

ALERT: HEALTH CARE REFORM BILL

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FIRST THINGS FIRST: HEALTH CARE REFORM IN 2010 AND 2011

The parts of health care reform getting the most fanfare – employer and individual mandates, health insurance exchanges and excise taxes on high value plans – aren't effective until 2014 or later. Health care reform has many provisions, however, and a surprising number of them become effective in 2010 and 2011. Employers may want to plan compliance starting with the items that have the earliest effective dates.

A temporary reinsurance program for early retiree coverage and a tax credit for certain small employers that provide health coverage are among the first measures to become effective. Several “insurance reforms” become effective as early as September 23, 2010 and will apply to both insured and self-insured employer-sponsored health plans. Other provisions that have early effective dates and affect employment-based plans include:

- Insurers reporting medical loss ratios and providing rebates if minimums are not met
- Restrictions on health FSAs, HRAs, HSAs and Archer MSAs reimbursing over-the-counter medications
- Increased penalties in the case of distributions from HSAs and Archer MSAs for non-qualifying expenses
- Reporting the value of health coverage on W-2s
- Simple cafeteria plans for small employers
- Preparing and providing uniform explanations of coverage

REINSURANCE PROGRAM FOR EARLY RETIREE COVERAGE

By June 21, 2010, the Department of Health and Human Services (HHS) is required to implement a temporary reinsurance program that provides for reimbursement to employers providing coverage for early retirees (those between the age of 55 and Medicare eligibility). The program may provide reimbursement of up to 80% of the costs of an individual's medical claim to the extent the costs exceed \$15,000 but are not more than \$90,000. The reinsurance program is a short-term fix to shore up early retiree coverage until longer-term measures (e.g., underwriting reform and health insurance exchanges) make coverage more widely available for this group. It also counteracts incentives for employers to drop early retiree coverage.

The reinsurance program is available to a group health plan maintained by one or more current or former employers (including state or local governments), an employee organization, a VEBA or a multiemployer plan.

- A plan receiving reimbursement must implement programs and procedures to generate cost savings for participants with chronic and high cost conditions. Reimbursements cannot be used as general revenue.
- Documentation must be kept and submitted for the actual costs of items and services for which a claim is submitted.
- Submitted claims are based on the actual amount expended by the plan within the plan year and take into account any discounts, subsidies, rebates or remuneration to the plan. Costs paid by the early retiree, spouse or dependent for deductibles, co-payments or co-insurance are included as amounts expended by the plan.
- Reimbursements from the reinsurance program will not be included in the employer's gross income.
- HHS will conduct audits of claims to ensure compliance with the program.

In order to participate in the program, application must be made in a manner to be determined by HHS. The total appropriated to this program is \$5 billion, and it ends on January 1, 2014 (sooner if funds run out). As this is a temporary program, participation applications may be denied based on funding availability, so qualifying employers will want to apply promptly when the process for doing so is established.

SMALL EMPLOYER TAX CREDIT

A temporary sliding-scale small employer tax credit to help offset the cost of employer-provided coverage is available starting this year. The tax credits are provided in two phases and the amount available depends, in part, upon whether the employer is tax-exempt. An eligible small employer has no more than 25 full-time equivalent employees with annual average wages of less than \$50,000. To qualify, the small employer must pay at least 50% of a benchmark premium toward the cost of health insurance coverage it purchases for its employees. Salary reduction (employee pre-tax) contributions are not counted as part of the employer's contribution.

From 2010 through 2013, qualifying small employers will be eligible for a tax credit of up to 35% (25% for tax exempt employers) of the employer's actual contribution (excluding salary reduction contributions) toward the employee's health insurance premium. The smallest businesses – those with 10 or fewer employees who have average annual wages of less than \$25,000 – will be eligible for full credit. The tax credits phase out as firm size and wages increase. In 2014, qualifying small employers must participate in an insurance exchange in order to claim the credit, but the maximum credit increases to 50% of employer contributions (a reduced credit is available for tax exempt employers). Qualifying employers may only claim the credit for up to two years after 2013.

The IRS has posted **information regarding this tax credit on its website**, including **responses to frequently asked questions** that provide details on which small employers qualify and how they go about claiming the credit. The IRS information makes clear that qualifying employers may claim the credit on the tax return they file for their 2010 tax year with respect to coverage they provide during 2010.

SOME INSURANCE REFORMS APPLY TO GROUP HEALTH PLANS

The health care reform law includes hundreds of insurance reform measures. Most apply to subsets of insurance coverage (e.g., policies sold in the small group market or policies sold on a health insurance exchange), and the insurers that issue those policies generally are responsible for compliance. While such “insurer-only” insurance reforms affect the insurance coverage that employers can buy and the premiums they will pay, employers generally are not responsible for making sure that coverage complies with those insurance reforms. That is not true of all insurance reforms, however. Several apply to “group health plans,” including self-insured plans.

GROUP HEALTH PLANS THAT MUST COMPLY

The insurance reforms that apply to group health plans were adopted in the health care reform law as amendments to the Public Health Service Act (PHSA) and were incorporated by reference into ERISA and the Internal Revenue Code (the Code). While not entirely clear, it appears from the location of the amendments within the PHSA, ERISA and the Code that the insurance reforms will apply to the same plans that currently are subject to HIPAA portability requirements. Very generally, those are plans – including ERISA plans, non-federal governmental plans and insured church plans – that directly or indirectly provide or pay for health care and cover two or more current employees at the start of a plan year. The insurance reforms described below, then, apply to both self-insured and fully insured group health plans unless noted otherwise.

Another consequence of the insurance reforms amending the PHSA, ERISA and the Code is that a variety of remedies and penalties may apply to violations.

INSURANCE REFORMS MAY NOT APPLY TO EXCEPTED BENEFITS

Several types of coverage that might otherwise be subject to the HIPAA portability rules are designated as excepted benefits that need not comply. We anticipate that these excepted benefits will also be exempt from the new group health plan insurance reforms. If so, most dental and vision plans and health flexible spending accounts will be exempt from the new requirements. (Details on the plans that are subject to or exempt from the HIPAA portability provisions are provided in Chapter 9 of Willis' online *Compliance Manual*.)

ADDITIONAL EXEMPTION FOR GRANDFATHERED PLANS

In addition to the HIPAA portability exemptions that we believe will apply, there is an exemption from some of the group health plan insurance reforms for grandfathered plans. A grandfathered health plan (sometimes referred to simply as a grandfathered plan) is any group health plan or individual coverage, provided that the coverage was in effect and an individual was covered under the plan on March 23, 2010 (the date of enactment). The grandfathered status continues for an unlimited time (previous health care reform bills only provided a limited five-year period).

Not only can grandfathered status continue indefinitely, grandfathered plans can retain their status even if they allow current enrollees to add family members or allow new enrollees into their coverage. Similarly, the coverage and terms of grandfathered plans may be changed without losing grandfathered status. (There is speculation, however, that regulators will issue guidance indicating that major changes may result in loss of grandfathered status.) Therefore, it appears that current employer plans will be grandfathered indefinitely.

Unfortunately, grandfathered plans are not exempt from all of the group health plan insurance reforms (making them not grandfathered for these purposes). Many proposed exclusions for grandfathered plans were stripped out of the final health care reform bill (see the chart below for specific insurance reforms that apply to grandfathered plans).

Many employers who currently sponsor group medical plans are questioning the utility of continued maintenance of those plans. The general feeling is that if all plans are the same, then there is little business sense in using group medical plans as a differentiator. However, a closer look at the legislation reveals that reasons to maintain current plans may continue. That is because, despite many of the benefit mandate requirements, the grandfather provision will permit those plans that were in existence as of March 23, 2010 to retain many individual components that employers can use to the benefit of their employees.

The only exemptions that apply to grandfathered plans relate to insurance reform provisions (i.e., the provisions listed in the chart below). There are many other provisions in the health care reform legislation that will affect employer plans, including tax law changes and the employer and individual mandates. Among the items that apply equally to grandfathered and non-grandfathered plans are the following provisions – which are addressed following the section below on 2010/2011 insurance reforms:

- Insurers reporting medical loss ratios and providing rebates if minimums are not met
- Restrictions on health FSAs, HRAs, HSAs and Archer MSAs reimbursing over-the-counter medications
- Increased penalties in the case of distributions from HSAs and Archer MSAs for non-qualifying expenses
- Reporting the value of health coverage on W-2s
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SUMMARY OF EFFECTIVE DATES FOR INSURANCE REFORMS AND IMPACT OF GRANDFATHER RULES

The listing below shows the general effective dates of insurance reforms that apply to group health plans, and the exemptions that grandfathered plans receive from those reforms.

EFFECTIVE DATE	INSURANCE REFORM MEASURE	PLANS AFFECTED
EFFECTIVE FOR PLAN YEARS STARTING ON OR AFTER SEPTEMBER 23, 2010	<ul style="list-style-type: none"> ■ No lifetime dollar limits on “essential health benefits” ■ No annual dollar limits on “essential health benefits” (except as determined by HHS) ■ No revocation of coverage (except for fraud/intentional misrepresentation) ■ No preexisting condition exclusions for enrollees under age 19 ■ Requirement that plan coverage be available for children until they reach age 26 (grandfathered plans may deny coverage to any child who is eligible for other employment-based health coverage) 	APPLIES TO BOTH GRANDFATHERED AND NON-GRANDFATHERED PLANS
	<ul style="list-style-type: none"> ■ Requirement for coverage of certain preventive health services and immunizations without cost-sharing ■ No discrimination in favor of higher-wage employees (self-insured plans continue to be subject to prior non-discrimination rules) ■ Requirements to provide patient protections regarding emergency services, choice of primary care provider, and access to gynecological/obstetric services ■ Requirement for internal and external appeals processes 	APPLIES ONLY TO NON-GRANDFATHERED PLANS
EFFECTIVE FOR PLAN YEARS STARTING ON OR AFTER JANUARY 1, 2014	<ul style="list-style-type: none"> ■ Waiting periods longer than 90 days prohibited ■ Preexisting condition exclusions prohibited for all enrollees ■ All annual dollar limits on essential benefits prohibited (including those previously allowed by HHS) ■ Grandfathered plans lose the ability to deny coverage to employees’ children who are under 26 based on eligibility for other employment-based coverage 	APPLIES TO BOTH GRANDFATHERED AND NON-GRANDFATHERED PLANS
	<ul style="list-style-type: none"> ■ Plans must cover routine patient costs for care in connection with clinical trials ■ Discrimination against providers prohibited as long as they act within the scope of their licenses ■ Out-of-pocket maximum can be no greater than that allowed for a high-deductible health plan offered in connection with a health savings account ■ Deductibles can be no greater than \$2,000 for single coverage and \$4,000 for family coverage (may apply only to plans offered in the small group market) ■ Wellness incentives up to 30% of individual COBRA rate permitted (federal agencies may allow additional increases up to 50%) 	APPLIES ONLY TO NON-GRANDFATHERED PLANS

2010/2011 INSURANCE REFORMS

As shown above, several of the insurance reforms that affect group health plans are effective for plan years beginning on or after September 23, 2010. (This is January 1, 2011 for calendar plan years and sooner for plans having a plan year beginning October, November or December 1.) We refer to these as the 2010/2011 reforms. A second group of insurance reforms, also shown in the chart above, is effective for plan years starting on or after January 1, 2014.

2010/2011 INSURANCE REFORMS: RESTRICTIONS ON ANNUAL AND LIFETIME DOLLAR LIMITS

Starting with plan years beginning on or after September 23, 2010, group health plans are prohibited from applying certain lifetime and annual limits on benefits. There is no exemption from these prohibitions for grandfathered plans. The prohibitions relate only to limits on the dollar value of benefits, however. Experience under the Mental Health Parity Act (MHPA) – before it was amended in 2008 – indicates that health plans can readily substitute treatment limitations (e.g., limits on the number of office visits or hospital days) for dollar limitations. Whether or not such limitations will be acceptable once regulatory guidance is issued remains to be seen.

Insurers issuing group health insurance policies are required to comply with these provisions, but reinsurers and stop-loss carriers are not directly subject to these requirements. Therefore, employers that sponsor self-insured plans will need to determine whether their current reinsurance or stop-loss coverage arrangements will be adequate once this provision becomes effective.

LIMITS PROHIBITED FOR ESSENTIAL HEALTH BENEFITS

To the extent that a plan provides benefits other than “essential health benefits,” the plan may apply annual or lifetime per-beneficiary limits on specific covered items. HHS is charged with defining essential health benefits according to criteria set out in the legislation and ensuring that essential health benefits include at least items and services in the following broad categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Because these categories are so broad, it appears that almost all benefits provided by most employer-sponsored medical benefits will qualify as essential health benefits and cannot be subject to lifetime or annual dollar limits. In the case of annual dollar limits, HHS may allow plans to impose such limits with respect to essential health benefits during plan years beginning before 2014.

INTERACTION WITH MENTAL HEALTH PARITY REQUIREMENTS

Under the MHPA as amended in 2008, lifetime or annual dollar limits on mental health and substance use disorder benefits generally cannot be any lower than similar limits on medical and surgical benefits. (Restrictions on financial requirements and treatment limitations were added to the MHPA in 2008, but the basic parity requirement for annual and lifetime dollar limits was retained.) When the prohibition of annual and lifetime dollar limits on essential health benefits becomes effective, any such limits on mental health and substance use disorder benefits must also be eliminated.

COVERAGE EXEMPT FROM INSURANCE REFORMS MAY STILL APPLY LIMITS

As noted earlier, if the HIPAA portability rules define the plans that are subject to the insurance reforms, we can reasonably expect that the exemptions from the HIPAA portability rules will also apply. In the case of lifetime and annual dollar limits, this is particularly important for dental plans, vision plans and health FSAs. In addition, so-called “mini-med” programs may avoid these prohibitions if, among other things, they provide only fixed indemnity insurance coverage (e.g., paying \$15 each time an enrollee visits a doctor, regardless of the actual charges for the visit). If these programs provide even one benefit that reimburses the cost of health care, however, they cannot qualify for this exemption. Employers relying on this exemption will want to review these programs carefully.

2010/2011 INSURANCE REFORMS: RESCISSIONS PROHIBITED

Under these provisions, group health plans – including grandfathered group health plans – are prohibited from rescinding an enrollee’s coverage once the enrollee is covered under the plan, unless the enrollee has engaged in fraud or made an intentional misrepresentation of material fact. It is not clear currently how this provision will affect an employer’s ability to terminate coverage upon discovery of an enrollee’s ineligibility (e.g., an ex-spouse that the employee did not drop at

the time of the divorce). Regulatory guidance is needed to clarify whether retroactive cancellation is ever permitted in such cases and the circumstances in which prospective cancellation is permitted. Like the other 2010/2011 insurance reforms, this prohibition is effective for plan years starting on or after September 23, 2010.

2010/2011 INSURANCE REFORMS: NO PREEXISTING CONDITION EXCLUSIONS FOR CHILDREN

The health care reform legislation substitutes a complete ban on applying preexisting condition exclusions to children for the current restrictions on preexisting condition exclusions under HIPAA. Currently, plans may not apply preexisting condition exclusions to newborns and children under age 18 so long as they are enrolled in creditable coverage within 30 days after birth, adoption, or placement for adoption and have not had a break in creditable coverage exceeding 63 days. For plan years starting on or after September 23, 2010, the rule is much simpler – plans cannot apply any preexisting condition exclusion to anyone under age 19. This rule applies to both grandfathered plans and non-grandfathered plans. In addition, the requirement expands to cover all enrollees (i.e., no preexisting condition exclusion may be applied to anyone) for plan years beginning in 2014 or later.

Presumably, the prohibited preexisting condition exclusions are those defined in the HIPAA portability rules: limitations or exclusions of benefits relating to a condition based on the fact that the condition was present before the first day of coverage.

2010/2011 INSURANCE REFORMS: COVERAGE OF ADULT CHILDREN TO AGE 26

Normally, to be considered a dependent, the child must be financially dependent and live with the parent. Historically, employer-sponsored group health plans often provided that children who are full-time students may continue on their parent’s coverage to a certain age, such as 22.

In recent years, state legislatures around the country have enacted a variety of proposals intended to reduce their numbers of uninsured. One popular approach has been the passage of insurance laws requiring the extension of coverage for dependent children. Although many health insurance plans already provided dependent coverage up to age 19 (typically with an available three- to five-year eligibility extension for full-time students), these state laws began to require coverage for even older dependents regardless of student status. In some instances, state mandates for insured coverage required longer

periods of coverage that took a dependent beyond financial dependency and occasionally raised federal income tax issues for parents. (Tax issues further discussed below.)

As with other employee benefits initiatives, the federal government has taken its cue from the states and has now enacted a requirement stipulating that plans that cover dependent children must provide health coverage for such children until they reach age 26. (In other words, eligibility may end at the attainment of age 26.) The law does not mandate coverage for dependent children, but if dependent coverage is available, then eligibility must be extended until a child turns age 26. This requirement is effective for plan years beginning after September 23, 2010 (January 1, 2011 for calendar-year plans).

Although coverage for dependent children generally must remain available to age 26, until plan years starting in 2014, grandfathered plans may exclude children who are eligible for other employment-based coverage. (In other words, until 2014, grandfathered group health plans only have to cover dependents that do not have another source of employer-sponsored coverage.)

It's worth noting that there is no requirement for employer plans to cover the children of covered dependent children (e.g., a worker's grandchild). Further, while plans cannot limit coverage to unmarried adult children under age 26 – no mention is made of a need to offer coverage to the spouse of an adult child. Presumably, since an adult child is different from an adult child-in-law, coverage need not be available to the adult child's spouse, but forthcoming regulatory guidance may explain the distinction.

The expansion of health coverage eligibility for adult children applies to all group health plans – both insured and self-funded. Although employers are likely to see increased plan costs due to the anticipated higher enrollment numbers, tax code changes should generally help simplify payroll administration. In addition, plan sponsors will need to carefully review and update all of their health plan materials (e.g., summary plan descriptions, plan documents, enrollment materials, employee handbooks and related miscellaneous documents) to ensure that participants are accurately advised of the newly expanded enrollment opportunities.

EFFECT ON OTHER LAWS

State Mandates. Nothing in the federal health care reform package changes rules under state law. Consequently, insured programs currently subject to states' coverage mandates that extend beyond age 26 would continue to apply. For example, in New Jersey insured coverage generally applies for dependents through attainment of age 31. New Jersey law also imposes other qualifying criteria on the dependent (e.g., must be unmarried, have no dependents, ineligible for Medicare or covered under other insurance, and a New Jersey resident). (For additional information about state insurance mandates for dependent coverage, please see ***HR Focus, Issue 12, "Over-Age and Under-Insured: Extending Benefits for Dependents."***)

Michelle's Law. When Congress enacted Michelle's Law in 2008 (a law which applies to plan years beginning on or after October 9, 2009), it provided for the continuation of health care coverage during a medically necessary leave of absence for seriously ill or injured college students who are dependents. Group health plans cannot terminate coverage of a dependent child due to loss of full-time student status during a medically necessary leave of absence before the date that is the earlier of:

- The date that is one year after the first day of the medically necessary leave of absence
- or**
- The date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage

Although nothing in health care reform rescinded Michelle's law duties, the fact that federal law now extends coverage until age 26 (an age well past student status for most individuals), the need for Michelle's law protections is obviated to some degree.

Federal Tax Law. Benefits provided to adult children until the end of the year in which they turn age 26 are non-taxable regardless of dependent status. In fact, the health care reform legislation changed the federal tax exclusion of amounts expended for medical care to include medical care received "by any child of the taxpayer who as of the end of the taxable year has not attained age 27" (i.e., any child who is age 26 or under on December 31).

This welcome change presumably offers comprehensive protection against parents incurring surprise tax liability based on coverage received by their child, which might otherwise necessitate imputing the value of coverage received by the adult child to the employee.

Interestingly, though Congress had the opportunity to also address the long-standing "domestic partner" tax problem (an issue that generally obligates plan sponsors to impute the value of health coverage received by domestic partners), it chose to maintain the status quo. Consequently, where a plan offers health coverage to domestic partners (or children of domestic partners) who do not fit the precise tax definition of qualified dependent, the employer will have a duty to calculate the value of coverage and impute that amount as additional taxable compensation. (For additional information about taxation of benefits for domestic partners, please see Willis ***Employee Benefits Alert #63.***)

2010/2011 INSURANCE REFORMS: COVERAGE OF PREVENTIVE CARE

This requirement is effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). Grandfathered plans are exempt from this provision, however.

Group health plans will have to cover specific preventive care services with no cost-sharing. In other words, plans must provide unrestricted, first-dollar coverage for certain types of preventive care, such as well-child care or certain immunizations.

Preventive services are those that are included on the list of preventive services of the **U.S. Preventive Services Task Force** that are either Strongly Recommended (A rating) or Recommended (B rating).

Important questions remain about what specific types of coverage will be directed in the future as comparatively little detail was included in the statutory language – apart from alarmingly reserving the HHS huge regulatory authority to impose necessary changes as it sees fit down the road.

2010/2011 INSURANCE REFORMS: NONDISCRIMINATION RULES FOR INSURED PLANS

Grandfathered plans are exempt from this provision. Otherwise, this change will apply to plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans).

Under the health care reform law, nondiscrimination rules of Code § 105(h) that were previously applicable only to self-insured health plans are now extended to fully-insured group health plans. This means that affected group health plans will be required to comply with the Code § 105(h) rules that prohibit self-insured plans from discriminating in favor of highly compensated individuals.

The Code imposes a variety of discrimination testing rules on different types of employee benefits (e.g., life insurance benefits, retirement programs, cafeteria plans, etc.) For group health plans, the actual applicable testing obligation depended on whether a plan was self-funded or insured. Fully insured plans avoided the toughest discrimination testing requirements. By contrast, self-funded plans face fairly strenuous nondiscrimination obligations under Code § 105(h). Now, among the health care reform statute's many significant changes, those obligations will also apply to insured group health plans.

Nondiscrimination rules are generally designed to measure whether a plan impermissibly favors highly compensated workers for purposes of eligibility or benefits. If the IRS were to determine an employer's plan discriminatory, those highest-earning employees are the ones that would likely feel the impact, since the IRS would likely deem any discriminatory benefits as additional taxable compensation to the recipients. Not only would this produce the unwelcome result of generating unexpected compensation for the highly compensated individuals, but it might also result in penalties to the employer for under-reporting income and under-paying corresponding employment taxes that would be due (with corresponding penalties and interest).

The discrimination testing exception for grandfathered insured programs offers a useful loophole for many organizations to deliver enhanced benefits to select employees. Now that governing health care reform requirements add discrimination testing requirements to new insured health plans, many employers will have to rethink strategies for providing richer benefits to highly compensated employees.

2010/2011 INSURANCE REFORMS: NEW PATIENT PROTECTIONS

Effective for plan years beginning at least six months after enactment (January 1, 2011 for calendar-year plans), group health plans are required to provide participants with certain rights. The good news for existing group health plans is that these requirements are subject to the grandfathered plan exemption.

CHOICE OF PRIMARY CARE PROVIDER

For those group health plans that require a plan participant to designate a primary care provider, the plan must allow each participant to choose any participating primary care provider (who is available to accept the participant as a patient). In addition, the plan must allow participants with children to select a doctor who is participating in the network and specializes in pediatric medicine as a child's primary care provider. The right to choose a pediatrician as the child's primary care provider is not intended to waive any coverage exclusions under the terms of the plan in regard to pediatric care. Several states already have insurance laws that provide similar "freedom of choice" rights to participants in insured plans.

ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

Female plan participants seeking obstetrical or gynecological care from a participating health provider (specializing in those specific areas of medicine) under a plan that provides coverage for obstetric and gynecologic care and requires the designation of a participating primary care provider must be provided direct access to the provider. This means that the plan cannot require pre-authorizations or referrals for obstetrical or gynecological care services. Obstetrical and gynecological care providers will have the same authority to provide obstetrical and gynecological care and order related services and items as primary care providers. This right is not intended to waive any coverage exclusions under the terms of the plan relative to obstetrical or gynecological care or preclude the plan from requiring that the provider notify the plan or primary health care provider of any treatment decisions.

BENEFITS FOR EMERGENCY CARE

If a group health plan covers any services in a hospital's emergency department, the law requires that the plan cover emergency care services without the need for preauthorization and regardless of whether the health care provider furnishing the services is a participating provider. Among other things, this means that, if services are provided by a non-participating

provider, the plan cannot require prior authorization or impose any limitations on coverage that are more restrictive than the limitations that apply to emergency department services rendered by participating providers. If emergency care is provided on an out-of-network basis, cost-sharing requirements (expressed as a copayment amount or coinsurance rate) must be the same as those that apply to services provided in-network. Emergency services must be provided without regard to any other term or condition of such coverage other than exclusion or coordination of benefits, affiliation or waiting periods (as permitted for purposes of limitations on pre-existing condition exclusion periods under the PHSA, ERISA, and the Code) and applicable cost-sharing.

The law defines emergency services as including the following, when applied to emergency medical conditions: medical screenings (within the capabilities of the hospital's emergency department) and ancillary services routinely available to the emergency department to evaluate such conditions, as well as any additional examinations and treatments necessary to stabilize the patient. An emergency medical condition is defined as a condition which manifests itself through symptoms of such severity that a prudent person (with average medical knowledge) would reasonably think that failure to receive immediate medical attention will:

- Place the individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any bodily organ or part

Many plans already cover services for emergency medical conditions, but applying the same cost-sharing arrangement to in- and out-of-network care will likely result in increased costs for the plan.

2010/2011 INSURANCE REFORMS: INTERNAL AND EXTERNAL APPEAL PROCEDURES

For plan years beginning on or after September 23, 2010, group health plans are required to implement an appeals process that addresses both coverage determinations and specific benefits claims. For calendar-year plans, claim appeals procedures must be in place on January 1, 2011. To the extent that an insured plan or a self-insured plan existed on March 23, 2010, the plan is permanently grandfathered and is exempt from the new appeals process requirements (but, that plan sponsor must have already complied with the ERISA medical claim appeal procedures that were published back in 2000).

The appeals procedures must:

- Inform enrollees, in a culturally and linguistically appropriate manner (there is no current guidance about what "culturally and linguistically appropriate" means – it may mean more broad use of summary materials that are translated into various languages appropriate for the employer's employee population) that is easily understandable by the average plan enrollee, that there is an internal and external appeals process.
- Enrollees must also be told that, to the extent that their state has created an "office of health insurance consumer assistance" or a "health insurance ombudsman program," enrollees may receive appeals assistance from these resources. The duties of persons working within these state resources include the following:
 - Assisting enrollees with the filing of complaints and internal and external appeals
 - Collecting, tracking and quantifying problems and inquiries encountered by consumers
 - Educating consumers on their rights and responsibilities with regard to health plan and health insurance coverage
 - Assisting consumers with enrollment by providing information, referrals and assistance
- The appeals procedures must also allow an enrollee to review his/her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.
- The *internal appeals process for group health coverage subject to ERISA* must incorporate the appeals procedures (including those for urgent claims) that are currently in force under ERISA. The claim procedures must be updated to reflect any additional standards established by the Department of Labor (DOL).

- The *internal appeals process for health coverage which is not subject to ERISA* must incorporate an appeals process that is set forth under existing applicable law as of the date of enactment (March 23, 2010). The claim procedures must be updated to reflect any additional standards established by the HHS.
- The *external appeals process for group health coverage* must:
 - In the case of an insured plan, comply with the applicable state external review process, provided that process includes at least the provisions outlined by the National Association of Insurance Commissioners (NAIC) in the Uniform Health Carrier External Review Model Act
 - In the case of a self-insured plan (or if the applicable state external review process does not meet the NAIC guidelines), the plan or insurer must implement an effective external review process that meets minimum standards established by HHS and is similar to the NAIC guidelines

INSURERS MUST REPORT MEDICAL LOSS RATIOS

All health insurers – including grandfathered plans – are required to file a medical loss ratio report with HHS for each plan year starting on or after September 23, 2010.

Generally speaking, “medical loss ratio” means the ratio of total premium collected as compared to the cost of the plan, with the cost of the plan including such factors as claims, administrative cost, risk, contingencies and provision for reserves. The legislation does not specifically note that the medical loss ratio requirements apply to dental, vision, and other ancillary coverage, so this section only contemplates these ratios for strictly medical coverage.

The medical loss ratio annual report is required for each plan year, and the legislation specifies that the report must include the ratio of the incurred claims plus any change in reserves as compared to earned premiums. The annual reports must disclose the loss ratios for any clinical services, for activities that improve health care quality and also for all non-claim costs other than federal and state taxes and licensing or regulatory fees. These reports will be available to the public via the HHS website.

In addition to the annual reporting, beginning not later than January 1, 2011, each health insurance issuer must provide a rebate for each plan year to each enrollee on a pro rata basis if the medical loss ratio (or value of the benefits compared to the cost of the providing the benefits) is less than 85% with respect to coverage offered in the large group market or less than 80% in the small group market. (States may, by regulation, designate a ratio larger than 85% in the large group market.)

Beginning on January 1, 2014, the annual rebate will be based on the averages of the premiums expended for clinical services and premiums expended for improving health care quality as well as the total premium revenue for the previous three plan years. Currently there is no definition for “clinical services,” but the NAIC is expected to issue one.

This provision seems like good news for employers. If, however, insurers pay rebates to employers rather than to individual enrollees, employers may incur liability for their handling of those rebates. Under ERISA, employers usually cannot just keep such amounts and must apply them for the benefit of plan participants.

REIMBURSEMENT FOR OTC ITEMS

In recent years, many employers have designed their health FSAs to permit reimbursement of over-the-counter drugs. However, starting with taxable years beginning after December 31, 2010, health FSAs can no longer reimburse participants for non-prescribed over-the-counter drugs/medicines (OTC items) other than insulin. Similarly, OTC items will no longer be qualifying medical expenses reimbursable under Health Savings Accounts (HSAs), Archer MSAs or Health Reimbursement Arrangements (HRAs), unless the OTC item is prescribed by an appropriately licensed health care provider or is insulin.

To the extent that plan sponsors have allowed over-the-counter drug reimbursement (without prescription) under the employer-sponsored health FSA, then the legal plan document for the FSA will need to be amended to clarify that over-the-counter drugs purchased in the new plan year that starts after December 31, 2010 will require proof of a doctor's prescription in order to be reimbursable under the plan.

Plan sponsors and TPAs administering FSAs and HRAs will need to establish a procedure for verifying that reimbursements are only granted for non-prescription drugs after a copy of a doctor's prescription is furnished to the plan administrator or TPA.

Plan sponsors must also distribute either an updated Summary Plan Description or a Summary of Material Modifications for the Health FSA or HRA.

Since employers neither administer nor hire TPAs to administer distributions from HSAs and Archer MSAs, there are no administrative steps for employers in connection with those plans. Employers may wish to review their communications materials in connection with contributions to HSAs and Archer MSAs, however, to ensure that they do not include statements about OTC items that will be inaccurate in 2011.

PENALTIES FOR NON-QUALIFYING DISTRIBUTIONS FROM HSAs AND ARCHER MSAs

Many employers have been adopting or contemplating the adoption of consumer-directed health plans. A type of consumer-directed health plan, a high deductible health plan (HDHP) coupled with an HSA was authorized by the Medicare Modernization Act of 2003, and another type of similar account with much less penetration was the Archer MSA. Both types permit distributions from the account for qualifying medical expenses on a tax-free basis, the economic theory being that the participant in such a plan can save on a tax-favored basis to pay for medical expenses. Since the consumer of the services is the same person that owns and controls the funds, the consumer will be more aware and a better steward of the funds. However, to make sure the individual uses the funds as intended (medical expenses), if the funds are used for expenses other than qualifying medical expenses (as defined by the IRS), then the distribution would be included in the participant's taxable income and be subject to an additional penalty. Starting January 1, 2011, the penalty for such non-qualifying distributions increases to 20%, in addition to the inclusion in income.

W-2s MUST INCLUDE VALUATION INFORMATION

Beginning with W-2s for the 2011 taxable year (i.e., those that are sent by the end of January 2012), the value of the employer-provided medical coverage as determined by reference to the applicable COBRA rates for the applicable coverage must be reported. For this reporting requirement, there is generally no distinction between ERISA and non-ERISA coverage, pre-tax or after-tax, employer-paid or employee-paid benefits – the value of all coverage is reported.

The only exceptions to that rule (i.e., the only amounts excluded from reporting) apply to HSA contributions made by the employee, Archer MSA contributions made by the employee and any health FSA contributions made by the employee through salary reductions. (Employer contributions to HSAs, Archer MSAs and health FSAs are included in the reported amounts.)

Presumably because of the reference to COBRA, this obligation applies to any type of benefit to which COBRA applies, regardless of whether the contributions are otherwise pre-tax or after-tax. That would seem to belie common sense as the after-tax contributions have already been included in the reported taxable income. Perhaps additional guidance or technical corrections will clarify that glitch.

SIMPLE CAFETERIA PLANS

Starting in 2011, the cafeteria plan rules are relaxed for certain small employers to encourage them to offer tax-free benefits, including those related to health insurance coverage. The rules are relaxed by carving out a safe harbor from the nondiscrimination requirements for cafeteria plans maintained by employers with no more than 100 employees. For the safe harbor to apply, the cafeteria plan must satisfy minimum eligibility, contribution and participation requirements.

UNIFORM EXPLANATIONS OF COVERAGE

No later than March 23, 2011 (12 months after passage), HHS must issue a set of standards that all medical plans will use to describe their benefits. The standards are required to ensure that every summary of benefits includes uniform definitions of standard insurance and medical terms so that consumers may compare health insurance coverage and understand the terms of coverage (or exceptions to such coverage).

Insurers and employer-sponsored medical plans will be required to start providing a summary that complies with the standards for each enrollment or reenrollment that occurs on and after March 23, 2012. Therefore, plans must have compliant summaries available starting on March 23, 2012, even if that timing does not coincide with the plan's annual enrollment cycle. For example, a calendar-year plan would begin complying on March 23, 2012 rather than waiting to implement the new requirements for enrollment materials that apply for the 2013 plan year. The new standards will specifically preempt any current state law standards that might otherwise apply.

The standards described in the law are already very precise in some ways, such as mandating the minimum size font (12-point) and the maximum number of pages (4). The language must be “culturally and linguistically appropriate” and understandable by the average plan enrollee. In addition, the HHS standards must require the summary to include:

- A description of the coverage, including cost sharing, for each of several categories of health benefits
- Exceptions, reductions, and limitations on coverage
- Cost-sharing provisions, including deductible, coinsurance, and co-payment obligations
- Renewability and continuation of coverage provisions
- A coverage facts label that includes examples to illustrate common benefits scenarios
- A statement of whether the plan provides minimum essential coverage (as defined by HHS)
- A statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions
- A contact number for the consumer to call with additional questions
- An internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

One positive feature to note is that the information can be provided either in hard copy or electronically.

AFTER 2011 – MORE

Several additional insurance reforms become effective for group health plans in 2014, and those are noted above. In addition to those, several other requirements that are relevant to employers' health plans become effective in 2012 or later.

MARCH 23, 2012

- Deadline for group health plans to provide uniform explanations of coverage (see discussion above)
- Group health plans must notify enrollees of material changes to the coverage described in the uniform explanation no less than 60 days before the change is effective
- Deadline for HHS to develop standards for annual reports to enrollees and HHS on plan benefits that improve health
- No deadline is set for HHS to issue standards for "transparency" reports that plans are to send to HHS and make publicly available, but it is expected that plans may forego preparing these reports until standards are issued (these reports are to provide information on matters including claim payment policies and practices, finances, enrollment, disenrollment, claim denials, rating practices, cost sharing, and enrollees' rights)

SEPTEMBER 30, 2012

- For policy years ending after this date, a fee of \$1 times the average number of covered lives is required for both insured and self-insured coverage

JANUARY 1, 2013

- Annual salary reduction contributions to a health FSA may not exceed \$2,500
- Subsidy for employers that provide certain retirees with coverage equivalent to Medicare Part D is no longer deductible
- 1.45% Medicare payroll tax increases to 2.35% on wages over \$200,000 (\$250,000 for joint return filers)

SEPTEMBER 30, 2013

- For policy years ending after this date, the fee noted at September 30, 2012 increases to \$2 times the average number of covered lives

JANUARY 1, 2014

- Temporary reinsurance program for early retiree coverage ends
- Employers with 50 or more full-time employees may incur "free rider" penalties if they offer no coverage or coverage that is unaffordable or insufficient

- Employers must offer free choice vouchers to certain employees
- Individuals who do not have qualifying coverage must pay an excise tax (coverage under any grandfathered plan satisfies requirement)
- Plans must report coverage information to enrollees and the IRS
- Employers with 200 or more full-time employees become subject to automatic enrollment requirements (effective date unclear – regulatory guidance needed)
- Employers become subject to notification requirements regarding insurance exchanges and subsidies
- State health insurance exchanges begin operation for individuals and small employers
- Employers that offer coverage through an exchange may permit pre-tax contributions through their cafeteria plans

JANUARY 1, 2016

- State health insurance exchanges must be available for employers with up to 100 employees

JANUARY 1, 2017

- States may allow employers of any size to access coverage through health insurance exchange

JANUARY 1, 2018

- Excise tax applies to high-cost coverage

JANUARY 1, 2020

- Fee noted at September 30, 2012 and September 30, 2013 sunsets

The observations, comments and suggestions we have made in this publication are advisory and are not intended nor should they be taken as legal advice. Please contact your own legal adviser for an analysis of your specific facts and circumstances.

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

NORTHEAST

Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
212 915 8802

Norwalk, CT
203 523 0501

Radnor, PA
610 254 7289

Wilmington, DE
302 397 0171

ATLANTIC

Baltimore, MD
410 584 7528

Bethesda, MD
301 581 4261

Knoxville, TN
865 588 8101

Memphis, TN
901 248 3103

Nashville, TN
615 872 3716

Norfolk, VA
757 628 2303

Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

SOUTHEAST

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404 224 5000

Birmingham, AL
205 871 3300

Charlotte, NC
704 344 4856

Gainesville, FL
352 378 2511

Greenville, SC
704 344 4856

Jacksonville, FL
904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
352 378 2511

Raleigh, NC
704 344 4856

Savannah, GA
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Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

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414 259 8837

Chicago, IL
312 288 7700
312 621 4843
312 348 7678

Cleveland, OH
216 357 5921

Columbus, OH
614 326 4788

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI
414 259 8837

Milwaukee, WI
414 203 5248
414 259 8837

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763 302 7131
763 302 7209

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309 764 9666

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412 586 3524

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972 715 6272

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303 773 1373

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713 625 1017
713 625 1082

McAllen, TX
956 682 9423

Mills, WY
307 266 6568

New Orleans, LA
504 581 6151

Oklahoma City, OK
405 232 0651

Overland Park, KS
913 339 0800

San Antonio, TX
210 979 7470

Wichita, KS
316 263 3211

WESTERN

Fresno, CA
559 256 6212

Irvine, CA
949 885 1200

Las Vegas, NV
602 787 6235
602 787 6078

Los Angeles, CA
213 607 6300

Novato, CA
415 493 5210

Phoenix, AZ
602 787 6235
602 787 6078

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503 274 6224

Rancho/Irvine, CA
562 435 2259

San Diego, CA
858 535 1800
858 678 2130

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415 291 1567

San Jose, CA
408 436 7000

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