Healthcare Reform: The Top 10 Issues for Employers

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Healthcare reform became reality this spring when President Obama signed the Patient Protection and Affordable Care Act and the related Health Care and Education Reconciliation Act of 2010. The following is a list of top 10 questions, issues and changes as businesses begin to look ahead to 2011 and 2012. Unless otherwise indicated, changes will apply starting with the first plan year that begins after September 22, 2010.

I. ARE COMPANIES REQUIRED TO PROVIDE HEALTH COVERAGE TO EMPLOYEES?

A. NO requirement to provide health coverage to employees.

B. Play or Pay: Starting in 2014, companies with 50 or more full-time equivalent employees (FTEs) generally will be subject to an expensive excise tax (a “free-rider” penalty) if they either do not provide health coverage for their full-time employees or any coverage does not provide certain “minimum essential coverage.”

C. The excise tax to apply starting in 2014 would equate to $2,000 per year for each FTE over 30 of the company.

II. IS YOUR PLAN GRANDFATHERED OR EXEMPT?

A. Grandfathered Plans: Group medical plans that existed on March 23, 2010, are “grandfathered” until changes cause them to lose grandfathered status.

1 Grandfathered Plans are exempt from the following mandates:

   (a) Nondiscrimination rules for insured plans (self-funded plans already are subject to nondiscrimination rules).

   (b) Expanded internal and external claims review and appeals processes.

   (c) No employee cost for certain preventative services.

   (d) Women must be permitted to select their own OB-GYN.

2 The following changes will cause plans to lose grandfathered status:

   (a) Entering into a new policy, certificate or insurance contract with the plan’s insurer.
(b) Changing the insurance carrier of the group health plan.

(c) Any increase in the employee’s percentage for co-insurance.

(d) Any increase in employee cost for deductible or out-of-pocket limits beyond a “maximum percentage increase” (the overall medical care component of the Consumer Price Index for All Urban Consumers plus 15%).

(e) Any copayment increase beyond the greater of (i) $5 (increased by medical inflation) or a total percentage of medical inflation plus 15%. These are measured from March 23, 2010.

(f) Over a 5% decrease in the employer’s contribution toward the cost of coverage for any class of similarly situated individuals.

(g) Any decrease in existing benefits or imposing of a new annual limit on the dollar value of benefits under a plan.

3 Is “Grandfathered” worth it or even possible?

(a) Notice requirements must be met. A model notice can be found at www.dol.gov/ebsa/grandfatherregmodelnotice.doc

(b) If insurance companies simply change their contracts to conform with the new requirements, non-self funded health plans effectively lose grandfathered status.

B. Exempt Plans:

1 Stand-alone Retiree Medical Coverage (plans with no more than 1 current employee).

2 Accident and disability insurance.

3 Vision-only and dental-only plans.

4 Most cafeteria plans.

III. REIMBURSEMENT FOR RETIREE MEDICAL. Employers that offer retiree health coverage for retirees age 55 to 64 may qualify for a temporary (now through December 31, 2013) reimbursement.

A. Employers may obtain reimbursement for costs, premiums or cost-sharing for 80% of the costs of a covered individual between $15,000 and $90,000.

B. A $5 billion fund was established in July to fund this reimbursement.

1 Employers should apply as soon as possible to receive reimbursements until the fund is depleted.
C. Employers must have their program approved for reimbursement and one condition is that the employer have programs or procedures in place for designed to generate cost savings of more than $15,000 in a year for participants with chronic and high risk conditions.

1. The company’s insurance (including stop-loss) carrier should have information on its programs/procedures.

D. Information about the reimbursement and an application has been published by the U.S. Department of Health and Human Services at: [http://www.errp.gov/](http://www.errp.gov/).

IV. **SMALL EMPLOYER TAX CREDITS.** A tax credit against regular or alternative minimum tax is available to certain small employers that pay at least 50% of the cost for health insurance for their employees.

A. The credit is available for the 2010 through 2013 tax years.

B. The maximum credit is an offset for 35% of the employer’s cost for health insurance. The credit is phased out:

1. Employers with 10 or less full-time equivalents (FTEs) employed during the tax year and average FTE wages of $25,000 will be eligible for the full credit.

2. Phased out credit ends with employers with 25 full-time equivalent employed during the tax year and full-time equivalent wages of $50,000.

C. No credit is available for self-employed individuals (including partners, over 2% S corporation shareholders and over 5% C corporation shareholders) and most of their family members and these individuals are also excluded when calculating FTEs and FTE wages.

D. The IRS has published detailed information about the credit and eligibility at: [http://www.irs.gov/newsroom/article/0,,id=223666,00.html](http://www.irs.gov/newsroom/article/0,,id=223666,00.html).

V. **NONDISCRIMINATION REQUIREMENTS FOR INSURED HEALTH PLANS.**

A. Noncompliance penalties of $100 per day for each affected participant.

B. The new rules are added in ERISA Section 715(a)(1) and Code Section 9815 and incorporate the non-discrimination rules that apply to self-funded plans under Code Section 105(h).

C. Types of arrangements the new rules will affect:

1. Providing employer-sponsored health insurance or coverage options for highly compensated employees (but not rank and file).

   (a) Plans for a single employee are exempt.

2. Greater percentages of insurance paid for higher compensated groups.
D. Planning to satisfy the new rules:

1. Passing the test: The IRS has asked for comments on the testing and seems inclined to simply continue the existing regulations under Code Section 105(h).

2. Individual policy for one employee.

3. Employer payments treated as taxable income to key employees.

VI. THE END TO REIMBURSEMENTS FOR NON-PRESCRIPTION MEDICINE.

A. No over-the-counter medicine (except insulin) purchased after December 31, 2010 will be eligible for reimbursement without a doctor’s prescription.

B. This rule applies to cafeteria plans that use the 2-1/2 month “grace period” for the current plan year.

C. Medical aids (e.g. bandages, contact lenses, contact solutions, blood sugar monitors) are still eligible for reimbursement even though purchased over-the-counter.

VII. HEALTH COVERAGE CHANGES FOR CHILDREN.

A. No pre-existing condition exclusions are allowed for children under age 19.

B. Plans that provide dependent health coverage must permit coverage for adult children until their 26th birthday.

1. A special notice and 30 day enrollment period must be given (and may be given solely to employees). A model notice can be found at www.dol.gov/ebsa/dependentsmodelnotice.doc.

2. Coverage must be permitted for both married and unmarried children.

3. A very limited exclusion (through 2013) applies solely to “grandfathered plans” under which a plan can exclude a child who is eligible for coverage under another employer’s health plan.

C. “Children” include the employee’s biological child, adopted child, stepchild and foster child.

1. Plans with expanded definitions of “children” (such as grandchildren) are not required to extend coverage to those “children.”

D. All eligible children under age 26 must be treated the same, including the charging of the same premium.

E. Cafeteria plans need to coordinate coverage with these rules.
1 Pre-tax premiums, coverage and medical expense reimbursements permitted for children who will not attain age 27 during the plan year.

2 Should the cafeteria plan:
   (a) Exclude coverage,
   (b) Cover only to age 26, or
   (c) Cover to end of plan year in which child attains 26?

VIII. LIMITS ON ESSENTIAL HEALTH BENEFITS.

   A. No aggregate lifetime limits and lifetime limits are permitted for “essential health benefits.”

   1 Essential health benefits are yet to be defined in regulations from HHS but will include, at a minimum, benefits in the following categories:
      (a) Ambulatory patient services
      (b) Emergency services
      (c) Maternity and newborn care
      (d) Prescription Drugs
      (e) Hospitalization
      (f) Laboratory services
      (g) Mental health and substance use disorder services
      (h) Rehabilitative and habilitative services and devices
      (i) Preventative and wellness services and chronic disease management
      (j) Pediatric services, including oral and vision care.

   2 Limits on non-essential benefits are still permitted.

   3 Exclusions for specific conditions are still permitted.

   4 Former participants who reached the plan’s lifetime maximum (but who are otherwise eligible) must be allowed to rejoin the plan through a 30-day special enrollment period. A model notice can be found at www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc.

   B. Annual individual dollar limits on coverage will be phased out.
1 Maximum **individual** limits on essential health benefits will be:
   (a) $750,000 for the next 2 plan years;
   (b) $1,250,000 for the plan year that begins in 2012;
   (c) $2,000,000 for the plan year that begins in 2013; and
   (d) No limit after that.

2 Limits that are not expressed in dollars (such as limits on treatment or office visits) are still permitted.

IX. **NEW APPEALS RULES.** Both insured and self-funded plans adopt new expanded claims appeals procedures:

A. Internal claims and appeals procedures must add the following new obligations:

1 A broader definition of an “adverse benefit determinations” will cover, for example, rescissions of coverage, claims denials due to ineligibility for participation, benefits not covered by the terms of a plan, and both pre-service and post-service claims.

2 Urgent care claims must be decided as quickly as possible and no later than 24 hours
   (a) Compare with the old 72 hour standard.
   (b) If claimant fails to provide sufficient information to determine whether or to what extent benefits are covered under the plan, plan may require and must provide claimant with at least 48 hours to provide additional information.

3 Plans must provide claimants with any new or additional evidence considered or relied upon (including the rationale) by the plan in connection with the claim.
   (a) This information must be provided prior to the initial or appeal determination so that claimant has time to respond prior to the final benefit or appeal denial.

4 In order to avoid conflicts of interest, plans may not hire, promote, compensate (such as through bonuses for claims denials) or terminate claims reviewers based on the likelihood the reviewers will support a denial of benefits.

5 Where a significant portion of a company’s employees cannot read English, substitute notices must be provided in a different language.
6 Notices must provide:

(a) Information identifying the claim, including diagnosis code, treatment code and the corresponding meaning of those codes.

(b) The reasons for an adverse benefit determination, including the denial code and its corresponding meaning.

(c) A description of available internal appeals and external review processes, including how to initiate an appeal.

(d) Contact information for any available consumer assistance established under the health care reform laws to assist individuals with internal claims and appeals and external review processes.

7 Plans must strictly adhere to all internal claims and appeals processes or there will be a “deemed exhaustion” of claims, meaning that claimants can then proceed to external review or to litigation.

B. Health plans must provide continued coverage pending the outcome of the internal appeal, so ongoing treatment cannot be reduced or terminated without advance notice and an opportunity for advance review.

C. A new external appeals process will apply. Either:

1 A state external review process that meets certain minimum standards outlined in regulations, or

2 A new federal external review process.

(a) “Safe harbor” standards have been issued which generally require a plan (or third party administrator) to contract with at least 3 independent review organizations and rotate claims among them.

D. A non-enforcement grace period until July 1, 2011 has been provided to allow plans that are making good faith progress toward compliance to fully implement the new standards.

E. For insured plans, compliance with these rules by the insurer will result in compliance by the plan/employer.

F. Self-Funded plans will need to incorporate these new rules into their plan documents. With regard to external review, self-funded plans may either choose to apply a state external review process (assuming it meets the required minimum standards) or can apply the federal process. Minnesota has an external claims review law at Minn. Stat. §62Q.73.
G. Model notices to comply with the new rules can be found at:

1  www.dol.gov/ebsa/IABDModelNotice1.doc
2  www.dol.gov/ebsa/IABDModelNotice2.doc
3  www.dol.gov/ebsa/IABDModelNotice3.doc

X. WHAT DO THE ELECTION RESULTS MEAN FOR HEALTHCARE REFORM?

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