August 4, 2010

Health Care Reform Legislation

Critical guidance for employers in addressing the Health Care Reform Act (a collective reference to the Patient Protection and Affordable Care Act and the related Health Care and Education Reconciliation Act of 2010) was issued on June 14, 2010 defining "grandfathered" health care plans. In addition to addressing the grandfather rules, this Alert outlines key provisions of the Act and how the grandfather rules apply to those provisions. Also addressed are other recent law changes affecting health plans including the new excise tax reporting requirements effective for 2010.

Importance of Grandfathering. As addressed in this Alert, some of the mandates of the Health Care Reform Act do not apply to grandfathered plans and other mandates will have a delayed effective date. Because of the potential favorable economics of grandfathered status, it is important for employers to determine if their plan is grandfathered and how to maintain that status. In certain limited situations it may be possible to take remedial action to revert to grandfathered status.

Other New Laws Affecting Health Plans. At a time when employers are focused on the new law and the sweeping changes it brings, it is important that they not overlook other new health care requirements including an increased focus on compliance. This Alert also addresses the new excise tax reporting requirements effective for 2010.

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1. Grandfathered Status – Can I Keep My Health Plan?

What Do I Test? Before addressing the grandfather rules in detail, it is important to determine how testing applies. Each "benefit package" maintained by an employer is reviewed separately for determining grandfathered status. If an employer has a PPO and HMO as constituent plans in a single ERISA plan, it has two separate benefit packages and the rules apply separately to each package.

> ***Smith Anderson Comment:*** *Employers should confirm the basic structure of their health plans and fundamental compliance with ERISA as they consider potential plan changes. Amendments will need to be properly adopted and disclosed to be effective. In some situations, the Health Care Reform Act requires specific disclosures even if no amendments are adopted. Advance disclosures are required for certain plan amendments.*

A plan has the potential for grandfathered status if it had at least one individual enrolled on March 23, 2010. Many of the potential changes that could result in the loss of grandfathered status are tested against the benefits that existed on March 23, 2010.

What Plan Changes May Result in the New Law Applying Sooner? The following are among the changes that could result in the loss of grandfathered status:

- **Elimination of Benefits.** Elimination of all or substantially all plan benefits necessary to diagnose or treat a particular condition.

- **Increase in Percentage Cost-Sharing.** Any increase in coinsurance or other percentage cost-sharing arrangement above the level in effect on March 23, 2010.

- **Increase in Fixed-Amount Cost-Sharing Other than a Copayment.** An increase in a deductible or other fixed-amount cost-sharing other than a copayment above the level on March 23, 2010 by more than the sum of medical inflation plus 15%.

- **Copayment Increase.** An increase in a copayment above the level on March 23, 2010 by more than the greater of: 1) the sum of medical inflation plus 15%; or 2) $5 increased by medical inflation.

  > ***Smith Anderson Comment:*** *Medical inflation is defined as the increase in the medical care component of Consumer Price Index over the March 2010 level.*

- **Decrease in Employer Contribution Rate.** A decrease in the employer contribution rate for any tier of coverage by more than 5% from the contribution rate in effect on March 23, 2010.

- **Decreasing or Imposing an Annual or Lifetime Limit.** The following changes to annual or lifetime limits will result in losing grandfathered status: 1) the adoption of an annual limit if the plan had no annual or lifetime limit on March 23, 2010; 2) the adoption of an annual dollar limit less than an existing lifetime limit on March 23, 2010; or 3) the reduction in an annual lifetime limit that existed on March 23, 2010.

- **Change in Insurers.** For a fully insured plan, a change in insurers will result in loss of grandfathered status. A change in administrators for a self-insured plan is allowed.

Special Considerations for Grandfathering. Special rules may provide relief for some employers:

- **Transition Rules.** Certain changes made after March 23, 2010 and prior to June 14, 2010 can be revoked or modified effective as of the first day of the first plan year beginning after September 23, 2010, provided that the plan or coverage would not then be inconsistent with grandfathered status.

- **Good Faith Rule.** If a good faith effort at compliance is made, a change that results in only a modest violation may be disregarded.

- **Collectively Bargained Plans.** Special grandfather rules apply to collectively bargained plans. Plans with *insured coverage* can make changes even if the result would otherwise be loss of grandfathered status without any adverse consequences until the expiration of the last collective bargaining agreement that relates to the coverage that existed on March 23, 2010.

- **Retiree Only Plans and Other Exceptions.** It appears that retiree only plans as well as stand-alone dental and vision plans are exempt from the insurance mandates of the Health Reform Act rules and HIPAA portability and other mandates such as Mental Health Parity.

  Smith Anderson Comment: *Sponsors of retiree coverage, dental and vision benefits will want to confirm that plans with such "exempt" coverages are kept separate from plans that provide active coverage. The grandfather provisions must be carefully considered in modifying plans that have integrated such coverages with general health coverage.*

2. The Importance of Grandfathered Status – Should I Keep My Healthcare Plan As Is?

Certain provisions of the Health Care Reform Act do not apply to grandfathered plans and others have a delayed effective date. Because there are potentially significant cost savings, direct and indirect, to maintaining grandfathered status, employers need to undertake a cost benefit analysis before making a change that results in the new law applying in full. Since new plans (i.e., plans that are not grandfathered) are likely to be more attractive to those with health issues, an indirect benefit is that grandfathered plans may ultimately wind up with healthier individuals and lower premiums.

Key 2011 Requirements (Plan Years Beginning After September 23, 2010) of the Health Reform Act that Do Not Apply to Grandfathered Plans:

- First dollar coverage of certain preventive services
- Prohibition against discrimination in fully insured plans
- Establishment of procedure for internal appeals and independent external review
- HHS reporting and disclosure requirements
- Ability to select any participating primary care provider
- Emergency services without preauthorization or additional cost sharing or less favorable coverage out-of-network
- Full implementation of coverage for adult child until age 26 (includes adult children eligible under another employer plan)

Key 2014 Requirements of the Health Reform Act that Do Not Apply to Grandfathered Plans:

- Out-of-pocket limits not in excess of the limits for high-deductible plans
- Annual deductibles cannot exceed $2,000 or $4,000 for families (as indexed)
- Nondiscrimination in health care providers
- Participation in clinical trials without prejudice
- Guaranteed issue, guaranteed renewability and rating limitations for certain insured plans

Do I Have to Apply for Grandfathered Status?

No application is required, but maintaining grandfathered status requires providing a notice to participants as to the belief of compliance in all materials describing the plan. The notice must include instructions on how to file a complaint or request additional information. This notice presumably applies to a summary plan description, summary of material modification and enrollment materials and heightens the need for these documents to be up to date.

Smith Anderson Comment: *The notice requirements are likely to evolve and future guidance is expected. For example, it may be necessary to disclose to employees the provisions of the new law that don't apply. The notice requirements are another reason for confirming that your healthcare plan is in basic compliance with ERISA.*

Employers also must maintain documentation of the plan terms on March 23, 2010 and other documents necessary to verify grandfathered status. These documents could include formal plan documentation, insurance policies, administrative service agreements and employee election forms describing costs.

3. Health Care Reform Act – When Are Changes Required?

The Health Care Reform Act overhauls health care and insurance rules in stages for the next eight years, with the first required changes becoming effective in plan years beginning after September 23, 2010. As addressed above, grandfathered plans are exempt from certain required change, while certain other provisions have a delayed effective date for grandfathered plans. Some of the earliest key changes, and the respective applicability of these changes to grandfathered and non-grandfathered plans, are addressed below:

Key Changes for Plan Years Beginning After September 23, 2010 for All Plans, Grandfathered and Non-Grandfathered:

- **Limits on Essential Health Benefits.** Prohibition of lifetime limits on essential health benefits; and for plan years beginning after September 23, 2010 and before September 23, 2011, a prohibition on annual limits greater than $750,000 for essential health benefits (in 2014, annual limits will be prohibited altogether).

  Smith Anderson Comment: *Individuals who reached a lifetime limit must be given notice by the first day of the first plan year beginning after September 23, 2010 and the opportunity to enroll on the same basis as similarly situated individuals. The specifics of "essential health benefits" have not been defined but the broad categories include preventive care, hospitalization, maternity and newborn care, mental health and substance abuse and prescription drug coverage.*

- **Pre-existing Condition Exclusions.** Pre-existing condition exclusions for children under age 19 are eliminated (expanded to all enrollees in 2014).

- **Limits on Rescission.** No recession of coverage after enrolling except for fraud or material misrepresentation. A prospective termination of coverage is possible as is retroactive termination if due to the failure to pay required contributions.

- **Coverage for Adult Children.** Adult children are eligible for coverage under employer-sponsored group health plans until the age of 26, without regard to whether they are financially dependent, students, married, or eligible for other

group coverage. Note that grandfathered plans may exclude adult children who are eligible to participate in plans other than those of their parents until January 1, 2014. Dependent coverage also will not result in imputed income as of March 31, 2010. Special enrollment opportunities must be provided for children who previously were excluded.

Smith Anderson Comment: *The above dependent coverage rules may result in other welfare plans maintained by an employer having eligibility provisions that are different than in the health plan. This may present a communication challenge.*

- **Early Retiree Reinsurance Program.** An inducement rather than a requirement, the Early Retiree Reinsurance Program (ERRP) will reimburse employer-sponsored health plans (insured and self-insured) for up to 80% of claims greater than $15,000 but less than $90,000 incurred by early retirees (age 55 to 64) and their covered spouses and dependents. The reimbursed funds must be used to lower costs for the plan and not as general revenues or gross income of the employer, although the employer must "maintain its current level of contributions." $5 billion has been set aside to fund the program. Interested employers are encouraged to begin pulling together their applications now, since the application process is fairly demanding (the details are set out in Interim Final Regulations issued May 3rd) and HHS may stop accepting applications once it determines that projected claims will exceed $5 billion. HHS announced on June 29, 2010 that it has begun accepting applications.

- **Automatic Enrollment.** Employers with 200 or more employees that offer a health plan will be required to automatically enroll new full-time employees (who can then opt out if they choose.) This provision is intended to be effective in accordance with yet to be issued guidance.

- **Over-the-Counter Drugs.** Drugs purchased over-the-counter after January 1, 2011 (regardless of plan year) are no longer reimbursable under flexible spending accounts, health reimbursement accounts or health savings accounts.

- **HSA Distributions.** The 10% excise tax for nonqualified HSA distributions is increased from 10% to 20%.

- **W-2 Reporting.** Effective for the 2011 plan year (for W-2 forms typically issued in 2012), employers are required to begin including the value (corporate cost) of health benefits that are provided for each employee on individual W-2 forms.

- **Cost Reporting and Rebates.** For an insured plan, the insurer must report medical loss ratio and a rebate must be provided to enrollees if limits are exceeded.

- **Expanded Notification Rules.** In addition to the existing summary plan description requirement, a short form explanation consistent with HHS uniform definitions, not longer than four pages and in easily understood language, of benefits and coverage is required effective as of March, 2012. Also, a notice of a material modification must be given 60-days in advance of the effective date of the change. The penalty for a violation is up to $1,000 per violation per participant.

Key Changes for Plan Years Beginning After September 23, 2010 for Non-Grandfathered Plans – These Requirements Do Not Apply to Grandfathered Plans:

- **First-Dollar Coverage for Preventive Care.** Plans must provide first-dollar coverage (no cost-sharing) for preventative care, including immunizations and breast cancer screening.

- **Nondiscrimination Rules.** Insured plans must comply with nondiscrimination rules of Code Section 105(h) that are currently applicable only to self-insured plans.

- **Appeals Process.** Plans must have an effective internal appeals process and must implement HHS-approved external review procedures including the right to present evidence and testimony on appeal. An additional and potentially significant requirement is that coverage must continue during the appeals process.

  Smith Anderson Comment: *ERISA currently requires that a plan include an appeals process and it is prudent for employers to confirm that the existing process is consistent with current law.*

- **Transparency Disclosures.** Disclosure to the HHS and public availability is required each year for healthcare information related to enrollment, claims payments, cost-sharing and ratings policies, out-of-network coverage and participant rights.

- **Choice of Provider.** Plans must allow the selection of any participating primary care provider. Female participants must be able to select any in-network OB/GYN without prior authorization. This right must be included in the summary plan description and other similar documents.

- **Emergency Services.** Plans must allow emergency services without preauthorization and cannot impose administrative or cost-sharing requirements for out-of-network emergency services that are any greater than those required for in-network services.

Key Changes for Plan Years Beginning After January 1, 2014 <u>for Non-Grandfathered Plans</u> – These Requirements Do <u>Not</u> Apply to Grandfathered Plans:

- **<u>Cost-sharing Limits</u>.** Plans cannot impose cost-sharing limits for a year that exceed the out-of-pocket limits of high-deductible health plans; currently $5,950 for individual coverage and $11,900 for family coverage. The maximum deductible is limited to $2,000 for individual coverage and $4,000 for group coverage.

- **<u>Clinical Trials</u>.** Certain minimum coverage must be provided for eligible participant in approved clinical trial for life-threatening disease.

- **<u>Guaranteed Coverage</u>.** Health coverage must be provided on a "guaranteed issue" and "guaranteed renewability" basis.

- **<u>No Discrimination Based on Health Status</u>.** Essentially these rules are the same as currently exist under HIPAA but the maximum incentive for a wellness program is increased.

- **<u>Fair Health Insurance Premiums</u>.** Factors and limits are established for determining premium rate variances for coverage in the small group market.

Key Changes for Plan Years Beginning After January 1, 2014 <u>for All Plans, Grandfathered and Non-Grandfathered</u>:

- **<u>Waiting Periods</u>.** Eligibility waiting periods for new enrollees cannot exceed 90 days.

- **<u>Pre-existing Conditions</u>.** Pre-existing conditions exclusions are banned for all enrollees.

- **<u>Coverage Limits</u>.** Annual limits on coverage for essential benefits are prohibited.

4. <u>Initial Steps for Employers</u>

The specifics and details of the Health Care Reform Act are being addressed at a rapid pace by the issuance of governmental guidance, but a great many issues are unresolved. At this time, it is difficult for most employers to make informed, long-term decisions about the future of their health plans. At the same time, employers have to comply with the law changes that are currently effective. At a minimum, employers need to adopt a strategy for addressing Health Care Reform that considers both short-term and long-term goals.

As addressed below, employers need to understand the basic structure of their existing health plans and the basic requirements of the new law that apply to that type plan. Employers

need to identify their service providers and confirm what responsibilities each is assuming in terms of compliance with the Health Care Reform Act.

Key Action Steps for Employers

- Confirm the types of health plans you maintain (group health, HSA, HRA, and/or FSA (cafeteria)) and whether they are insured or self-insured and compile the basic plan documentation and participant disclosures.
- Confirm the basic ERISA structure of your health plans, including the plan year, the identity of the plan administrator, how amendments are made and basic reporting and disclosure compliance.
- Determine who will be responsible internally for compliance with the Health Care Reform Act and identify service providers to assist with the process.
- Confirm with insurance providers and/or third-party administrators of self-insured plans the process they are adopting for addressing Health Care Reform Act changes. Determine and address any gaps in the provider process and the employer's internal process.
- Review contracts with service providers, particularly since much in the Health Care Reform Act is unanticipated and it is unlikely that contractual arrangements exist that adequately address the new requirements.
- Make certain a process exists to avoid plan changes that inadvertently result in loss of grandfathered status.
- Confirm required changes for 2011 and related disclosures.
- Establish disclosure process and document how disclosures made.
- Continue monitoring new developments - the government has been issuing guidance at a rapid pace.

5. New Excise Tax and Reporting Requirements for Health Plan Violations

In the past, the IRS has been relatively inactive both in assessing excise taxes for violations of health plan requirements discovered in audit and in requiring employers to report violations. A recent move by the IRS to issue Form 8928, which requires payment of excise taxes for and the reporting of certain health plan violations, signals that the playing field has changed. Now, for example, Form 8928 subjects violations of COBRA, the HIPAA portability and nondiscrimination rules, and the Genetic Information Nondiscrimination Act (GINA) to excise taxes and reporting (other requirements subject to reporting are set forth below). The type of violation and the identity of the responsible party determine when Form 8928 must be filed and when any excise taxes must be paid, but as with other reporting requirements, taxpayers can be hit with interest and other penalties for late filing or late payment of taxes due.

The amount of the excise tax can be significant. The tax generally is $100 per participant for each day of violation, except for certain violations related to health savings accounts that apply an excise tax of 35% of the employer's contributions. Importantly, violations due to reasonable cause and promptly corrected by a responsible party who has exercised reasonable diligence may not be subject to tax. Such corrective efforts may require retroactive action and

corrective "make whole" payments to affected individuals, and a filing may be required for the tax to be waived.

What Should Employers Do?

- Review the list of requirements to analyze potential risks.
- Design a system to monitor and capture instances of noncompliance.
- Determine responsibility for compliance with the Form 8928 reporting requirements.

Health Plan Requirements Subject to Reporting by Form 8928

- General COBRA notice
- COBRA election form
- HIPAA special enrollment rights and required notice
- HIPAA pre-existing condition exclusion limits and general and specific notices
- HIPAA creditable coverage notice
- Health status nondiscrimination requirements
- Mental health and substance abuse parity
- Newborns' and mothers' health protection act and required notices
- Women's health and cancer rights and required notices
- Genetic information nondiscrimination
- Michelle's law and required notice

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For specific technical or legal advice on the information provided and related topics, please contact Craig Wheaton at cwheaton@smithlaw.com 919.821.6627; Caryn McNeill at cmcneill@smithlaw.com 919.821.6746, or Jamie Hinkle at jhinkle@smithlaw.com 919.821.6686.

SMITH, ANDERSON, BLOUNT, DORSETT, MITCHELL & JERNIGAN, L.L.P.

Offices:
2500 Wachovia Capitol Center
Raleigh, North Carolina 27601
Mailing Address:
Post Office Box 2611
Raleigh, North Carolina 27602
Telephone: 919.821.1220 **Facsimile**: 919.821.6800
Email: info@smithlaw.com **Website**: www.smithlaw.com