

Benefits Alert

January 2011

HHS Clarifies Annual Limit Waiver Process

Under interim final regulations, grandfathered group health plans, including mini-med plans, that place annual limits on the dollar value of essential health benefits are restricted to imposing an annual limit of \$750,000 for plan years beginning on or after September 23, 2010. However, plans can apply to the Department of Health and Human Services (HHS) for waivers if they can show that there would be a significant increase in premiums or loss of coverage if they were to raise the limit. The HHS is imposing new disclosure rules on plans that receive waivers. The rules apply regardless of when the waiver was granted.

DISCLOSURE DETAILS

As a condition of receiving

waivers, the HHS is requiring plans to provide a notice to employees informing them that the plan doesn't meet the restricted annual limits for essential benefits because it received a waiver. The notice will be required to include the dollar amount of the annual limit, along with a description of the plan benefits to which the waiver applies. The notice must also state that the waiver is for one year only. The notice must be prominently displayed in clear, conspicuous, 14-point bold type. The HHS has created a model notice, which is available online at www.hhs.gov/ociio/regulations/index.html. *Important omissions:* The HHS doesn't state when or how often the notice must be provided to employees.

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KEY CLARIFICATIONS

The HHS also clarified how it applies the phrase *significant increase in premiums or loss of coverage* when evaluating waiver applications. The HHS addresses these factors for each waiver application.

- The application's explanation as to how compliance with the restriction on annual limits would result in a significant decrease in access to benefits.



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Rules Ease Criteria For Maintaining Grandfathered Status

Grandfathered group health plans are excused from complying with substantial portions of the health care reform law. Whether a group plan qualifies as a grandfathered plan was determined in interim final regulations that were issued in June 2010. The IRS and the Department of Labor (DOL) have now amended those regs to allow insured group plans to maintain their grandfathered status if they change insurers but maintain the same benefits. In addition, the DOL recently added to its FAQs on grandfathered plans.

AMENDED INTERIM FINAL REGS

Under the original regs, insured group plans lost their grandfathered status if plan sponsors changed insurers, even if everything else about the policy remained the same. The amended interim final regs allow grandfathered group plans that enter into new policies,

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HHS Clarifies... (cont.)

- The plan's current annual limit.
- The change in premiums in percentage and absolute dollar terms.
- The number and types of benefits affected by the annual limit.
- The number of employees enrolled in the plan. ❖

certificates, or contracts of insurance after March 23, 2010, to maintain their status, provided no changes are made that would otherwise revoke their status (e.g., employees' cost-sharing goes up, benefits are cut back, or the employer's contribution is reduced). *Caution:* Both the old and new policies will need to be scrutinized to make sure they're identical. In addition, the plan must meet these two new conditions.

- The plan must provide the new insurer with documentation of its terms under the old policy sufficient to determine whether its grandfathered status is revoked. This documentation must cover benefits, cost-sharing, employer contributions, and annual limits. The regs note that documentation may include a copy of the policy or summary plan description.

- The new policy, certificate, or contract of insurance must be effective on or after November 15, 2010 (i.e., the amendment isn't retroactive). The date the new coverage becomes effective is the key date, not the date a contract for a new policy, certificate, or contract of insurance is entered into. So, for example, if a plan entered into an agreement with a new insurer on September 28, 2010, for a new policy to be effective on January 1, 2011, the plan could take advantage of this amendment.

NEW FAQs

Grandfathered plans must

notify employees of their status, and the original regs contain model language plans can use for this purpose. An FAQ clarifies that plans don't have to notify employees each time they communicate with them, as through an explanation of benefits, for example. *FAQ:* The model language must be included when a summary of benefits is provided to participants. For example, summary plan descriptions may be provided upon employees' initial enrollment, annually during open enrollment, or at other opportunities employees have to enroll in, renew, or change coverage. Plans are encouraged to identify other materials in which the model language can be included.

One of the keys to understanding the health care reform law is that it defines a set of essential benefits that cannot be subject to annual or lifetime limits. Grandfathered plans, therefore, may impose limits on benefits that aren't essential benefits. Until final regs are issued, plans may make a reasonable, good-faith interpretation of the definition of essential health benefits. Another FAQ clarifies that lifetime limits can apply to benefits provided under a plan that's not the employer's primary plan to employees with dependents who have physical, mental, or developmental disabilities (e.g., reimbursement for special therapy, day or residential special care, special educational facilities, and camps). The FAQ warns, however, that the definition of essential benefits could change when final regs are issued. ❖

IRS Releases Guidance On In-Plan Roth Rollovers

The 2010 Small Business Jobs Act allows 401(k) plans that already contain an after-tax Roth feature to accept rollovers of employees' eligible rollover distributions. In keeping with the after-tax nature of Roth accounts, employees must include these so-called in-plan Roth rollovers, plus any earnings, in income and pay income taxes on those amounts. Plans must be amended to reflect this feature. The IRS has issued guidance on in-plan Roth rollovers.

DISTRIBUTIONS AND CONTRIBUTIONS

401(k) distributions that employees want to roll over into Roth accounts must be allowed under the plan. The guidance makes clear that any vested amount (e.g., pre-tax contributions, after-tax contributions, or employer contributions) held in employees' accounts is eligible for an in-plan Roth rollover, provided the distribution is an eligible rollover distribution. However, there are limitations. Employees who haven't attained the age of 59½, aren't disabled or dead, or are not eligible for qualified reservist distributions can't roll over pre-tax contributions. To enable employees to make in-plan Roth rollovers, the law allows employers to expand their list of distribution options beyond those currently allowed. Further, employers may condition eligibility for new distributions on employees' elections to make in-plan Roth rollovers.

Although the law says that 401(k) plans must already have

an after-tax Roth feature for employees to make in-plan Roth rollovers, the guidance says that 401(k) plans can be amended retroactively to provide a Roth feature. *Key:* Plans must have been operating with the Roth feature by December 31, 2010, to allow employees to take half the income into account and pay taxes in ratably in 2011 and 2012. Employees may also elect to pay all the taxes in 2010.

The guidance requires Roth 401(k) plans to hold employees' rollovers in separate accounts. This separate accounting is important for tax purposes if employees later take early distributions from their Roth 401(k) accounts.

AMENDMENTS AND NOTICES

Plans can operate with in-plan Roth rollovers before they're amended. The guidance gives plans an extended deadline to amend to permit in-plan Roth rollovers, provided the amendment's retroactive effective date is the date the plan first operated in conformity with the amendment.

- 401(k) plans have until the later of the last day of the year in which the amendment is effective, or December 31, 2011, to amend.

- Safe-harbor 401(k) plans have until the later of the day before the first day of the plan year in which the safe-harbor plan provisions are effective, or December 31, 2011, to amend.

Plans that provide the IRS's safe-harbor explanation to participants who receive eligible

rollover distributions must include a description of the in-plan Roth rollover feature. ❖

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Cash Back From Your Health Insurer? Maybe So

Final regulations, formally called the medical loss ratio regulations, require that health insurers in the small group market spend 80 cents of every premium dollar on medical care and health care quality improvement, rather than on administrative expenses, such as advertising, overhead, and executive salaries. In the large group market — plans covering more than 50 enrollees — the medical loss ratio is 85 cents of every premium dollar. Insurers that fall short must make rebates to participants, beginning in 2012. The first rebate check would be due by August 1, 2012. While you don't need to know the details of how the medical loss ratio is calculated, you can use it to determine whether the company is getting the best bang for its health benefits buck.

INSURER REPORTING REQUIREMENTS

The primary purposes of these regs are to develop uniform definitions and methodologies for calculating insurers' medical loss ratios, and to require that most of the premium dollars collected go toward health care. To accomplish these goals, beginning in 2011, insurers will have to report the following data in each state

IRS Releases 2011 Inflation-Adjusted Benefits Figures

Last month, the IRS announced the 2011 inflation-adjusted figures that apply to 401(k) and other pension plans. Completing most of its annual duties, the IRS has released the 2011 inflation-adjusted figures for other popular employer-provided fringe benefits, including adoption assistance and long-term care premiums.

Employer-provided adoption assistance. For 2011, employers that have adoption assistance programs can exclude \$13,360 from employees' incomes. This amount is phased out for high earners. In

2011, the excludable amount begins to be phased out for employees who have modified adjusted gross incomes exceeding \$185,210. The benefit is completely phased out for employees who have modified adjusted gross incomes of \$225,210 or more.

Long-term care premiums. For tax and benefit purposes, employer-provided long-term care insurance is treated like health benefits, with one big exception. While employers' payment of employees' health premiums is completely tax-free to employees, the amount employers can

pay tax-free on long-term care insurance contracts is limited, based on employees' age. *Reminder:* These benefits can't be part of a cafeteria plan.

For employees who are 40 years old or younger, employers can pay up to \$340.

- For employees who are older than 40 but not older than 50 years old, employers can pay up to \$640.

- For employees who are older than 50 but not older than 60 years old, employers can pay up to \$1,270.

- For employees who are older than 60 but not older than 70 years old, employers can pay up to \$3,390.

- For employees who are older than 70, employers can pay up to \$4,240. ❖

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Cash Back From Your Health Insurer? Maybe So (cont.)

in which they do business to the Department of Health and Human Services (HHS), which will post the data on its website:

- the total earned premiums;
- the total reimbursement for clinical services;
- the total spending on activities to improve quality; and
- the total spending on all other non-claims costs, excluding federal and state taxes and fees.

If the ratio of premiums spent for medical care and activities that improve health care quality to the total premiums collected is less than the statutory 80%/85%, employees will receive rebates in proportion to the premium paid. Those who are owed rebates will see a reduction in their premi-

ums or receive rebate checks. Employers may also receive the rebates on employees' behalf.

Companies that self-insure aren't subject to these rules, presumably because they don't incur the same administrative costs as insurers. In addition, very small insurers (i.e., those with fewer than 1,000 enrollees) won't be required to pay rebates at least for the first year, and insurers with fewer than 75,000 enrollees will get an adjustment.

SPECIAL RULES FOR MINI-MED PLANS

The HHS had indicated earlier that mini-med plans — plans with very low annual dollar limits and low premiums — would receive special

consideration under the medical loss ratio rules. The final regs make good on that understanding. For calendar year 2011, the HHS will apply a methodological adjustment to the way the medical loss ratio is calculated for these plans. The adjustment will address the unusual expense and premium structure of these plans, and enable insurers to apply for an adjustment to reported medical claims and quality improvement expenses. *Catch #1:* Since limited data are available regarding this adjustment, insurers of mini-med plans are on an accelerated reporting schedule. *Catch #2:* Mini-med plans must provide prominent notice regarding the benefits and coverage provided by the policy. ❖