of the safe harbor. The FAQs, however, caution that plan fiduciaries will still have a duty to monitor the selection and performance of the "independent review organization."

Expanded Coverage of Dependent Children: The FAQs clarify that the requirement to extend health coverage to children up to the age of 26 without limitation applies only to children described in Section 152(f)(1) of the Internal Revenue Code. This includes sons, daughters, stepsons, stepdaughters, adopted children and eligible foster children. As a result, if a plan elects to offer coverage to other adult children (such as nieces, nephews or grandchildren), then the plan may

impose additional eligibility requirements for such individuals (such as residency, full-time student status or financial dependency).

Rescissions: The FAQs clarify that if a plan only covers active employees and an employee terminates employment and pays no premium for coverage after his or her termination of employment, the Departments will not consider the retroactive elimination of coverage back to the employee's termination date to be a rescission. Similarly, if a plan does not cover ex-spouses and the plan is not notified of an employee's divorce and the employee or the ex-spouse does not pay the applicable full COBRA premium for coverage, then the Departments will not consider the termination of the ex-spouse's coverage retroactive to the date of the divorce a rescission of coverage. These examples are particularly useful for employers who only reconcile their health plan rolls on a monthly basis. However, given the expansive interpretation taken by the Departments in the interim regulations regarding rescissions, employers should continue to use caution when attempting to rescind the coverage of an employee or their dependents.

W-2 Reporting Relief: The Internal Revenue Service recently issued Notice 2010-69 which suspends the W-2 reporting requirement regarding the costs of employer-provided healthcare until 2012. This relief will provide employers with additional time to make any necessary changes to their payroll systems or procedures in preparation for compliance with the new reporting requirement.

The recently issued guidance indicates that the Departments are aware of the difficulties that employers face with compliance with healthcare reform, and that the Departments have indicated their intent to work with employers to ensure compliance.

If you have questions regarding the information in this alert, or with respect to other provisions of the health reform legislation as it relates to your employee benefits plans, please contact any of the attorneys in our Employee Benefits Practice Group listed below.

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