December 2010

The Patient Protection and Affordable Care Act legislation continues to impact employers who offer health insurance coverage to their employees. Recent events and/or updated regulations have resulted in the following areas of note:

Non-discrimination rules in effect for non-grandfathered health plans

For plans that are not considered “grandfathered” according to the rules surrounding the Patient Protection and Affordable Care Act (health care reform legislation passed this past March 23, 2010) these non-grandfathered fully insured health plans will now be subject to non-discrimination rules formerly applicable only to self insured plans (IRC 105(h). The basic premise of the non-discrimination rules require plans to **not** benefit highly compensated employees (HCE’s) any greater than non-highly compensated employees as respects the group health plan.

In GENERAL, an insured plan that treats all employees the same (all are eligible, the waiting periods are the same, no one is treated differently on the basis of age, years of service or compensation, there are no differences in policy limits or covered benefits) generally needn’t be concerned about testing.

However, if there is a concern about a plan being discriminatory there are three tests that can be run to determine if a health plan is discriminating in favor of highly compensated employees:

(1) **70% Test**. The plan benefits 70% or more of all “non-excludable” employees meaning that at least 70% of non-excludable employees actually participate in the plan. “Excludable employees” include part-time/seasonal, collectively bargained employees, employees under age 25, and employees employed less than 3 years provided these employees are not eligible for benefits. (for example, if you made part time employees eligible for benefits than they are no longer excludable employees). After subtracting these excludable employees from your employee roster, 70% of the remaining employees must be eligible and actually participate in the health plan.

(2) **70%/80% test**. 70% of all “non-excludable” employees are eligible under the plan and 80% actually participate. For those employees who can’t get to 70% participation, they can pass this test by showing that 70% of their non-excludable employees are eligible to participate and that 80% of those eligible actually do participate. For example, a plan that has 100 non-excludable employees has 80 employees eligible for benefits but only 60 participate. They don’t pass the 70% test; however, they would pass the 70/80 test because at least 70% of the non-excludable employees are eligible and at least 80% of those eligible actually participate.

(3) **Non-Discriminatory Classification Test**. If you can’t meet either of the first two tests, you may still pass the eligibility test if you can demonstrate that the plan benefits employees that qualify under an employment classification set up by the employer and found by the IRS to be non-discriminatory. It is a fact and circumstances determination made by the IRS. Additionally, what exactly this test means and how you run it is not specified in the rules. There are two schools of thought on how you apply it and the most conservative approach is to apply it as follows: (i) the plan benefits employees who qualify under a reasonable classification established by the employer (uses objective business criteria that identifies the category of employees who benefit such as job category, nature of compensation (salaried v. hourly), and geographic location); and (ii) the classification of employees is nondiscriminatory meaning that the group of employees

included in the class that benefits under the plan must include an objective Safe Harbor Percentage of non-HCEs. The IRS has a table which outlines what the Safe Harbor Percentage is based on your Non-HCE Concentration.

To run the non-discrimination tests the employer needs to determine which employees to include for counting purposes as non-excludable employees and who in that group are your "HCEs" (5 highest paid officers, top 25% paid employees, 10% or more shareholders). The Plan Year in question for your plan will not necessarily be the renewal date for your plan with your insurer—if there is no evidence to tht contrary the Plan Year will be the time when deductibles and coinsurance refresh which for a majority of plans is January 1. Your Bearence Risk Consultant has information on evaluation and testing of plans.

Over the counter drugs

Effective January 1, 2011, regardless of the plan year, health flexible spending accounts can no longer reimburse over-the-counter drugs unless the participant has a prescription for the OTC that indicates it is being prescribed to treat a specified medical condition. The effective date of this provision is not tied to the plan year but is January 1, 2011 regardless of the plan year. This means that an employer who has a health flexible spending account with a plan year that does not begin on January 1 will need to implement this provision mid-year. Employers who have a plan year that begins January 1 but with a grace period can not reimburse employees out of 2010 funds for OTCs purchased on or after January 1 but during the grace period.

W-2 Reporting Requirement Delayed

On October 12, the Internal Revenue Service announced that it will delay the compliance date for this requirement. The IRS and the Treasury Department have provided the relief in order to give employers more time to make any necessary changes to their payroll systems or procedures in preparation for compliance with the reporting requirement.

The temporary relief from the reporting requirement is found in IRS Notice 2010-69. This notice states that reporting the cost of employer-sponsored group health coverage will not be mandatory for 2011 Forms W-2, which would be issued in 2012. Due to the extension, employers will have to include this information for the first time on the 2012 W-2s instead, which are not issued until 2013.

Changing Carriers and Grandfathered Status

They have revised the grandfathering rules to allow fully-insured plans to change carriers effective November 15, 2010 and continue to keep their grandfathered status provided no other changes are made that would cause a loss in grandfathered status. Plans that changed carriers prior to November 15, 2010 with a coverage date prior to November 15, 2010 are not covered by this new rule and will lose their grandfathered status as a result of the change in carriers. For example, an employer that moved from Carrier A to Carrier B effective November 1, 2010 would not be able to maintain its plan's grandfathered status regardless of whether the plan designs changed.

Long Term Care

Rules surrounding the proposed Long Term Care (LTC) program outlined in the original legislation have not been released as of November 4, 2010. The original legislation called for a national LTC plan that employers could "opt" into on behalf of their employees starting January 1, 2011. We will communicate as soon as these rules are written and released.

Political Climate

A number of questions have arisen in the aftermath of the recent election as to how these results impact healthcare reform on a state by state and national basis. Most of the insurance reforms that were created in the original legislation are in motion and will continue to be driven throughout the coming year. As any updates/changes are developed around the PPACA, either in rules development or funding decisions on various aspects of the bill we will be updating you.

Questions

If you have any questions regarding the information contained here or any other questions related to the PPACA call or email your Bearence Risk Consultant.

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