

HEALTH CARE REFORM WHAT EMPLOYERS NEED TO KNOW NOW

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Over the next several years, employers and group health plan sponsors face significant new challenges under the lengthy and complex Health Care Reform Law. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and then was immediately amended by the Health Care and Education Reconciliation Act on March 30th (collectively, the “Health Care Reform Law”). These two Acts, which consist in some form or another of over 2,400 pages of legislation, drastically change health care as we know it and require immediate action and ongoing analysis and restructuring of health care benefits in the years to come.

The purpose of this handout is to alert employers and group health plan sponsors of some of the provisions within the Health Care Reform Law coming into effect in the next year that impact employee health and welfare benefits and require immediate action.

Overview

The Health Care Reform Law has numerous provisions with various effective dates which are applicable depending on group health plan status. Of key importance, the law draws a distinction between “grandfathered” and “non-grandfathered” group health plans. A group health plan (fully-insured or self-insured) or health insurance coverage which had an individual enrolled in it on March 23, 2010 (and for as long as it maintains that status pursuant to the Health Care Reform Law and its implementing regulations) is deemed “grandfathered” and is exempt from certain provisions. In contrast, a non-grandfathered health plan is required to comply with all aspects of the Health Care Reform Law applicable to group health plans. The determination of grandfather status is made separately for each benefit package made available under a group health plan. Employers and group health plan sponsors should contact an attorney immediately to determine whether they have maintained their grandfather status.

This handout summarizes various provisions of the Health Care Reform Law, indicating the effective date for each and whether grandfathered plans are exempt from the listed requirements. Please note that this memorandum does not detail every provision going into effect in any given year. An employer or plan sponsor should contact an attorney to determine what other provisions may be of impact.

Dependent Coverage for Children Up to Age 26

- Effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans)
- Application:
 - Applies to grandfathered plans (subject to exception)
 - Does not apply to HIPAA excepted benefits (i.e., stand-alone dental or vision plans)

- Requirement:
 - General: Group health plans, including grandfathered plans, that provide dependent coverage must continue to make such coverage available for an adult child until the child reaches age 26.
 - Limitation for Grandfathered Plans: For plan years beginning before 2014, a grandfathered group health plan that provides dependent coverage of children must only continue to make such coverage available for an adult child until the child reaches age 26 if such adult child is not eligible to enroll in another eligible employer-sponsored health plan other than a group health plan of a parent.
- Taxation Issues:
 - Coverage for eligible adult children will not be considered taxable income to the employee or the child through the end of the taxable year in which the child attains age 26.
- 30-day special enrollment right (including notice) and special enrollee treatment for applicable children
- Action Needed:
 - Group health plan documents, enrollment forms, notices, handbooks and any other documentation describing dependent coverage must be reviewed and appropriately updated.
 - Plan administration must be ready to handle these changes and, for the next few years, grandfathered plans should have certifications in place to ensure dependents do not have other employer coverage available.

Prohibition on Lifetime Benefit Limits and Restricted Annual Benefit Limits

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Applies to grandfathered plans
 - Does not apply to HIPAA excepted benefits
- Requirement:
 - Grandfathered and new group health plans:
 - May not establish lifetime limits on the dollar value of benefits for any participant or beneficiary; and
 - May only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of essential health benefits.
 - Beginning in 2014, group health plans may not establish annual limits on the dollar value of benefits for any participant or beneficiary.
 - Group health plans may still place annual or lifetime limits on specific covered benefits that are not essential health benefits and may still exclude all benefits for a specific condition.
- 30-day special enrollment right (including notice) and special enrollee treatment for individuals who had previously reached an applicable lifetime limit.
- Action Needed:
 - Documents and procedures must be reviewed and modified to comply with this provision.

Limited Grounds for Rescinding Coverage

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Applies to grandfathered plans
 - Does not apply to HIPAA excepted benefits

- Requirement:
 - Grandfathered and new group health plans are prohibited from rescinding coverage for individuals (including a group to which the individuals belongs or family coverage in which individuals are included) who are enrolled under the plan or insurance coverage, unless the covered individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud or unless the individual makes an intentional misrepresentation of material fact prohibited by the terms of the plan or policy.
 - 30-day Notice Requirement
- Action Needed:
 - Must determine if your plan rescinds coverage retroactively. If it rescinds coverage retroactively, plan documents must be revised so that retroactive rescission is limited to the above reasons and is adequately documented in writing in your plan.

Prohibition of Preexisting Condition Exclusions

- Effective for plan years beginning on or after September 23, 2010.
- Application:
 - Applies to grandfathered plans
 - Does not apply to HIPAA excepted benefits
- Requirement:
 - Group health plans may not impose any preexisting condition exclusions for children up to age 19.
- Action Needed:
 - Documents and practices must be in compliance with this new provision.

Cost Ratio Requirements

- Effective January 1, 2011
- Application:
 - Applies to grandfathered plans
 - Does not apply to HIPAA excepted benefits
 - Does not apply to self-insured group health plans
- Requirement:
 - Reporting: A health insurance issuer offering group or individual health insurance coverage, must, with respect to each plan year, submit to the Secretary of Health and Human Services a report concerning the ratio of its incurred loss or claims plus the loss adjustment expense to earned premiums.
 - Rebate: Beginning no later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage must, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on (i) reimbursement for clinical services provided to enrollees and (ii) for activities that improve health care quality, to the total amount of premium revenue is less than 85% in the large group market, or 80% in the small group market.
- Action Needed:
 - No action required if you are a self-insured group health plan.
 - If you are a fully-insured plan, you must annually submit the required report.

Extension of Nondiscrimination Rules

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Grandfathered plans are exempt from this requirement
 - Does not apply to HIPAA excepted benefits
 - Does not apply to self-insured group health plans
- Requirement:
 - The nondiscrimination rules of IRC section 105(h)(2) are extended to apply to non-grandfathered fully-insured group health plans.
- Action Needed:
 - No action required if you are a self-insured group health plan.
 - If you are a fully-insured plan, you must comply with the nondiscrimination rules.

Mandated Claims Appeals Processes

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Grandfathered plans are exempt from this requirement
 - Does not apply to HIPAA excepted benefits
- Requirement:
 - Non-grandfathered group health plans must implement an effective appeals process for appeals of coverage determinations and claims which at a minimum:
 - Has an internal claims appeal process which incorporates the claims and appeals procedures of ERISA;
 - Provides notice to enrollees of the internal and external appeals process in a culturally and linguistically appropriate manner and the availability of any applicable assistance with the appeals process; and
 - Allows enrollees to review their file, present evidence and testimony as part of the appeals process and to receive continued coverage pending the outcome of the appeal.
 - A group health plan must comply with the applicable state external review process for such plans, which meets minimum standards set forth by the either the National Association of Insurance Commissioners or the Secretary of Health and Human Services.
- Action Needed:
 - If you lose your grandfathered status, you will need to update your appeals processes to conform with this requirement.

Mandated Coverage of Preventive Health Services

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Grandfathered plans are exempt from this requirement
 - Does not apply to HIPAA excepted benefits
- Requirement:
 - Group health plans must provide and cannot impose any cost sharing requirements on:
 - Certain preventive care items and services that have been recommended by the U.S. Preventive Services Task Force;

- Immunizations recommended by the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration;
- Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration; and
- The current recommendations of the U.S. Preventive Task Force regarding breast cancer screenings, mammography, and prevention.
- Action Needed:
 - If you lose your grandfathered status, you will need to carefully review your plan and component benefits to ensure that they do not impose any cost sharing requirements in violation of this provision.

Mandated Patient Protections

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Grandfathered plans are exempt from this requirement
 - Does not apply to HIPAA excepted benefits
- Requirement:
 - Group health plans must contain the following patient protections relating to choice of health care professional (applicable only to a plan or health insurance coverage with a network of providers):
 - Designation of primary care provider;
 - Designation of pediatrician as primary care provider; and
 - Patient access to obstetrical and gynecological care.
 - Notice requirement (related to choice of health care professional)
 - Group health plans must contain the following patient protections relating to benefits for emergency services (applicable to all plans or health insurance coverage), if it provides or covers benefits with respect to services in an emergency department of a hospital:
 - Without requiring prior authorization determination (even if the emergency services are provided on an out-of-network basis);
 - Regardless of whether the service provider is a participating network provider with respect to the services;
 - Without imposing requirements or costs different than those imposed on in-network participating providers, and
 - Generally without regard to any other term or condition of coverage.
- Action Required:
 - If you lose your grandfathered status, you must review your plan and component benefits to ensure compliance with this provision.

Information to Secretary of Health and Human Services

- Effective for plan years beginning on or after September 23, 2010
- Application:
 - Grandfathered plans are exempt from this requirement
 - Does not apply to HIPAA excepted benefits

- Requirement:
 - A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide the following information to the Secretary of Health and Human Services, the State insurance commissioner, and the Exchange (when applicable) and make such information available to the public:
 - Claims payment policies and practices;
 - Periodic financial disclosures;
 - Data on enrollment;
 - Data on disenrollment;
 - Data on the number of claims that are denied;
 - Data on rating practices;
 - Information on cost-sharing and payments with respect to any out-of-network coverage;
 - Information on enrollee and participant rights; and
 - Other information as determined appropriate by the Secretary of Health and Human Services.
- Action Required:
 - If you lose your grandfathered status, you must provide the required information to the Secretary of Health and Human Services.

Over-the-Counter Drug Prohibition

- Effective for taxable years beginning after December 31, 2010
- Requirement:
 - Costs for over-the-counter drugs and medicine may not be reimbursed through an HSA, HRA, health FSA, or Archer MSA unless such drugs or medicine are prescribed by a doctor or are insulin.
- Action Needed:
 - Plan documents and administrative procedures must be changed to ensure compliance.
 - Plan participants must be notified of change.

HSA, Archer MSA Penalty Increases

- Effective for distributions made on or after January 1, 2011
- Requirement:
 - The penalty tax on distributions from HSAs and Archer MSAs that are not for qualified medical expenses is increased to 20% (from 10% for HSAs and 15% for Archer MSAs).
- Action Needed:
 - You should notify your plan participants of this penalty change.

Small Employer Tax Credit

- Effective January 1, 2010
- Requirement:
 - An employer with no more than 25 full-time employees and average wages of less than \$50,000 that purchases health insurance for its employees and covers at least 50 percent of the total premium cost is eligible for a tax credit of up to 35% of the cost of the employer's premium contribution in the small group market (up to 25% in the case of tax-exempt employers).
- Action Needed:

- If you are eligible for the tax credit, you should speak with your accountant or attorney about how to obtain such credit.

Simple Cafeteria Plans

- Effective for plan years beginning after January 1, 2011
- Requirement:
 - A simple cafeteria plan may be established by an employer that employed on average 100 or fewer employees in the preceding two years.
 - An employer maintaining a simple cafeteria plan will be treated as meeting any applicable nondiscrimination requirements.
 - Employers that establish a simple cafeteria plan, but grow beyond 100 employees in a subsequent plan year may continue to offer the simple cafeteria plan, provided they do not reach 200 employees.
 - Simple Cafeteria Plan Defined:
 - A simple cafeteria plan is a cafeteria plan that is established and maintained by an eligible employer and complies with contribution, eligibility, and participation requirements.
 - Contribution—each employee who is not a key employee or a highly compensated employee must receive an employer contribution of at least: (1) 2% of the employee’s compensation for the plan year; or (2) the lesser of 6% of the employee’s plan year compensation for the plan year or twice the employee’s salary reduction contributions.
 - Eligibility—all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate and elect any benefits available under the plan.
- Action Needed:
 - If you have employed on average 100 or fewer employees in the preceding two years, you should discuss this plan document option with your attorney.

Reasonable Break Time for Nursing Mothers

- Effective Date: March 23, 2010
- Requirements:
 - An employer is required to provide:
 - a reasonable break time for an employee to express breast milk for her nursing child for one year after the child’s birth each time such employee has need to express the milk; and
 - a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.
 - But, an employer is not required to compensate an employee receiving reasonable break time for any work time spent for such purpose.
 - Limited exception for small employers
 - If state law provides greater protections to employees than the Health Care Reform Law, then the employer must comply with the more expansive provision.
- Action Needed:
 - Designate a place, other than a bathroom, which may be used by employees to express breast milk.
 - Update employment manuals and similar documents to incorporate an employee’s right to take a reasonable break to express milk.
 - Notify employees and management of the new policy.

What Do These Requirements Mean?

Over the next several years, individuals, employers, and group health plans will face significant new challenges under the lengthy and complex Health Care Reform Law. With regard to provisions becoming effective within the next year, plans sponsors and group health plans should immediately have their plan design, procedures, and administration thoroughly reviewed. This legislation is overwhelming in nearly every sense of the word, and Fraser Trebilcock Davis & Dunlap, P.C. is ready to assist you in planning your strategies and steps toward compliance, as well as updating your documents as required. If you have any questions, or need assistance in planning your strategies and steps toward compliance with the Health Care Reform Law, please contact:

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