

# SAVITZ ADVISORY

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May 27, 2010

Philadelphia ♦ Atlanta ♦ Boston

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## Savitz Health Care Reform News

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We're all being bombarded by the media and professional publications with topics and opinions about health care reform. Some information is valuable, some is confusing and some is wrong. Savitz has chosen to share what is known with our clients and friends of the firm and to update you as events and official clarifications unfold. With a few "effective dates" already here or in the near future, we want to give you a heads up for things you may need to address in the next few months related to health care reform and related legislation.

This is a difficult time for employers because reform has created significantly more questions than answers and guidance from the responsible agencies is still being developed. Keeping this in mind, here are some changes you need to make and/or evaluate.

### **FLSA Breast Feeding Break Requirement**

As soon as the reform law was enacted, employers subject to FLSA were immediately required to furnish reasonable breaks to nursing mothers with an infant up to one year of age to express milk for their infants in a place that is shielded from public view, other than a bathroom. Breaks taken during work hours do not have to be compensated. Employers are not free to dictate when or how long the breaks must be. Employers with less than 50 employees who can demonstrate that they would experience undue hardship in complying with these regulations are exempt. Further guidance on how employers are to comply is forthcoming.

This is a federal mandate now but the federal law does not override existing state laws if those laws provide more generous benefits. Many of the mid-Atlantic and New England states have laws allowing breastfeeding in any private or public location.

### **Temporary Reinsurance Program**

Guidance has been issued and applications for this program will be accepted starting June 1, 2010. For employers who still offer retiree medical benefits, a retiree reinsurance program will reimburse plan sponsors for 80% of claims between \$15,000 and \$90,000 for early retirees who are age 55 or older and who are not eligible for Medicare and their covered dependents regardless of age. Both fully insured and self funded employers are eligible to apply. The application process is described as very similar to RDS (Retiree Drug Subsidy). Claims from June 1, 2010 are eligible for reimbursement and the program is scheduled to run to 2014. This is a "first come, first served" program and once projected payouts meet the \$5 billion dollar budget, there is a distinct possibility that the program will not accept any further entrants.

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## Grandfathered Plans

Many plans in existence as of March 23, 2010 are considered “grandfathered”, which means some of the healthcare reform laws do not apply until they lose that grandfathered status. We are waiting for further guidance to determine what will trigger the loss of that status. With respect to collectively bargained plans, they are considered grandfathered provided the latest collective bargaining agreement has been ratified prior to or up through March 23, 2010. When the latest collective bargaining agreement expires, sometime after March 23, 2010, unions will be required to comply with the applicable health care reform regulations.

## Within the next few months

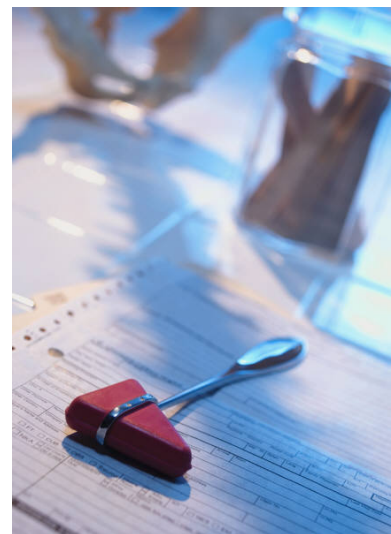
A few of the key mandates that employers will need to address for plan years beginning after September 23, 2010, even those employers who have “grandfathered” plans include:

- **Adult Dependent Children to Age 26** - must be eligible for coverage under their parent’s medical plan, even if they are married. (If the plan was in existence as of March 23, 2010, the plan is not required to provide coverage to any child who is eligible for coverage under another employer plan until 2014.) On April 27<sup>th</sup>, the IRS issued guidance for employers about the taxability of these benefits. The IRS notification and guidance can be accessed at <http://www.irs.gov/pub/irs-drop/n-10-38.pdf> . This guidance is causing some confusion since it addresses the preservation of the tax free status of health benefits for dependents up to age 27 vs. PPACA’s guidance to offer coverage to dependents up to age 26. The IRS guidance allows retroactive changes to plans to allow adult dependents into the plan and preserves the non-taxability of benefits and the ability to pay for plan costs with pre-tax dollars. Plan documents need to be amended for this change retroactively to no earlier than March 30, 2010 and amendments must be in place no later than December 31, 2010. HHS also released guidance on May 10th that states that a “qualified individual must be offered all of the benefit packages available to children who did not lose dependent status and he/she cannot be

required to pay more for coverage”. This means that the employer can not increase plan premium costs to employees for adding adult dependents. They must be treated as all other dependents.

- **Pre-existing Conditions** - For children under age 19, pre-existing condition exclusions must be eliminated in group health plans.
- **Lifetime/annual Dollar Limits** - Lifetime dollar limits can no longer be imposed by health plans beginning with renewals effective September 23, 2010 and later. For fully insured employers with lifetime maximums at or below \$1 million, this provision is expected to cause an increase in premiums at renewal. For self funded employers, there may be some cost implications for stop loss renewals. Carriers are exploring the impact of these provisions on their books of business now. The annual limits on “essential health benefits” must comply with caps (to be defined by HHS) for plans renewing effective September 23, 2010 and later.

All of the above mandates will require employers to amend plan documents and SPDs and coordinate plan design changes with insurance carriers and TPAs.



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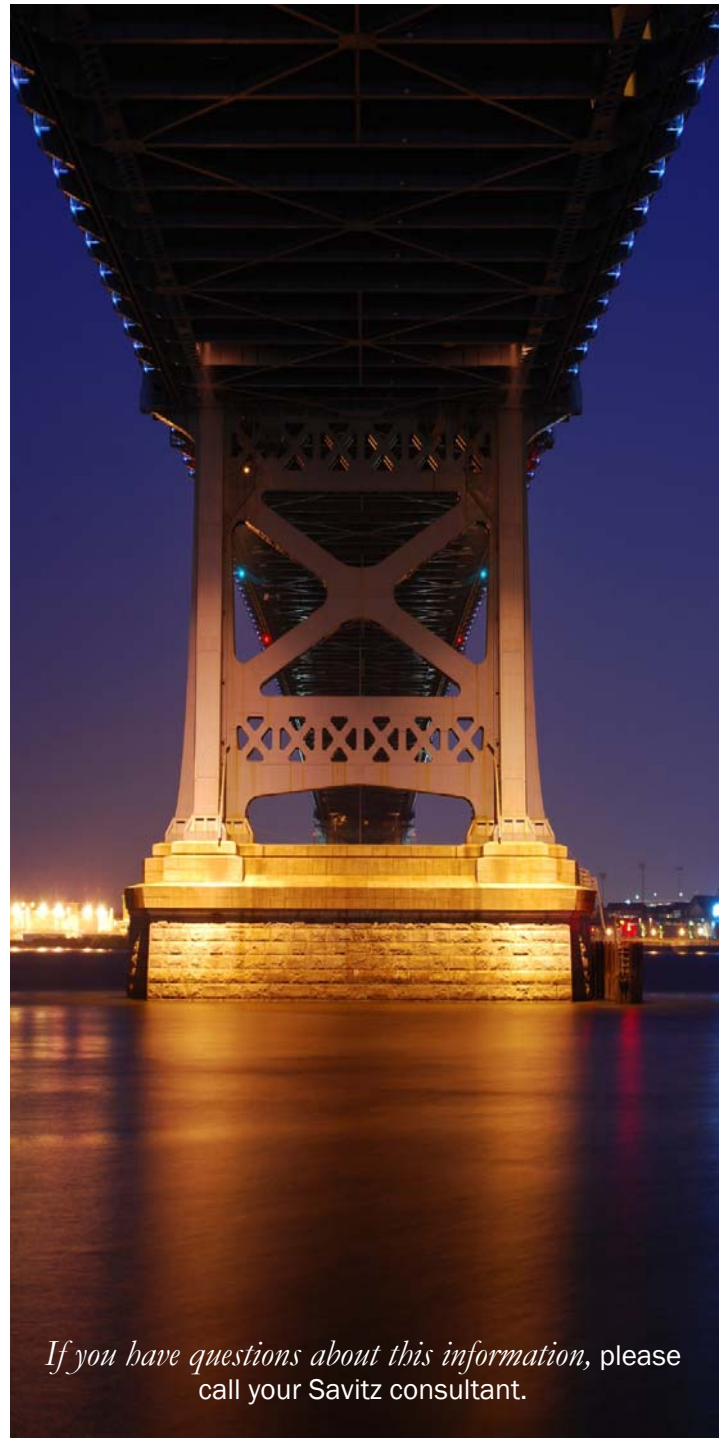
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Changes effective for January 1, 2011 and later include:

- **OTC Medication Limits** – After January 1, healthcare flexible spending accounts (FSAs), HSAs and HRAs will only be allowed to reimburse OTC medications if the employee's healthcare provider writes a prescription for the medication.
- **W-2 Reporting** - Companies will be required to report the value of 2011 employer-provided health insurance coverage on the annual Form W-2 provided to employees in 2012. This will require payroll to be ready to capture and report this information. Benefits subject to this reporting include medical, prescription drugs, EAPs, dental/vision IF they are bundled with the medical plan, on-site medical clinics if they provide more than *de minimus* care, and Medicare supplement or Advantage plans.
- **Federal Long Term Care** - Employers may permit employees who desire to participate in the new federal long term care program to make contributions by means of a payroll deduction. (The employer is not required to contribute toward this long-term care program and may not be required to allow payroll deduction for the premiums.) Guidance on this is not required until October 2012 but the program is effective January 1, 2011.

This is not intended to be an exhaustive list. Our intention is to make you aware of the benefits issues emerging as a result of reform and to help you work through them in an organized manner so you will not be overwhelmed with changes at plan year end. For employers who want to do further research, we have found the following resources to be accurate and reliable and you can sign up for automatic email updates as news breaks on reform:

- Kaiser Family Foundation - <http://healthreform.kff.org/>
- American Benefits Council - <http://www.americanbenefitscouncil.org/>
- DOL/ EBSA - <http://www.dol.gov/ebsa/faqs/faq-PPACA.html>



*If you have questions about this information, please call your Savitz consultant.*