

CLIENT BULLETIN

Update on Retiree Reinsurance Provision, Grandfathered Plans, Collectively Bargained Effective Date and Dependent Coverage Provisions

In this *Client Bulletin* we will take a closer look at selected provisions of the health care reform bills discussed in [Client Bulletin 2010-26](#). A detailed 69-page summary integrates the provisions of the 3-parts to what is commonly called the "health care reform law" is available at: <http://dpc.senate.gov/healthreformbill/healthbill96.pdf> or by "[clicking here](#)". The items of immediate interest to you are found in the first few pages.

The Research Department recently participated in a webcast presented by the International Foundation of Employee Benefit Plans (IFEBCP) (www.ifebp.org) as well as a presentation by the National Coordinating Committee on Multiemployer Plans (NCCMP) (www.nccmp.org) for attorneys and administrators presented in Washington D.C., held in the Samuel Gompers Room at the AFL-CIO headquarters, named for a giant in the history of organized labor. In 1864, Gompers joined Local 15 of the United Cigar Makers and eventually became the first and longest-serving president of the American Federation of Labor (AFL), serving from 1886-1924. (<http://www.aflcio.org/aboutus/history/history/gompers.cfm>)

One message that came through "loud and clear" at these presentations as well as through industry reports in general is that much of the law relating to group health plan reforms needs immediate explanation and guidance as it is unclear, ambiguous and contradictory in many places. In spite of that, we will take a look at the best guesses so far and add some clarification where clarification has been made.

First, we will note that the Department of Health and Human Services (HHS) has set up an extensive, informative website worthy of an Oscar at <http://www.healthreform.gov>. The website has a section entitled "*Your Questions Answered*" that contains [answers for families \(parents, consumers and seniors\)](#) and [small businesses](#), some of which we discuss. HHS is hosting weekly webchats on the health care reform bill. The Research Department will be tuned into the webchats and will report on group health compliance developments. The site has an email news update listserv.

HOWEVER, one must be careful when reading the information and determine if the compliance dates and reforms discussed apply to insured plans, self-insured plans, grandfathered plans, group health plans, individual plans and/or collectively bargained plans of any stripe.

Also in this *Client Bulletin*, we will take a look at the compliance dates for grandfathered plans and non-grandfathered plans on lifetime/annual limits, the age 26 extension for dependent coverage, the effect of the delayed effective date for collectively bargained plans and the retiree reinsurance subsidy. Since the implementation date of the retiree reinsurance subsidy is clear (June 23, 2010) and some "guidance" has been issued, we will look at this area first.

Reinsurance for Early Retirees

Section 1102 of the *Patient Protection and Affordable Care Act (PPACA)* provides for a temporary reinsurance (subsidy) to employer-based group health plans for a portion of the cost of providing health care coverage to "*early retirees and their eligible spouses, surviving spouses and dependents of such retirees.*" This program is to be established on or about June 23, 2010 and runs through January 1, 2014.

The process is said to be similar to the Medicare Part D drug subsidy procedures (electronic filing, delegation of various filing responsibilities, etc). The law sets aside five billion dollars to fund these reimbursements.

The HHS website contains a Fact Sheet on the Reinsurance Program for Early Retirees, which is available by "[clicking here](#)" or online at:

http://www.whitehouse.gov/sites/default/files/rss_viewer/reinsurance_early_retiree_s_fact_sheet.pdf. The Fact Sheet contains the following information:

Effective date: The program becomes effective June 23, 2010. Payments are retroactive for a plan year, so employers and early retirees will be able to take advantage of them for costs incurred from the date the program is established. The program ends on January 1, 2014, when early retirees will be able to choose from the additional coverage options that will be available in the health insurance exchanges.

Who qualifies: Payments will be made to employer-sponsored health plans on behalf of an early retiree (and his or her spouse, surviving spouse, and dependents). An "early retiree" is defined as an individual age 55 and older who is neither an active employee nor eligible for Medicare.

Eligible firms: Payments will be made to employer-sponsored health plans on behalf of early retirees. To receive assistance, plans must apply, document claims, and implement programs and procedures to generate cost savings for participants with chronic and high-cost conditions. Plans will be subject to audits to assure fiscal integrity.

Amount of assistance: For each such early retiree (and his or her spouse, surviving spouse, and dependents), the employer plan will receive up to 80% of costs, minus negotiated price concessions, for health benefits between \$15,000 and \$90,000. This reinsurance corridor shall be adjusted in subsequent fiscal years by the medical component of the consumer price index.

Savings for enrollees: Plans must use these proceeds to lower health costs for enrollees (e.g., premium contributions, copayments, deductibles, etc.).

Frequently Asked Questions:

Who applies and when? Employer and union-based plans will submit an application to HHS to participate in the program. Many of them will already be familiar with the process for submitting applications for the Retiree Drug Subsidy program; we expect the process will be similar. The application will be available in June.

How will payments be made? Plans with approved applications will submit paid claims to the Department of Health and Human Services.

What types of employer-sponsored plans are eligible? Both self-funded and insured plans can participate, including plans sponsored by private entities, state and local governments, nonprofits, religious entities, unions, etc.

What types of services qualify for reimbursable services under the program? Plans can get program payments for medical, surgical, hospital, and prescription drug costs.

How should employers treat reinsurance payments when it comes to taxes? Proceeds are excluded from gross income.

We will report on more details as they are released.

Compliance Dates

Most of the health care reforms don't take effect until 2014, with the dreaded "Cadillac plan" tax not beginning until 2018. In order to understand the most immediate changes and compliance dates, one must understand the structure of the law. Before discussing compliance dates for: (1) prohibitions on lifetime limits and unreasonable annual limits; and (2) the extension of dependent coverage through age 26, let's review the law's structure.

To recap, what is commonly referred to as the health care reform law consists of three separate parts that must be read together to get the whole picture. First, there is *the Patient Protection and Affordable Care Act (PPACA)* (H.R. 3590). The *PPACA* consists of 10 Titles. However, Title 10 consists of amendments to Titles 1-9 and those 9 Titles must be read in light of these amendments as Title 10 is not incorporated into the first 9 Titles. So, the *PPACA* has two parts that must be reviewed on any given subject. Look to see what it says in Titles 1-9 and then see if Title 10 changes it. In addition to looking at the *PPACA*, one must also look at the [reconciliation bill](#) (RB) (H.R. 4872) which makes amendments to the *PPACA*.

In addition, we would note that while the laws are couched in terms amending the *Public Health Service Act (PHSA)* they also amend the *Employee Retirement Income Security Act of 1974 (ERISA)* and the *Internal Revenue Code (Code)* by incorporating certain changes made to the *PHSA* into *ERISA* and the *Code*. Sections 1562(e) of the *PPACA* adds a new *ERISA* Section 715 that incorporates by reference the provisions of part A of Title XXVII of the *PHSA*, as amended by the *PPACA*, into *ERISA*. Subsection 1562(f) of the *PPACA* does the same for the *Code*. Both Sections contain certain qualifiers, including the fact that the *PPACA* trumps any *ERISA* or *Code* provisions that contradict the *PPACA*.

Grandfathered Plans and Lifetime Prohibitions-Annual Limits

This “compliance dates” discussion is limited to the lifetime/annual limit prohibitions and age 26 dependent coverage. *PPACA* Section 1001 adds *PHSA* Section 2711 *No Lifetime Or Annual Limits*, prohibiting lifetime limits and unreasonable annual limits. *PPACA* Section 1004 says the effective date for these prohibitions is:

SEC. 1004. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall *become effective* for *plan years beginning on or after* the date that is *6 months after the date of enactment* of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

To avoid a discussion of the view that the Act has two different effective dates, we’ll use the date of 10/30/10 for the date which is 6 months after the enactment of the Act. This would make the prohibition on lifetime or annual limits effective for calendar year plans January 1, 2011. That may seem simple, but it’s not.

To paraphrase the portions relevant to our discussion, Section 1251(a)(2) of the *PPACA* says the prohibitions on lifetime limits and unreasonable annual limits and age 26 dependent coverage do not apply to “*grandfathered*” plans (a term meaning plans in effect on March 23, 2010). So, it looks like under Section 1251(a)(2) an existing group (grandfathered) health plan would not need to comply with the “lifetime prohibitions-annual limits/dependent care extension.” To make interpretation of compliance dates even more interesting, is the somewhat unusually worded delay in effective date for collectively bargained plans in Subsection 1251(d):

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements [CBA] between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

Thus, it appears to some that collectively bargained plans “lose” their grandfathered status on the date “*the last of the collective bargaining agreements relating to the coverage terminates.*” This conclusion is based on the language that the coverage was *maintained* by a CBA ratified before March 23, 2010. The implication of the language is that this delay applies to existing CBA plans. The Research Department and others have noted that a strict reading of the language would limit this delay to only “insured” plans and it would not apply to self-insured CBA plans. Even an “*in para matria*” reading of the text has limits. “[Click here](#)” for a technical look at the reasoning behind this conclusion. For our purposes, we will assume the CBA delay applies to both insured and self-insured group health plans. **As with any statements or conclusions reached herein, Trustees are advised to get the opinion of their Fund Counsel.**

Ordinarily, a delayed effective date for collectively bargained plans starts the FIRST PLAN YEAR AFTER the collectively bargaining agreement terminates. Here, the language says the prohibitions on lifetime/annual limits apply after the last collective bargaining agreement regarding coverage terminates. Not the plan year following termination.

If a CBA based plan had its last CBA expire in June 2010, one interpretation would be the plan would have to comply with the lifetime prohibitions-annual limits/dependent care extension immediately. This would put such CBA plans in worse shape than if they were not given a delayed effective date. Even though that is what the text may say, it is more logical to conclude that such plans would have at least as long as a grandfathered plan. A technical correction should be made instead of a regulatory band-aid, but, unlike the Rolling Stones who could boast *Time is on My Side*, time isn't on the side of the regulatory agencies as the sands of time until explanations are needed fly by.

But, to return to our discussion of the effective dates on grandfathered plans, we need to look at Section 2301 of the RB which makes certain reforms applicable to grandfathered plans. This Section makes the prohibitions on lifetime limits and unreasonable annual limits and age 26 dependent coverage apply to grandfathered plans the first plan year beginning after October 1, 2010:

Section 2301 of the RB extends certain reforms, including the two we have been discussing, to grandfathered plans stating:

(4) APPLICATION OF CERTAIN PROVISIONS.—

(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) **shall apply to grandfathered health plans** for plan years **beginning with the first plan year to which such provisions would otherwise apply** [explanatory note – this means the 1st plan year after 10/01/10]:

- (i) Section 2708 (relating to excessive waiting periods).
- (ii) Those provisions of section 2711 relating to lifetime limits.
- (iii) Section 2712 (relating to rescissions).
- (iv) Section 2714 (relating to extension of dependent coverage).

(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.—

(i) **PROVISIONS DESCRIBED.—**Those provisions of Section 2711 relating to **annual limits** and the provisions of Section 2704 (relating to **pre-existing condition exclusions**) of the Public Health Service Act (as added by this subtitle) **shall apply to grandfathered health plans** that are **group health plans** for **plan years beginning with the first plan year to which such provisions otherwise apply** [explanatory note – the 1st plan year after 10/01/10].

(ii) **ADULT CHILD COVERAGE.—****For plan years beginning before January 1, 2014,** the provisions of Section 2714 of the Public Health Service Act (as added by this subtitle) shall apply in the case of an **adult child** with respect to a **grandfathered health plan** that is a **group health plan** only if such adult child is **not eligible to enroll in an eligible employer-sponsored health plan** (as defined in Section 5000A(f)(2) of the Internal Revenue Code of 1986) other than such grandfathered health plan.”

Subsection (b) of Section 2301 further clarifies that the under age 26 dependent can even be married and must be given coverage.

One question raised by many to which there is no clear understanding or any guidance is *"How does the delayed CBA effective date apply to this Section of the RB which accelerates certain health reforms?"*

The general advice is for collectively bargained plans to be ready to implement the above reforms by the first plan year beginning on or after October 1, 2010 and hope you get a delayed date if your plan's CBA expires at a later date. **UNDOUBTEDLY GUIDANCE WILL BE ISSUED BEFORE THEN.** Some plans are being proactive and complying by the first plan year after October 1, 2010; that is, January 1, 2011 for calendar year plans.

We note that for plans established on or after March 23, 2010, some have noted there is no clear guidance on when such plans would have to comply with the lifetime prohibitions-annual limits/dependent care extension and any other applicable reforms. It would seem logical for such plans to be compliant upon establishment, although if the plan was new as of June 1, 2010, some would argue the plan could wait until the first plan year on or after October 1, 2010 to comply.

Grandfathered Plans and the Extension of Dependent Coverage

The general discussion of the compliance date for grandfathered plans would also apply to the extension of dependent care coverage. Section 2301(a) of the RB amends Section 1001 of the *PPACA*, which contains *PHSA* 2714 extending dependent coverage to age 26, even if the "child" is married. **HOWEVER**, before January 1, 2014, this extension only applies if the dependent is NOT eligible to enroll in different employer-sponsored health plan. This "other coverage availability" limitation does not apply after January 11, 2014.

Section 1004 of the RB makes changes to the Code requirements for providing tax-free health care coverage to dependents and extends the tax-free nature of such benefits to age 27, the VEBA extension is at Subsection XX. Section 1004 allows health plans to cover the dependent until the end of the year the dependent turns age 26 with no adverse tax consequences.

According to an answer at <http://www.healthreform.gov/about/answers.html>, if a dependent has aged out of coverage and is still under 26, he/she must be given a chance to be covered again by the plan on the applicable effective date that the dependent care extension applies. Guidance will be needed on how this is to be accomplished. Plans may have the duty to offer to re-enroll such aged dependents.

Conclusion

Guidance is needed for these issues and more. According to published reports and "insider" scuttlebutt, the responsible federal agencies are working feverishly to get guidance out. All plans can do until then is "sit tight" and prepare for the worst – compliance by the first plan year on or after October 1, 2010 for these reforms.

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