



**Q&A from Health Care Reform Webinar Series: Part I
Employee Benefit Plans: What Employers Need to Know in 2010**

“Grandfathered” Plans

Q-1: Does sponsoring a “new” plan mean starting a group health plan where an employer has no existing plan, or is a plan considered new once it starts a new plan year or changes insurance carriers?

A-1: Under the Patient Protection and Affordable Care Act (the “Act”), a “new” plan is one that was not in existence on March 23, 2010, the date of enactment of the Act. The statute expressly provides that allowing new employees to enroll in an existing plan, and allowing dependents of current participants to enroll, does not create a new plan. In addition, the Act does not indicate that the start of a new plan year, in and of itself, will eliminate a plan’s status as a grandfathered plan. However, it is currently unclear whether a change in plan design that is effective after March 23, 2010 will create a new plan for purposes of the grandfathering provision, and the statute is silent with respect to this issue. Under existing law, amending a plan to modify plan design does not create a new group health plan; in fact, a plan remains in existence until terminated by the plan sponsor, and we believe the grandfathering provision of the Act should be interpreted in a manner consistent with the law. However, this is a subject of substantial debate, and until formal guidance is issued related to this provision, we recommend a cautious approach to plan design changes in order to preserve grandfathered plan status.

In order for a plan to move from one insurance carrier to another, one underlying group policy must be terminated and another issued by an insurance company. An insurer issuing a health policy after March 23, 2010 will itself be required to comply with the Act. As a result, we believe that any new policy issued after March 23, 2010 is likely to contain provisions consistent with those applicable to all plans, without benefit of grandfathering, effective the first plan year on or after September 23, 2010. Again, guidance in this area is expected.

Q-2: When must “Grandfathered Plans” comply with all of the “New Plan” requirements?

A-2: The health care reform legislation does not require a “Grandfathered” plan to comply with the “New Plan, Only” requirements. In other words, it is only after a “Grandfathered Plan” becomes a “New Plan” that it would be required to meet the “New Plan, Only” requirements. See our response to Q-1 regarding when a “Grandfathered” plan becomes a “New Plan”.



Adult Dependent Child Coverage

Q-3: If an adult child has already been removed from their parent's health coverage but is not yet attained age 26, can the child be reenrolled:

A-3: Yes. In fact, because plan eligibility criteria must be amended to add coverage for adult children up to age 26 regardless of student status (unless the adult child is eligible for other employer-sponsored coverage other than a parent's coverage), plans will be required to allow adult children in this age group who have previously been removed from a parent's health coverage to enroll at the annual open enrollment coinciding with the effective date of the statute for that plan (the first day of the plan year beginning on or after September 23, 2010.) Under Interim Final Regulations issued May 10, 2010 (the "May 10 regulations"), the agencies (DOL/HHS/Treasury) made clear that a plan without an open enrollment period is required to allow a special enrollment for adult dependent children. The special enrollment period must be a minimum of thirty days in length. The special enrollment period can coincide with the plan's general open enrollment period, and written notice of eligibility for adult children can be provided separately or as part of the open enrollment materials, as long as notice is prominent.

Q-4: Must group health plans charge the same premium that is charged for other dependents, and provide the same employer subsidy, if applicable, for the coverage provided to adult dependent children whose coverage is provided solely because of the adult child eligibility provision of the Act?

A-4: The Act does not address the issue of cost of coverage for adult children covered as a result of this eligibility mandate; however, the May 10 Regulations specifically addressed the issue of cost and other "terms of the plan." The May 10 Regulations establish a "uniformity" requirement indicating that the terms of coverage cannot vary based on age of a dependent child. In addition, the same plan coverage options available for all dependents must be made available for adult children.

Q-5: Does the new law require a plan to cover the pregnancy of a dependent child?

A-5: Although the Act makes clear that grandchildren are not included in the federal mandate, it does not address the issue of providing coverage for the pregnancy of a dependent child. Under existing federal law, there is no requirement to cover pregnancy of dependent children, and unless future guidance indicates otherwise, such exclusions are still permitted.

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Flexible Spending Account Limits

Q-6: Does the \$2,500 contribution limit applicable to health flexible spending accounts effective January 1, 2013 impact premium payroll deductions under Internal Revenue Code Section 125?

A-6: No. The \$2,500 contribution limit contained in the Act applies only to the health flexible spending account arrangements offered under a Section 125 “cafeteria” plan. It does not impact the amount of elective pre-tax salary reductions made by an employee to pay premiums and/or contributions for participation in employer-sponsored qualified benefits. In addition, this new limitation does not impact the \$5,000 maximum contribution currently permitted for dependent care flexible spending account arrangements.

Coverage of Preventive Care

Q-7: Please elaborate on the coverage of preventive care.

A-7: For new plans, only, plans cannot apply deductibles, coinsurance provisions, or any other cost-sharing provisions for certain services, as follows:

- Preventive care services recommended by the United States Preventive Services Task Force. See <http://www.ahrq.gov/clinic/USpstfix.htm#Recommendations>;
- Immunizations recommended by the Centers for Disease Control. See <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>;
- Preventive care and screenings recommended by the Health Resources and Services Administration for women, infants, children, and adolescents. See www.hrsa.gov.

New Plans will be required to provide first-dollar coverage for all preventive services, immunizations, and screenings recommended by these entities. Plans will have one Plan Year after a new recommendation from any of these entities to implement the coverage of the service in accordance with this mandate.



105(h) Nondiscrimination Testing for Fully-Insured Plans

Q-8: Will the 105(h) nondiscrimination rules apply to fully-insured plans that have different eligibility periods for management versus hourly employees?

A-8: Yes. For any and all new fully-insured plans, the 105(h) nondiscrimination rules will apply. Plans with different eligibility periods for management versus hourly employees are at risk of failing the eligibility component of the 105(h) nondiscrimination rules. Failure of this component of the rule will result in the highly compensated individuals, which are the top 25% of employees, being taxed on the value of benefits received under the plan (not the amount of premiums paid).

Q-9: Will a plan fail non-discrimination tests if the employer pays a higher percentage of premiums for executives compared to the rest of the employee population?

A-9: The 105(h) nondiscrimination tests determine whether a plan discriminates with respect to eligibility to participate in the plan and benefits received by participants in the plan, not percentage of premiums paid by employees. So, an employer paying a higher percentage of premiums for executives would not violate 105(h). However, if the employer is funding employee contributions through a 125 plan, the 125 plan nondiscrimination rules would apply and this type of arrangement could cause the employer to fail the 125 plan nondiscrimination rules.

Q-10: What about union employees when you have both union in the field and a nonunion plan for the office?

A-10: Union employees can be excluded from 105(h) testing of a non-union plan if union employees are excluded from the non-union employee plan and there is a collective bargaining agreement in place, as determined by the Secretary of the Department of Labor, under which accident and health benefits were the subject of good faith collective bargaining. Other employees that can be excluded include employees who have not completed 3 years of service, employees who have not attained age 25, part-time or seasonal employees, and non-resident aliens with no earned income in the United States.



Dental and Vision

Q-11: Does this affect dental and vision plans?

A-11: Most provisions do not affect stand alone dental and vision plans, separate ERISA retiree-only plans, and Health FSAs, unless otherwise noted. This is because of the way the Act added the provisions to the Public Health Service Act and then incorporated them into ERISA by adding them to Title I, Part 7 and to Chapter 100 of the Internal Revenue Code. However, the Act's provisions do apply to dental and vision benefits that are included in a medical plan.