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Benefits Bulletin

In this Issue

Regulations Issued on Grandfathered Plans

The health care reform law passed earlier this year brings many changes to employers and health plans. The extent of the impact will depend, in part, on whether you maintained a health care plan on March 23, 2010, the date the primary legislation was enacted. If your company sponsored a plan on that date, it is considered a "grandfathered" plan. Grandfathered plans are exempt from certain health care reform requirements, such as no cost-sharing for preventive care and other patient protections.

On June 14, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury issued regulations regarding grandfathered plans. Importantly, these regulations clarify what types of changes can be made to existing plans that will allow them to retain their "grandfathered" status.

Summary

The regulations essentially state that plans will lose their grandfathered status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers. Losing grandfathered status means that a plan would have to comply with additional health care reform requirements, such as first-dollar coverage of recommended prevention services and patient protections such as guaranteed access to OB-GYNs and pediatricians.

Permitted Changes

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Prohibited Changes

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. Specifically, making the following changes would cause a plan to lose its grandfathered status:

- *Significantly Cutting or Reducing Benefits.* For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- *Raising Co-Insurance Charges.* Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- *Significantly Raising Co-Payment Charges.* Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on

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March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from $30 to $50 over the next two years, it will lose its grandfathered status.

- *Significantly Raising Deductibles.* Many plans require patients to pay the first bills they receive each year (for example, the first $500, $1,000 or $1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-5 percent so this formula would allow deductibles to go up, for example, by 19-20 percent between 2010 and 2011, or by 23-25 percent between 2010 and 2012. For a family with a $1,000 annual deductible, this would mean if they had a hike of $190 or $200 from 2010 to 2011, their plan could then increase the deductible again by another $50 the following year.
- *Significantly Reducing Employer Contributions.* Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- *Adding or Tightening an Annual Limit on What the Insurer Pays.* Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- *Cannot Change Insurance Companies.* If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

Pre-existing Condition Exclusions for Children Eliminated

Plans may not apply pre-existing condition exclusions to children under the age of 19, effective for plan years **beginning on or after September 23, 2010**. This rule applies to both grandfathered and new plans. Note that for plan years beginning on or after January 1, 2014, all pre-existing condition exclusions will be prohibited.

Nondiscrimination Rules Apply to Fully-Insured Plans

Effective for **plan years beginning on or after September 23, 2010**, new fully insured plans must satisfy the requirements of Internal Revenue Code section 105(h)(2). That section provides that a plan may not discriminate in favor of highly compensated individuals as to eligibility to participate and that the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.

Additional Requirements for Grandfathered Plans

The regulations also contain additional requirements to keep health plans from using the grandfather rule to avoid providing important consumer protections.

To promote transparency, the regulations require a plan to disclose to consumers, every time it distributes materials, whether the plan believes that it is a grandfathered plan and therefore is not subject to some of the additional consumer protections of the health care reform law. This allows consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed.

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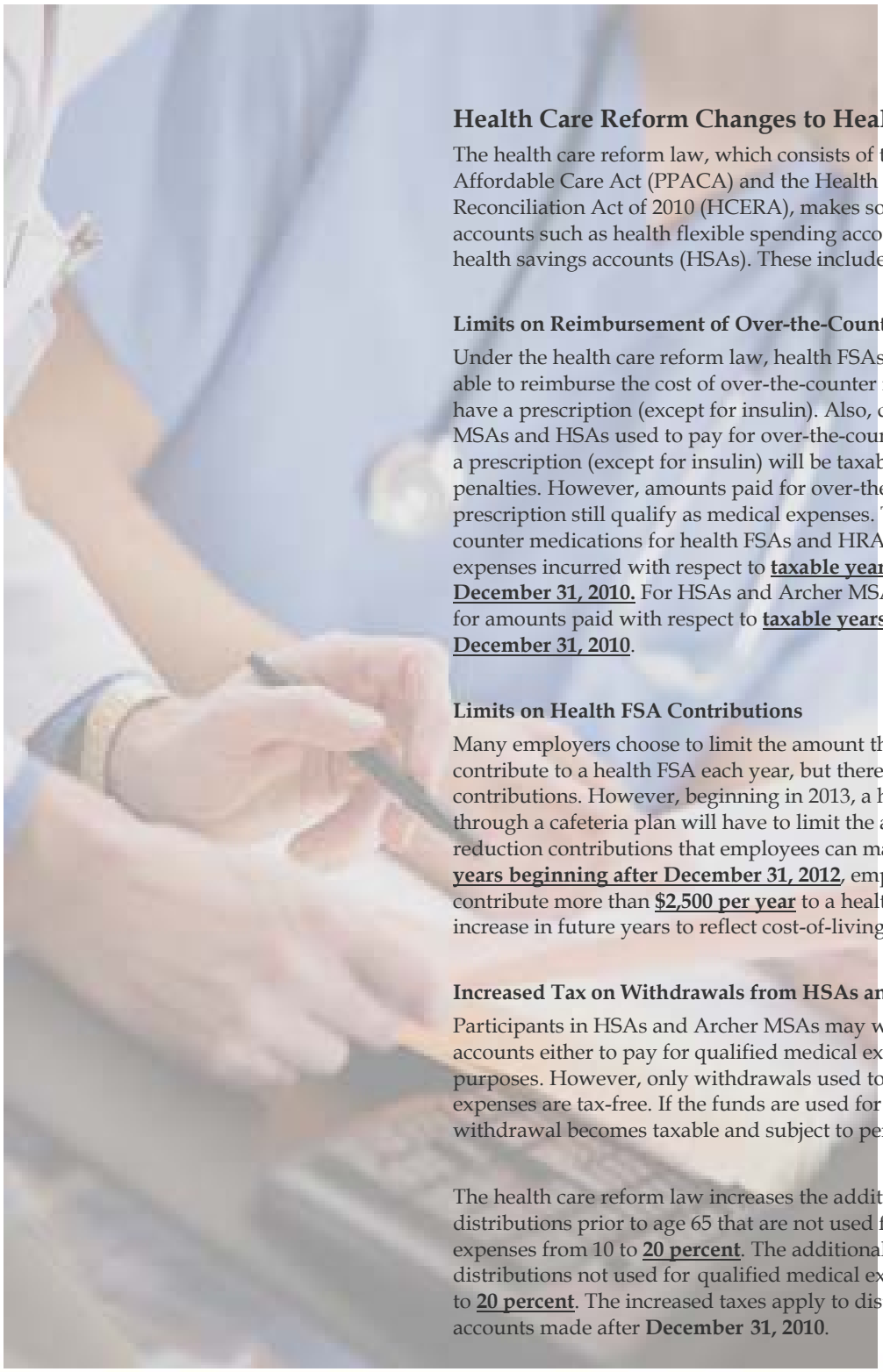
The regulations also provide that a plan's grandfathered status may be revoked if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections. Grandfathered status may also be revoked if a plan is bought by or merges with another plan simply to avoid complying with the law.



Health Care Reform Changes to Health Accounts

The health care reform law, which consists of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), makes some significant changes to accounts such as health flexible spending accounts (health FSAs) and health savings accounts (HSAs). These include:

Limits on Reimbursement of Over-the-Counter Medications

Under the health care reform law, health FSAs and HRAs will not be able to reimburse the cost of over-the-counter medications that do not have a prescription (except for insulin). Also, distributions from Archer MSAs and HSAs used to pay for over-the-counter medications without a prescription (except for insulin) will be taxable and subject to penalties. However, amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses. The limits on over-the-counter medications for health FSAs and HRAs are effective for expenses incurred with respect to **taxable years beginning after December 31, 2010.** For HSAs and Archer MSAs, the limits are effective for amounts paid with respect to **taxable years beginning after December 31, 2010**.

Limits on Health FSA Contributions

Many employers choose to limit the amount that employees may contribute to a health FSA each year, but there is no federal limit on contributions. However, beginning in 2013, a health FSA offered through a cafeteria plan will have to limit the amount of salary reduction contributions that employees can make. Effective for **taxable years beginning after December 31, 2012**, employees may not elect to contribute more than **$2,500 per year** to a health FSA. This amount will increase in future years to reflect cost-of-living increases.

Increased Tax on Withdrawals from HSAs and Archer MSAs

Participants in HSAs and Archer MSAs may withdraw funds from those accounts either to pay for qualified medical expenses or to use for other purposes. However, only withdrawals used to pay for qualified medical expenses are tax-free. If the funds are used for other purposes, the withdrawal becomes taxable and subject to penalties.

The health care reform law increases the additional tax on HSA distributions prior to age 65 that are not used for qualified medical expenses from 10 to **20 percent**. The additional tax for Archer MSA distributions not used for qualified medical expenses increases from 15 to **20 percent**. The increased taxes apply to distributions from these accounts made after **December 31, 2010**.

Health Care Reform Implications on Wellness Programs

Under the recently passed health care reform legislation, employers can offer increased incentives to employees for participating in a workplace wellness program or meeting certain health status targets starting in 2014. Grants will be made available for small businesses who implement comprehensive workplace wellness programs starting in 2011, and technical assistance will be made available to companies of any size.

Wellness Incentive Increases

Existing wellness regulations under HIPAA permit wellness incentives of up to 20 percent of the total premium, as long as the program meets certain conditions. Under the new legislation, the potential incentive increases to 30 percent of the premium in 2014 for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. Following a governmental study on wellness programs, the incentive may be increased to as much as 50 percent.

Small Employer Grants

Under the new legislation, there will be a five-year, $200 billion program for implementing comprehensive workplace wellness initiatives starting in 2011. Grants will be available to eligible employers who provide their employees with access to a new workplace wellness program. Eligible employers include businesses that employ fewer than 100 employees who work 25 hours or more per week and did not have a workplace wellness program as of March 23, 2010. To be eligible for the grants, wellness programs must be made available to all employees and include:

- criteria related to health awareness including health education, preventive screenings and health risk assessments;
- efforts to maximize employee engagement;
- initiatives to change unhealthy behaviors and lifestyle choices; and
- a supportive environment at the workplace including workplace policies to promote healthy eating, increased physical activity and improved mental health.

Calendar of Events

NJ School Boards Association Annual Workshop & Exhibition
October 19-20, 2010
www.njsba.org

NJ State League of Municipalities (NJLM)
November 15-18, 2010
www.njslom.com

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