



Alfred B. Fowler
Attorney at Law

**MEMORANDUM
2010-14**

**Health Care Reform: September 23, 2010
A Collision Course!**

July 15, 2010

At present, most welfare plan sponsors have begun work on group health plan renewals, with an understandable pre-occupation with the Health Care Reform Rules which go into effect for plan years beginning on or after September 23, 2010. The purpose of this Memorandum is to provide a summary and an analysis of those Health Care Reform Rules and their impact on the renewal process.

Setting the Table

The threshold question is whether plan sponsors who have grandfathered plans can or should attempt to retain grandfathered status. The recently released Interim Final Rules on grandfather status as well as the guidelines for “Patient Protections” appear to define “plan” very narrowly: instead of a single welfare plan, the employer’s consolidated welfare plan may contain three or four separate plans for purposes of these rules. For example, an employer may contract with Kaiser Foundation health Plan and with Anthem Blue Cross. For purposes of these Health Care Reform Rules, the employer has two (or more) plans. If there are no changes to the Kaiser plan and it was in effect on March 23, 2010, then it is grandfathered. If the employer makes fatal changes to the Blue Cross plan, it would no longer be grandfathered. For purposes of this Memorandum, we will use the term “plan” in the narrow sense (e.g. each insurance policy).

The Overview

If insurance renewal increases are significant, plan sponsors may choose to abandon their plan’s grandfathered status in exchange for maintaining the fiscal integrity of their overall benefits program. If so, then what are the consequences of that decision?

There are two main consequences: The insured group health plan must provide extensive first-dollar preventive care benefits (possible increase in premium expense) and must assure that these insured plans meet Health Care Reform’s non-discrimination requirements. Additionally, Health Care Reform requires non-grandfathered plans to adopt changes to the claims appeals process, provide coverage for emergency services without prior authorization and out of network, and allow direct access to OB/GYN professionals without authorization.



Official Guidance to Date

The Internal Revenue Service (IRS), the Department of labor (DOL), and Health and Human Services (HHS) collectively called “the Agencies” have just released [Interim Final Rule on preventive care](#) (July 14, 2010); and [recently issued rules](#) regarding pre-existing conditions, lifetime and annual limits, and patient protections (June 23, 2010). We also have DOL guidance on a variety of annual notices. However, we do not have regulatory guidance on the new discrimination testing requirements. At this point, the absence of guidance on the discrimination testing requirements presents a very big hurdle to many plan sponsors.

Discussion

In this Memorandum, we will discuss four main topics:

1. The Non-discrimination rules under HCR as we know them today;
2. Plans with annual limits, again;
3. The Preventive Care Interim Rule; and,
4. Employer/Plan Sponsor Health Care Reform communication requirements as published in regulations to date.

1. The Grandfathered Plans Interim Final Rule

On June 16, 2010, we released our analysis of the regulatory agencies’ Interim Final Rule on grandfathered status. In brief, the Rule sets forth the parameters a plan sponsor must follow to maintain grandfathered status beyond the last day of their current plan year ending on or after September 23, 2010. Perhaps the most difficult requirement in these rules for plan sponsors is the inability to cost shift premium increases to plan participants, especially with renewals running at 20% or more over last year’s premium requirements. For a discussion of the Interim Final Rule on grandfathered status, please visit our client library at <http://www.abferisa.com>.

2. Non-discrimination Testing Rule

The Health Care Reform law will require plan sponsors to maintain insured group health plans (e.g. Kaiser, Health Net, etc.) that do not discriminate in favor of highly compensated individuals. It appears that each carrier contract is to be tested separately, for the most part. The Health Care Reform Law relies on the non-discrimination tests found in [Section 105\(h\)](#) of the Internal Revenue Code (IRC), paragraphs (3), (4), and (8):

The Tests	
105(h)(3)	Non-discriminatory eligibility classification
105(h)(4)	Non-discriminatory benefits
105(h)(8)	Controlled groups, etc.

It deviates from IRC Section 105(h) when it comes to the penalties/excise taxes applicable to the discriminatory plan. Under the Health Care Reform Law, the employer will be subject to a \$100 per



day/per affected participant excise tax under Section 4980D for a failure to satisfy the non-discrimination requirements. Section 2722 of the PHSA also gives the Secretary of HHS the discretion to impose a civil penalty on employers of up to \$100 per day/per affected participant for certain violations. The DOL has enforcement power of violations of the discrimination rules. The maximum excise tax under Section 4980D for unintentional failures is \$500,000 per taxable year.

The Tests in Detail

- **The Eligibility Tests (105(h)(3)).** A plan satisfies the eligibility requirements if the plan is available to:
 1. 70% or more of all employees, or to
 2. 80% or more of all the employees who are eligible to benefit under the plan if 70% or more of all employees elect to participate in the plan.

Alternatively, a plan meets the eligibility requirements if it covers a classification of employees that does not discriminate in favor of highly compensated individuals.

The 80/70 percentage test requires a minimum of 56% of employees (80% multiplied by 70%) participating in the plan. The non-discriminatory classifications test will allow reasonable classifications generally including specified job categories, compensation categories such as hourly or salaried, geographic location to some extent, and similar bona fide business criteria.

Certain non-participating employees may be excluded from the eligibility tests, including employees who have not completed three years of service; employees younger than age 25; part-time or seasonal employees; union employees; and employees who are nonresident aliens and who receive no U.S. earned income.

- **The Benefits Test (105(h)(4)).** In addition to the eligibility rules, all benefits provided to highly compensated employees must be provided to all other participants.
- **Controlled Groups (105(h)(8)).** The controlled group rules specify that employees of controlled groups of corporations and partnerships and employees of affiliated service groups are to be treated as employees of a single employer.

Executive Plans

At present, it appears that insured group health plans which provide supplemental health care benefits only to executives (e.g. Exec-U-Care), if in effect on March 23, 2010 and not modified thereafter, will remain grandfathered and therefore not be subject to discrimination testing. Executive-type plans established or modified after March 23, 2010, will not be grandfathered since they were not in effect on Health Care Reform's date of enactment.

The Definition of Highly Compensated Individuals

The Law itself uses the definition of a highly compensated individual found at IRC Section 105(h)(5). In summary: The five highest-paid officers, any 10 percent owners (attribution rules apply), and the highest-paid 25 percent of all employees.



Boiling it Down

Since we don't have regulations for non-discrimination testing, we have no safe harbor test. However, some plan sponsors may have less risk of a violation than others. If the health care benefit package has the following characteristics, we expect there to be less risk of a violation:

1. One waiting period for eligibility applicable to all eligible full-time employees (e.g. 30 hours per week; first of the month following 30 days);
2. One set of employer contributions for all plan participants (either as a percentage or flat dollar amount) per insurance contract;
3. No executive type supplemental plan; and,
4. All group health plans are available to all eligible full time employees (except for region-specific plans).

3. Plans with Annual Limits, Again

In our June 28, 2010 Memorandum (2010-13), we discussed the status of plans with annual benefit limits. For that discussion, visit our client library at www.abferisa.com. Essentially, the Interim Final Rule permits a phase-in for annual limits on essential benefits and gives the Secretary of Health and Human Services the ability to provide a waiver in the event the cost of compliance results in a significant decrease in access to benefits or a significant increase in the cost of the benefit. Since the minimum annual limit is \$750,000 for plans whose plan years begin on or after September 23, 2010 and before September 23, 2011, medical reimbursement plans set up to pay just hospital deductibles, for example, appear to remain viable due to their integration with a larger/underlying group health plan. Free-standing limited plans such as reimbursement for smoking cessation aids such as "the patch" may need the Secretary's waiver to survive. The annual limit rule applies whether the plan is grandfathered or not grandfathered.

Mini-Meds

The most significant issue facing some employers involves so-called mini-meds (indemnity health plans with scheduled benefit maximums such as \$5,000 per hospitalization, \$100 for outpatient surgery, etc.) Plan sponsors who offer these types of plans to full time (30 hours) employees with little or no service may have an opportunity for a waiver from HHS, especially if the plan existed on March 23, 2010 and is renewed with no benefit changes. On the other hand, newly offered mini-meds (post March 23, 2010) may not receive a waiver according to our carrier sources. If on the other hand, the mini-med is being offered to part-time employees or seasonal employees (as defined), it seems likely that these plans may survive since Health Care Reform, to date, only appears to govern plans for full-time employees. Hopefully we will receive additional guidance with the issuance of the "waiver" rules.

4. Preventive Care Interim Rule

The Interim Final Rule calls for group health plans to provide a range of specific preventive services. The no-cost feature will apply to in-network services; however, the Rule will allow cost-sharing for out of network preventive care services. The Rule also allows a plan to offer other preventive care services not



required under HCR and to have cost-sharing requirements for those other services. Finally, if a service is de-listed, plans can delete the service or charge co-pays, etc.

Effective Date

Although HCR requires plans to offer preventive care services as of the first day of the plan year beginning on or after September 23, 2010, the law and the Interim Rule also anticipate the development of preventive care recommendations and guidelines. Plans must implement these additional recommendations or guidelines no later than the first plan year beginning on year after their issuance.

Mandatory Services

Plans must provide a specific set of preventive care services. Generally, these services include:

- **Evidence-based preventive services:** The U.S. Preventive Services Task Force, an independent panel of scientific experts, rates preventive services based on the strength of the scientific evidence documenting their benefits. Preventive services with a “grade” of A or B, like breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling will be covered under these rules.
- **Routine vaccines:** Health plans will cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.
- **Prevention for children:** Health plans will cover preventive care for children recommended under the *Bright Futures* guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children from birth to age 21 to keep them healthy and improve their chances of becoming healthy adults. The types of services that will be covered include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.
- **Prevention for women:** Health plans will cover preventive care provided to women under both the Task Force recommendations and new guidelines being developed by an independent group of experts, including doctors, nurses, and scientists, which are expected to be issued by August 1, 2011.

For a complete list of mandated services, please visit

<http://www.healthcare.gov/center/regulations/prevention.html>

Administrative Issues

- **Billing Methodology.** For network services provided during an office visit, and the provider bills separately for the office visit, then the plan may apply cost-sharing to the office visit. If the preventive service is not billed separately and the primary purpose of the office visit is the



receipt of the preventive service, then the plan may not apply cost-sharing with respect to the office visit. On the other hand, if the purpose of the office visit was more than just the preventive service, then the plan may apply cost-sharing to the office visit, but not the preventive service. For purposes of capitation plans, the issuer must follow the procedure for tracking the encounter. In other words, if the plan treats the office visit and preventive service as one encounter, then there would be no cost-sharing.

- **Reasonable Medical Management.** Plans will have flexibility in determining the frequency of services, the method of their delivery or treatment, or the setting for an item or service.
- **Non-listed Services and Treatment.** Issuers may still cover other preventive care services and may require cost-sharing on those services. Issuers may also limit preventive care services to those required by HCR unless it violates state insurance mandates. The Rule also points out that treatment resulting from preventive services may include cost-sharing requirements.

5. Health Care Reform Communications

The DOL has issued numerous notices in conjunction with the Interim Final Rules published over the last two months. Plan sponsors must pay attention to these notice obligations to avoid the \$100 per day per person penalties under Health Care Reform. There will be more notices as the government issues more and more regulations.

Dependent Coverage for Children under Age 26

As you know, insured and self-insured group health plans must make coverage available to adult children who may or who have termed out of the group health plan based on age limits or schooling requirements (aged-out). Children who will or who have lost health care coverage must have the opportunity to continue coverage up to age 26. Although the rule takes effect as of the first day of the plan year beginning on or after September 23, 2010, insurers, almost universally are allowing dependents currently covered but “aging-out” to remain on their plans. Dependents who have previously “aged-out” must wait for the next open enrollment.

The DOL notice applies to events occurring as of the first day of the new plan year (compliance date). Employers or their insurers, who currently are allowing coverage to continue prior to the compliance date, most likely have notified plan participants already or will be doing so shortly. The DOL notice applies to those who have already lost coverage.

[Download: Coverage for Adult Children Model Notice](#)

Lifetime Limits

The law will ban lifetime limits as of the first day of the new plan year beginning on or after September 23, 2010. The DOL notice clarifies the effective date of the ban and refers the plan participant to the plan sponsor (in the case of a self-insured plan) or to the insurer in the case of an insured plan, with any questions. Plan sponsors or insurers must provide the notice no later than the first day of the new plan year.

[Download: Lifetime Limits Model Notice](#)



Patient Protections

Plans must also provide notice to plan participants about choosing a primary care physician and the ability to obtain obstetrical/gynecological services without prior authorization. Plans become subject to this requirement as of the first day of the new plan year beginning on or after September 23, 2010.

[Download: Patient Protection Model Notice](#)

Grandfathered Status

For those plans which intend to maintain their grandfathered status, the Interim Final Rules applicable to grandfathering require a written notice to that effect which must be provided with all benefit materials distributed to plan participants and those eligible to participate, using the model rule provided in the guidance.

[Download: Grandfathered Health Plans Model Notice](#)

Other Notices

Health Reform Law also requires a 30 day notice in the event of a rescission of coverage for fraud or intentional misrepresentation, as well as notices involving cessation of coverage for over-the-counter medicines (January 1, 2011), and benefit changes such as inclusion of coverage for expanded preventive care services (summary of material modifications) etc. It also calls for new disclosures by insurers on their claims payment policies and other administrative practices, the extent of which will be subject to HHS guidelines yet to be published.

Methods of Delivery

Insurers or plan sponsors may provide notice of expanded coverage for dependents and the removal of lifetime benefits in the relevant open enrollment materials, but no later than the first day of the applicable plan year. On the other hand, the Summary Plan Description must contain the notice regarding patient protections. Plan sponsors claiming grandfathered status must attach its notice to all benefit materials distributed to participants or potential participants.

It is also important to note that delivery of the notices to the employee is sufficient. The law and regulations do not require separate notices to dependents. For the most part, either insurers or sponsors must provide these notices no later than the first day of the plan year beginning on or after September 23, 2010, and with the exception of the “grandfathered” status notice, insurers or plan sponsors must provide the notices whether the plan is grandfathered or not.

Action Plan

1. Review insurance carrier renewals on your group health plans:
 - a. Degree of rate increase
 - b. Whether the carrier has altered the plan design (other than for HCR compliances)



- c. What the carrier will do with the plan design if you are no longer grandfathered (i.e. what preventive care benefits it will include and its price tag)
2. Check your insured plans for potential discrimination issues.
3. Weigh the economics of retaining grandfathered status against your fiscal needs.
4. Set out a game plan, including procedures for meeting the HCR notice requirements.
5. Modify all ERISA plan documents and prepare a Summary of Material Modifications as needed.
6. Watch for non-discrimination testing regulations.

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mike@abferisa.com

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