



TUESDAY, DECEMBER 28, 2010

HEALTH CARE REFORM UPDATE

RECENT EVENTS IN HEALTH CARE REFORM

In this issue of *Health Care Reform Update*, we offer a brief recap of several significant recent health care reform issues and guidance.

We hope you find these updates helpful and invite you to review past issues of our *Health Care Reform Update* at <http://www.trion.com/healthreform>. As your trusted partner, we are committed to keeping you informed, and helping you understand and comply with the guidelines pertaining to the health care reform legislation.

IRS Announces Delay for Compliance with New Insured Plan Non-discrimination Rules

On December 23, 2010, the Internal Revenue Service announced in IRS Notice 2011-1 that the government will not require non-grandfathered insured plans to comply with the new prohibition on discrimination in favor of highly compensated employees until the IRS issues specific guidance on compliance for such plans. The IRS announcement cited concerns expressed in public comments about the ability of insured plans to comply given the inadequacy of existing guidance applicable to self-insured plans. Equally important, the IRS has decided to issue specific guidance for insured plans, rather than expecting insured plans to rely on guidance for self-insured plans that does not account for some of the unique challenges insured plans will face in implementing non-discrimination requirements.

While the IRS did not provide specific information on the length of the delay, it indicated that compliance would be required only after the issuance of specific regulations for insured plans, and that even then, it will allow some additional time for plans to implement any changes necessitated by the new regulations. Considering that the IRS has opened a new public comment period (discussed below) on the non-discrimination issue, which does not close until March 2011, it is reasonable to anticipate that it will be several months before compliance will be required. Thus, even though the Patient Protection and Affordable Care Act (PPACA) states that the non-discrimination requirement goes into effect for plan years starting on or after September 23, 2010, non-grandfathered plans operating on a calendar-year basis that must implement other PPACA reforms by January 1, 2011, for example, will not be expected to implement the non-discrimination requirements at that time. Keep in mind that the PPACA non-discrimination requirement applies only to non-grandfathered insured plans. Also, note that the announcement does not affect compliance by self-insured plans, which are already subject to the Internal Revenue Code Section 105(h) non-discrimination rules regardless of whether they are grandfathered, and does not affect compliance by cafeteria plans, which are subject to separate non-discrimination rules. The announcement is available at <http://www.irs.gov/pub/irs-drop/n-11-01.pdf>.

As mentioned, the announcement also opens a new public comment period on the non-discrimination issue, and seeks input on several substantive issues raised in earlier public comments, including: 1) IRS authority to provide for an alternative method of compliance that would involve only an availability of coverage test, rather than requiring plans to also pass a test for actual participation; 2) developing a safe harbor plan design; and 3) how to treat employees who voluntarily waive employer coverage, since such employees would have an adverse impact on the ability to pass the existing non-discrimination test. Comments are due March 11, 2011.

State Tax treatment of Dependent to Age 26 Provision: Check with your tax advisor

For plan years beginning after September 23, 2010, the PPACA requires group plans that are already providing dependent coverage for children to extend eligibility for that coverage to dependents up to 26 years of age. This provision amended the federal tax rules to allow the tax-free treatment of the value of



health coverage provided to an employee's child up to age 26 even if the child does not otherwise qualify as a dependent of the employee for tax purposes.

In addition to these federal laws, each state has its own income tax laws and, some states have not yet enacted legislation to make state revenue rules consistent with IRS definitions. This means that employers who implemented the dependent to age 26 provision in 2010 may need to withhold state employment taxes on the value of coverage for older dependents, and report different amounts of income for federal and state income tax purposes on the employee's W-2 form.

Since these laws apply to the 2010 tax year, we are recommending to all our clients and partners that you work individually with your tax preparers to assess the state tax laws for each state in which you have employees to ensure proper reporting of your federal and state taxes.

Additional guidance on Mini-Med Policies

On December 9, the Department of Health and Human Services (HHS) issued supplemental regulatory guidance affecting mini-med plans. The guidance restricts insurance carriers' ability to sell new mini-med policies in the group and individual markets, and requires additional notices to mini-med plan participants concerning annual limits. Employers who are considering changes to mini-med coverage should review this guidance to ensure any changes made will not deprive you of the opportunity to maintain a mini-med plan, or cause unintended loss of a plan's grandfather status. The full guidance may be viewed here: [HHS Guidance on Mini-Med Plans](#)

HHS has further clarified that it intends to grant waivers of the annual limit rules only for mini-med policies that were in existence on September 23, 2010. This means issuers cannot provide group plan sponsors with new mini-med policies effective after that date. The only exception is for group plan sponsors who had mini-med plans on September 23, 2010, and now wish to change carriers, as is now allowed by the grandfather rule. However, both the old and the new plan must have an HHS waiver of the annual limit rule. A condition of obtaining such a waiver is that a mini-med plan must provide participants with a notice that the plan has annual limits that do not comply with the PPACA and that the plan has obtained a waiver along with a general description of what the plan's annual dollar limits are. A model notice may be viewed here: [Model Notice for Mini-Med Plans](#)

HHS has advised that none of the foregoing restrictions will preclude an existing group health plan from enrolling new employees or beneficiaries in existing mini-med coverage.

Medical Loss Ratio Requirements

HHS issued Interim Final Regulations (IFRs) addressing Medical Loss Ratio (MLR) requirements for health insurers, applicable regardless of grandfather status. Under these rules, insurers are required to report how they spend premium dollars and must provide rebates to enrollees unless at least 80 cents of each small employer (< 100 employees) premium dollar, or 85 cents in the large employer group market, is spent on clinical services and health care quality improvement. HHS adopted the recommendations in the model regulations of the National Association of Insurance Commissioners. While these regulations directly apply only to insurers, we expect that insurers will begin to send focused communications to employers regarding plan expenses. Although we anticipate that these regulations will help insurance carriers move toward greater business efficiencies, we acknowledge they also can be viewed as burdensome requirements for carriers. We will continue to monitor the results of these requirements and any impact to our clients and partners.

Additional information on the Medical Loss Ratio is available here: http://www.hhs.gov/ociio/regulations/medical_loss_ratio.html

Health Care Reform in the Courts



In Virginia, U.S. District Judge Henry Hudson recently ruled that Congress exceeded its authority by requiring Americans to start buying insurance in 2014 or face a fine. Judge Hudson did not order the government to stop implementation of the law; rather he ruled that outside of the mandate the rest of the law should stand. The administration will appeal the decision. Also, this decision contradicts two other District Judge opinions on the same legal question.

These cases are just part of a larger set of legal actions against PPACA since its passage this past March. Most legal authorities anticipate that such cases collectively will move through the legal system, ultimately reaching the Supreme Court for a final decision.

In general, law suits to date have not been focused on the employer provisions, but rather the individual mandate. However, the outcome of these debates will have substantial implications to employers because the cost control strategies of health care reform rely in part on the individual mandate reducing the cost-shifting of unreimbursed medical expenses to private payors. We will continue to monitor the activity in the state and federal courts and keep you apprised of all major developments.

2011 Outlook

Certainly, 2010 was a year of great activity and change for the insurance industry and our clients and partners due to Health Care Reform, and we expect that 2011 will be an interesting year as well. Government agencies still have a substantial amount of guidance to provide through new interim regulations and final regulations based on public comment. At the same time, there will be continued heated debate regarding the impact of PPACA and its subsequent regulations on individuals, employers, states, health care providers, and on the overall economy.

Throughout 2011, we will continue to issue our *Health Care Reform Update* in as new information is released, and your Trion Account Management teams will continue to partner with you to help you navigate, understand and comply with all guidelines pertaining to health care reform legislation. We invite you to continue to share your questions and comments with us by emailing health.reform@trion.com or calling 610.945.1198.

Best wishes to all for a happy and successful New Year.

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