



Healthcare Reform Changes Affecting Coverage Of Children

By Callan Carter (San Francisco)

The recent health care reform legislation made two significant changes regarding health benefits provided to an employee's adult child:

1. Extension of group health plan eligibility to children up to age 26, effective with the first plan year following September 22, 2010; and
2. Favorable tax treatment of health plan coverage provided to an employee's child who has not attained the age of 27 as of the end of the calendar year, effective March 30, 2010.

This article will provide a brief overview of both provisions.

Extension of Coverage to Age 26

Most plans will now be required to provide coverage for adult children until age 26, beginning with the first plan year following September 22, 2010. Historically, group health plans could define dependent child any way they wanted, except for fully-insured plans which had to comply with the definition of "dependent" for the state in which the policy was issued. Recently, many states have started to require coverage of "older-age dependents" (children older than 23).

Now, all plans must cover children up to age 26, regardless of their student status, marital status or ability to financially support themselves. The plan does not, however, have to cover the older-age dependent-child's spouse or child. The plan may not impose a surcharge on older age dependents, other than an increase in premium resulting from a change in the elected tier of coverage when an employee adds their older-age dependent to their coverage. For plan years before 2014, grandfathered plans do not have to extend coverage to older-age dependents if the older age dependent is eligible for health insurance under their employer's health plan.

Employers must send a notice to all employees eligible to participate in health benefits informing them of this change and giving them a 30-day enrollment period in which to enroll their older age dependent. For calendar year plans, this notice must be sent in November 2010.

Tax Treatment Of Employees' Children Under Age 27

The Internal Revenue Service has provided the first guidance on the expansion of favorable tax treatment of health benefits provided to children up to age 27. Prior to March 30, 2010, only the employee, the employee's opposite-sex spouse and the employee's "tax dependents," were eligible to



receive employer-provided health coverage on a tax-favored basis. Tax dependent is defined under the IRS Code as either a "qualifying child" or a "qualifying relative" of the taxpayer.

The health care reform legislation does not change the definition of a tax dependent, but rather expands the exclusion from gross income for medical reimbursements and accident and health coverage. The definition now includes expenses incurred by, and coverage provided to, the "employee's child" who has not attained the age of 27 by the end of the calendar year.

The term "employee's child" includes the son, daughter, stepson or stepdaughter of the employee. It also includes the employee's legally adopted child, a child placed for adoption, and eligible foster children. It does not require that the child satisfy the Code's definition of a tax dependent.

Generally, this means that on and after March 30, 2010, an employee may pay premiums on a pre-tax basis for coverage provided to a child who has not attained age 27 during that calendar year. Also, any employer contribution on behalf of these children will not be treated as imputed income to the employee. Further, the child's qualified medical expenses are eligible for reimbursement from a health Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA). But such expenses are not eligible for reimbursement through the employee's Health Savings Account (HSA) unless the child qualifies as a tax dependent of the employee.

The legislation did not change the tax treatment of coverage provided to domestic partners and same-sex spouses. A domestic partner or same-sex spouse must still be a tax dependent of the employee to receive tax-favored treatment.

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CMS Release Updates HRA Coverage Reporting

By Callan Carter (San Francisco) and Patricia Harris (Atlanta)

On June 25, 2010, the Centers for Medicare and Medicaid Services (CMS) released an updated Group Health Plan User Guide related to the Medicare Secondary Payer Mandatory Reporting requirements applicable to group health plans. The new rules dictate when a group plan must pay claims as the “primary insured” for an employee or the employee’s spouse or eligible dependent if that individual is covered by both the plan and Medicare.

Among the issues addressed in the updated guide are references to changes in reporting for Health Reimbursement Arrangements (HRAs). CMS has removed all references from the updated guide that previously referred to reporting only for “free-standing” HRAs. Prior versions of the guide also referenced “imbedded coverage” as HRA coverage that was part of a more comprehensive or standard group health plan that need not be separately reported.

What does this mean for group health plans going forward? It means that all HRA coverage must now be reported by the “responsible reporting entity” (RRE) if it otherwise meets the reporting requirements, regardless of whether the HRA is considered to be “imbedded” or “freestanding” coverage. If a group plan provides both standard coverage and HRA coverage, then the RRE may need to submit two records to CMS – one for the standard coverage and one for the HRA coverage.

Note that RREs are not required to report HRA coverage retroactively. Instead, HRA coverage must only be reported for coverage effective on or after October 1, 2010. In addition, the guide stipulates that only HRA coverage which reflects an annual benefit value of \$1,000 or more is to be reported. Therefore, HRA coverage with an annual benefit amount that totals less than \$1,000 will be exempt.

Please contact a member of the Employee Benefits Practice Group if you have questions regarding the new reporting obligations applicable to HRAs.

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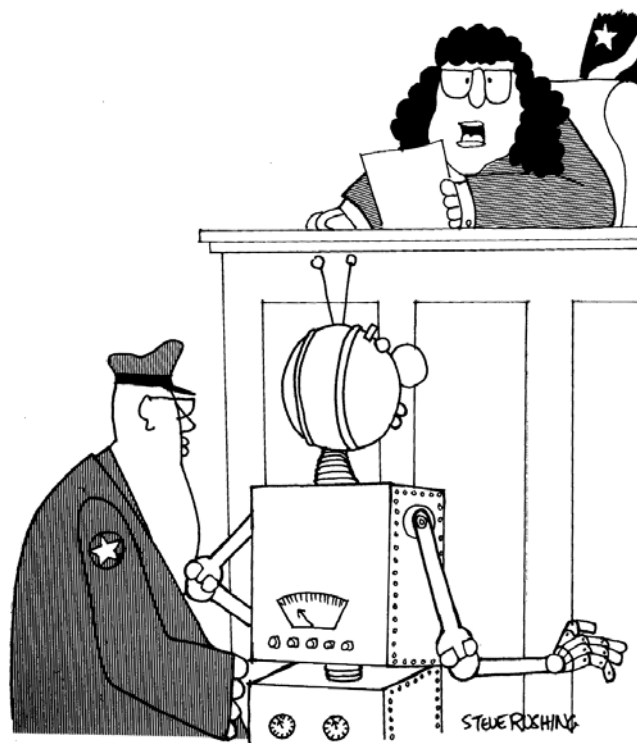
The Effect Of Changes On Plan Documents

Cafeteria plans must be amended to include children who have not attained the age of 27 as of the end of the taxable year as eligible dependents. As of March 30, 2010, you may permit employees to immediately make pre-tax salary reduction contributions for accident and health benefits under the cafeteria plan (including the FSA) for children under age 27, even if the plan has not yet been amended to reflect this change.

The amendment must be made *no later than December 31, 2010*, however, to reflect the first date in 2010 (no earlier than March 30, 2010) when employees were permitted to make pre-tax salary reduction contributions for children up to age 27. Also, as of January 1, 2011, health FSAs may no longer reimburse over-the-counter medicines without a doctor’s prescription (except for insulin). When you amend your cafeteria plan’s definition of eligible dependents, you might as well make this change to reimbursable medical expenses, as well.

Finally, since federal law will require most plans to provide coverage for adult children until age 26 beginning with the first plan year following September 22, 2010, health plan documents’ definition of dependent child must be reviewed and amended as well to reflect this change in the law.

For more information, contact the author at ccarter@laborlawyers.com or 415.490.9000, or contact any member of the Employee Benefits Practice Group.



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