

NOTE: Below are excerpts from a feature in our weekly "E-Benefits Newsletter" addressing the practical aspects of health care reform, with a special focus on how employers will be affected in 2011.

Agencies Issue Guidance on Grandfathered Plans

The U.S. Departments of Health and Human Services, Labor and Treasury yesterday issued interim final regulations on "grandfathered" health plans, including rules on what changes will cause a plan to lose "grandfathered" status and become subject to the full panoply of health reform requirements. The regulations generally provide that to preserve grandfathered status a plan must not: (1) significantly cut or reduce benefits; (2) raise co-insurance charges; (3) significantly raise co-payments or deductibles; (4) significantly lower employer contributions; (5) add or reduce annual dollar limits; or (6) change insurers. Changes for these purposes are generally measured against the plan as it existed on March 23, 2010. Plans must also notify participants of their grandfathered status in benefit-related materials. In addition, grandfathered plans must maintain sufficient records (e.g., prior plan documents) to demonstrate compliance with grandfathering requirements, and make those records available for examination.

The regulations include various anti-abuse provisions (e.g., revoking grandfathered status in the event of certain transfers of employees from one plan to another without an employment-based reason). The regulations also include guidance on the application of grandfathering rules for collectively-bargained plans as well retiree-only and "excepted benefit" plans.

Does it Matter if Our Health Plan is "Grandfathered"?

Many employers are already planning revisions to their medical plans for 2011. However, under health reform, if "grandfathered plans" (generally plans with at least one participant on March 23, 2010) make changes in their benefit structure, they may lose "grandfathered" status. Thus, employers are asking:

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What are the advantages of grandfathered status?

Grandfathered plans do NOT have to comply with the following otherwise applicable requirements:

Effective January 1, 2011:

- coverage of certain preventive care services without cost-sharing (some of which may be currently billed on a bundled basis with other services),
- coverage of adult children eligible for other employer-sponsored coverage,
- transparency reporting and quality of care reporting,

- non-discrimination regarding highly compensated employees in insured plans,
- certain appeals processes, and
- requirements relating to access to primary care physicians, emergency services, pediatric care, and ob/gyn services.

Effective January 1, 2014:

- nondiscrimination based on health status,
- no discrimination against providers,
- restricted annual out-of-pocket limits,
- dependents covered without regard to whether they have coverage available through their own employment, and
- coverage of clinical trials.

What changes will cause a plan to lose grandfathered status?

There is as yet no guidance on what will cause a plan to lose grandfathered status. We do know, however, that the following will not cause a plan to lose its grandfathered status:

- renewal of coverage or enrollment of family members by an individual who was enrolled in the plan on March 23, 2010 (if the plan provided dependant coverage on that date) or
- enrollment by new employees (and their families).

What are the consequences of losing grandfathered status?

Again, there is as yet no guidance. If a plan loses its grandfathered status, it will have to comply with the requirements described above, presumably beginning when grandfathered status is lost.

What if our health plan is subject to collective bargaining?

Health benefits that are the subject of a collective bargaining process

- have an effective date delay and
- generally will need to worry about being grandfathered only if grandfathered status can be preserved for a longer period than the collective bargaining delayed effective date.

In some cases, collective-bargaining agreements may require that changes for non-bargained employees be applied to bargained employees as well. Employers with both bargained and non-bargained employees will need to be especially attentive to health reform's varying effective dates, the terms and termination dates of their various collective bargaining agreements and the effect of grandfathered status.

Practical Considerations: Controlling Costs

As employers are considering plan changes for 2011 in light of healthcare reform, some of the items they may want to consider to control costs, after giving careful consideration to any possible legal implications (including "grandfathered" status), include: (1) "per child" pricing for family coverage, if their enrollment systems can accommodate it; (2) excluding maternity coverage for dependent children, if not already excluded; (3) excluding high risk activities, upon careful consideration of the overall impact; (4) imposing visit limits; and (5) imposing caps on biotech drugs.

Required Changes to Health FSAs and HRAs

Under current law, health flexible spending accounts (Health FSAs) and health reimbursement arrangements (HRAs) can provide reimbursement for over-the-counter medicine and drugs. However, under the new federal healthcare reform law, Health FSAs and HRAs must be amended to prohibit the reimbursement of non-prescription medicine or drugs (except insulin) effective as of January 1, 2011. Administrators of health and welfare plans should consider communicating this change to employees well in advance to avoid confusion and allow employees to adjust their elections accordingly. Expenses for non-prescription medicine or drugs incurred in 2010 may still be reimbursed in 2011 under the terms of the plan. Health savings accounts and Archer medical savings accounts are also prohibited from reimbursing non-prescription medicine and drugs (except insulin) effective as of January 1, 2011 (regardless of whether expense is incurred in 2010 or 2011), which is another reason why participants will need advance notification of this change.

Changes to Form W-2 Reporting: Coming Sooner than You Might Think

Beginning with any Form W-2 issued for a time period during 2011, employers must include the total cost of the individual's health insurance coverage for the period that an employee or former employee worked in 2011. This cost does not include contributions to health savings accounts or to health care flexible spending accounts, but does include the total cost of medical, dental, vision, and employee assistance program coverage. Employers may also need to provide this information for people who do not work in 2011, but who are covered in 2011 due to COBRA continuation coverage. Because employees who terminate employment in 2011 can request early receipt of their 2011 W-2 forms, employers may want to begin preparation for these changes to payroll and Form W-2 functions sooner rather than later.

Early Retiree Reinsurance Program Draft Application Now Available

As noted in last week's E-Benefits Newsletter, employers hoping to participate in the Early Retiree Reinsurance Program (ERRP) should be preparing the information required so they are prepared to

submit the application as soon as it is issued. A draft of the application and instructions has been released by the Department of Health and Human Services

Submitting Early Retiree Reinsurance Program Application? Remember to be Early and Accurate

For employers hoping to participate in the Early Retiree Reinsurance Program (ERRP), which offers funding to offset health care claim costs for early retirees and their families, it will be crucial that they complete the application correctly, with all required information, and submit it as soon as possible. Applications will be processed in the order they are received, and applications that do not meet all requirements will be denied and lose their place in line. Interim final rules have already been issued, and applications for ERRP are expected to be available by the end of June.