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This is not a calendar or checklist of routine items, nor are the articles intended as a complete list of all items which may affect your plan. Rather, they are intended to inform you of a few items unique to 2010 and should not be construed as legal advice. For more information, contact your regular Carmody & Torrance attorney, or any of the attorneys listed at the end of these articles.

Employee Benefits Update

July 29, 2010

2010 has been a very active year for employee benefit plan legislation and health care reform. Carmody and Torrance continually monitors developments affecting employee benefit plans and advises on the numerous changes that have recently taken place. Below are a few articles about some benefit plan issues that you may need to address in 2010.

Health Care Reform Update - Grandfathered Plans

At the Carmody & Torrance health care reform seminar on May 27, we introduced the concept of grandfathered plans, and indicated that guidance was coming from the government on what plans are grandfathered plans. As a reminder, to be a grandfathered plan, the health plan must have been in effect on March 23, 2010. In addition, a number of the consumer reforms apply to a health plan, regardless of whether it is grandfathered. The new rules defining under what conditions a plan is grandfathered are detailed and complex. Below are a few highlights:

The new rules are applied separately to various benefit options within a plan. Thus it is possible that part of a plan will be grandfathered and another option under the plan is not.

If a plan takes the position it is a grandfathered plan, records must be maintained accessible to participants and regulators regarding the terms of the plan and its features as they existed on March 23, 2010. The regulations contain a model notice which can be used to meet the requirements in the regulation that Participants be notified of the grandfathered status of the plan.

If an employer enters into a new policy or contract of insurance, then that policy or contract (for that benefit option) is not a grandfathered health plan. Also of note is that for plans with terms governed by a collective bargaining agreement that was ratified before March 23, 2010, there was a delayed effective date for health care reform, based on the expiration of the last agreement related to the plan. These regulations now state that a collectively bargained plan is subject to the health reform requirements that otherwise apply to grandfathered plans. However, an insured collectively bargained plan is allowed to change insurers and make other changes (which would otherwise cause the plan to lose grandfather status) before the end of the term of the bargaining agreement without losing grandfathered status.

Changes which will cause a plan to lose grandfathered status include:

- Elimination of a benefit to diagnose or treat a particular condition;
 - Example in the regulation-a plan provides benefits for a particular mental health condition which is a combination of counseling and prescription drugs. The plan eliminates benefits for counseling. Result, the plan loses grandfathered status.
- Any increase in the level of coinsurance;
- An increase in a cost sharing requirement such as a deductible or out of pocket limit beyond certain limits in the regulation based on the overall medical care component of the CPI, plus 15 percentage points;
- An increase in a co-pay if the increase exceeds the greater of \$5 (increased by medical inflation) or a total increase that exceeds medical inflation plus 15%;
- A decrease in a contribution rate towards the cost of any tier of coverage by more than 5%.
 - Example: On March 23, 2010, a self insured plan has two coverage tiers, self only at 80% employer cost and family with 60% employer cost. The plan is later amended to lower the employer contribution for family coverage to 50%. This causes the plan to lose its grandfathered status.

Items not addressed but for which the government has asked for input are whether changes such as switching from a health reimbursement arrangement to major medical coverage should be a permissible change. Also on the list of changes that the government is requesting input on are whether changes to a provider network and changes to a drug formulary should be permissible changes not causing a loss of grandfather status.

Finally, the regulations indicate that certain health care reform provisions will not apply to retiree only plans, as defined in the regulation.

Carmody & Torrance can advise you on the pros and cons of retaining grandfathered plan status.

Other Health Care Reform Updates

The government has released guidance on other health care reform requirements, specifically on:

- The rule against pre existing conditions, effective for plan years beginning on or after 9/23/2010 with respect to individuals under age 19;
 - This applies to grandfathered plans and non-grandfathered plans.
 - Effective January 1, 2014 the rule against pre existing condition exclusions applies to all ages.
- The rule on no lifetime or annual limits on essential health benefits;
 - There are now rules on annual limits on essential health benefits, with the annual limit for a plan year beginning on or after 9/23/10 but before 9/23/11 being \$750,000.
 - » Essential health benefits are defined in the statute to include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.
 - The annual limit permitted increases each year until no longer permitted for plan years beginning in 2014--(\$1.25 million for the 2012 Plan Year, \$2 million for the 2013 Plan Year).
 - There are notice requirements for individuals who have hit the lifetime limit regarding their ability to re enroll, with a 30 day enrollment period beginning with the effective date of the requirement (1/1/2011 for calendar year plans).
 - These rules apply to grandfathered and non-grandfathered plans.
 - Plans that add or lower limits may lose their grandfathered status depending on the changes made.
- The rule prohibiting rescissions, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, and is not permitted unless the individual makes an intentional misrepresentation of a material fact or performs an act that constitutes fraud;
 - This rule applies to both grandfathered and non-grandfathered plans.
 - A cancellation or discontinuance of coverage is not a rescission if it has only a prospective effect.
 - Any permitted rescission requires 30 days notice.
 - This rule applies for plan years beginning on or after 9/23/10.

- The rules on the new patient protections and the model notices that go with them. These new patient protections include the right to designate a primary care provider; the right to designate a pediatrician for your children; and direct access to obstetrical and gynecological care without an authorization or referral requirement. (The plan can still require the Ob-Gyn to obtain authorization for a particular procedure, but not for the right to see a participating Ob-Gyn);
 - The regulations contain model notices which must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan.
 - The rules apply to non-grandfathered plans and only apply where the plan uses a network of providers.
- Coverage of emergency services—they must now be covered without the need for prior authorization, even if the services are provided on an out-of-network basis. Any cost-sharing requirement expressed as a copayment amount or coinsurance rate cannot exceed the cost sharing requirement imposed with respect to a participant or beneficiary if the services were provided in network;
 - However a participant may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under the regulations.
 - Any cost sharing requirement other than a copayment or coinsurance—such as a deductible or out of pocket maximum may be imposed with respect to out-of-network emergency services if the cost sharing requirement generally applies to out-of-network benefits.
 - This coverage of emergency services rule applies only to non grandfathered plans.

Mental Health Parity

Lost in the shuffle of health reform is the fact that regulations were issued earlier this year under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. These regulations are effective for Plan Years beginning on or after July 1, 2010. Thus the provisions would be applicable on January 1, 2011 for a calendar year plan. The law and regulations prohibit group health plans from applying financial requirements or treatment limitations to mental health or substance use disorders that are more restrictive than those applied to medical and surgical benefits. These requirements do not apply to a group health plan for an employer with 50 or fewer employees. The regulations are complex and detailed. Below are just a few highlights.

The parity requirements apply to both quantitative and non-quantitative limitations. Of note is that quantitative treatment requirements cannot accumulate separately. The regulations contain an example of a plan with a \$250 annual deductible on all medical and surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits. This plan does not comply with the requirements of the regulation.

A group health plan may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any 'classification' that is more restrictive than the 'predominant' financial requirement or treatment limitation of that type applied to 'substantially all' medical/surgical benefits in the same classification. All these terms are defined and make the application of this parity rule potentially difficult.

For example, a financial requirement or quantitative treatment limitation is considered to apply to substantially all the medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If such financial requirement or treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that limitation cannot be applied to mental health or substance use disorder benefits in that classification. (Classifications include in and out patient, in and out-of-network.)

One other example of the effect of these regulations is that they also apply to non-quantitative treatment limitations. For example, a common design under medical plans is to condition eligibility for mental health and substance use disorder benefits on exhausting some limited number of mental health or substance abuse disorder counseling sessions offered through an Employee Assistance Program (EAP). This is often referred to as an EAP gatekeeper model. The preamble to the final regulations states that unless a similar gatekeeping model is applied to medical/surgical benefits, the requirement to exhaust mental health or substance use disorder benefits available under the EAP would violate the rule that non-quantitative treatment limitations be applied comparably and not more stringently to mental health and substance use disorder benefits.

In light of health reform, as well as the difficulty with the regulations themselves, several groups, (American Benefits Council, US Chamber of Commerce) have filed comments with the Department of Labor requesting a delay until the first plan year beginning on or after January 1, 2012. We will continue to monitor developments on this topic.

HEART Act/Pension, 401(k) Amendments

Although the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) remains in force, there is another more recent act for which plan amendments are needed. This is the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act).

A new Internal Revenue Code Section relating to retirement plan qualification was added by the HEART Act. Section 401(a)(37) requires that retirement plans provide a beneficiary of a participant who dies while performing 'qualified military service' with any benefits that would have been provided had the participant resumed employment and then terminated employment on account of death. (This section does not require benefit accrual, but would require, for example, accelerated vesting if that was required for an active employee death.) The new Code Section only applies to participants who would have been entitled to reemployment rights if such rights were available immediately before death.

This is a mandatory provision and generally requires a plan amendment by the last day of the first plan year beginning on or after January 1, 2010, (2012 for a governmental plan). There are other optional plan provisions in the HEART Act that an employer may wish to include.

One other mandatory provision in the HEART Act for qualified plans is that differential wage payments must be treated for certain Internal Revenue Code provisions as W-2 compensation. Such payments may, but are not required, to be treated as compensation for benefit or contribution purposes. The mandatory amendment due this year, regardless of the employer's decision about whether to provide benefits based on differential pay, includes this differential pay in the definition of compensation used for determining certain limits under the plan.

Carmody & Torrance can work with you or your pension service provider on the preparation of these amendments.

ERISA Plan Asset Rules/Reminder

The Department of Labor has issued a seven business day safe harbor for plans with fewer than 100 participants to deposit participant contributions to their 401(k) or health plan.

The Department of Labor enforces rules relating to the deposit of employee contributions to a pension (401(k)) or welfare plan. The general rule is that amounts withheld from a participant's pay become plan assets on the earliest date on which they can reasonably be segregated from the employer's general assets. This rule is important because once employee contributions become plan assets, prohibited transaction violations can occur.

Earlier this year the DOL issued a regulation under which plans with fewer than 100 participants will be deemed to have met this plan asset segregation rule. Under this safe harbor, if amounts are deposited with the plan no later than the seventh business day following the day on which the amount would otherwise have been payable to the participant, the amounts will be deemed to have been paid on the earliest date on which such contributions can reasonably be segregated from the employer's general assets.

For plans not eligible for this small plan safe harbor, it is important to be reminded about the general rule. For 401(k) plans not eligible for the safe harbor, in no event may amounts be deposited later than the fifteenth business day of the month following the month in which the amounts would have been payable to the participant. The Department has been very clear that this rule is not a safe harbor if assets could have been segregated sooner. Bottom line, employers should continue to be diligent about depositing employee 401(k) or health premium amounts to the applicable plan trustee or insurer.

This new rule is currently effective.

COBRA Excise Taxes

New for 2010 is Form 8928, a self reporting excise tax form for an employer to use if there are COBRA (or HIPAA) violations. Although the Code and regulations have for some time contained excise tax provisions, this obligation to self report is new. The Form is due at the same time as the regular tax return. There are penalties for late filing and late payment of the tax.

Examples of reasons the tax and form might be due include:

- A failure to offer COBRA coverage to a qualified beneficiary;
- A failure to provide the required 48 hour hospital length of stay in connection with childbirth for mothers and newborns as required by the Newborns' and Mothers' Health Protection Act.

There are exceptions to the excise tax if the violation is due to reasonable cause and the violation was timely corrected.

As a reminder, be sure there is a written agreement specifying which party (employer, insurer, third party administrator) is responsible for compliance with the various aspects of COBRA, as this will be referred to with respect to the tax filing.

We will continue to monitor benefit plan developments during the year, especially developments surrounding health care reform and from time to time send out news articles. Note these news items are not to be construed as legal advice. In the meantime, if you have any questions about this material or any other benefit plan issues, please contact any of the attorneys listed below:

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