Employment Law IN Brief ™

Recent Developments in Healthcare Reform: What Employers Need to Know

By: Gregory P. Kult*
October 20, 2010

The Departments of Health and Human Services ("DHHS"), Labor ("DOL") and Treasury ("DOT") recently issued several regulations and commentary to implement portions of the Patient Protection and Affordable Care Act ("PPACA") -- the federal healthcare reform law that was passed earlier this year. Faced with hundreds of pages of new regulations, employers have been asking: "What does all of this mean for me?" Set forth below is a summary of recent regulatory developments of which employers should be aware.

Pre-Existing Condition Insurance Plan Program

The PPACA provides for a temporary high risk health insurance program to provide affordable health insurance to uninsured people with pre-existing conditions ("Program"). The Program expires January 1, 2014, when Exchanges are to be established.

When passing the PPACA, Congress recognized that employers would have an incentive to single out high risk (high cost) individuals and offer them incentives to disenroll in employer-provided coverage and seek coverage under the Program. DHHS recently published an Interim Final Rule that prohibits employers from discouraging individuals from remaining enrolled in employer-provided coverage based on the individual's health status. Examples of prohibited conduct include, but are not limited to:

- Rewarding an employee or dependent for not enrolling in, or for disenrolling from, employer-provided coverage. An example would include paying the participant's premium for enrolling in the Program.
- Providing disincentives for remaining enrolled in employer-provided coverage.
- Increasing the premium for employer-provided coverage to an amount that exceeds the premium required by the Program, properly adjusted, when the increase "was not otherwise explained."

If an employer violates this rule and the individual at issue enrolls in the Program, the employer may be billed for the medical expenses incurred by the Program with respect to that individual and may be referred to appropriate federal and state authorities for other enforcement actions.

Citation: Federal Register, Vol. 75, No. 146 (July 30, 2010), pp. 45014-45033

Internal Claims and Appeals and External Review Processes

DHHS, DOL, and DOT recently implemented an Interim Final Rule regarding internal claims and appeals and external review processes under the PPACA. The Interim Final Rule does not apply to grandfathered plans.

Essentially, a group health plan (or issuer) must comply with the requirements of 29 C.F.R. § 2560.503-1, with the following additions:

- Rescission of coverage constitutes an adverse benefit determination.
- With limited exceptions, the plan must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, but not later than 24 hours after receipt of the claim by the plan.
- Claimants must have an opportunity to review the claim file and present evidence and testimony as part of the internal claims and appeals process. Claimants must be provided, free of charge, any evidence considered in making, and any rationale for, a final internal adverse benefit determination sufficiently in advance of the determination to give the claimant a reasonable opportunity to respond.
- All claims and appeals must be determined in a manner designed to insure the independence and impartiality of the decision-makers. Decisions concerning hiring, compensation, termination, promotion, *etc.* with regard to any claims adjudicator or medical expert must not be made based on the likelihood that the individual will support the denial of benefits.
- Notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The reason(s) for the adverse benefit determination or final internal adverse benefit determination must include the denial code and its corresponding meaning as well as a description of the plan's standard, if any, that was used in denying the claim.
- The plan must provide a description of available internal appeals and external review processes.
- The plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the claims and appeals process.
- The plan must provide continued coverage pending the outcome of an appeal.
- Notices of the claims and appeals process must be provided in a culturally and linguistically appropriate manner.
- External review processes also are addressed in the Interim Final Rule.

Citation: Federal Register, Vol. 75, No. 141 (July 23, 2010), pp. 43330-43364; Federal Register, Vol. 75, No. 165 (August 26, 2010), pp. 52597-52599

Coverage of Preventive Services

DHHS, DOL, and DOT recently issued an Interim Final Rule to implement the PPACA requirements that a group health plan provide benefits for certain types of preventive care with no cost-sharing requirements. The Interim Final Rule does not apply to grandfathered plans.

For plan years that begin on or after September 23, 2010, a group health plan must provide coverage for the following items and services with no cost-sharing requirements (such as a co-payment, co-insurance, or deductible):

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. (Recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November, 2009 are not considered to be current for purposes of the Interim Final Rule.)
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

If one of the above items/services is billed separately (or tracked as individual encounter data separately) from an office visit, the plan may impose cost-sharing requirements with respect to the office visit. However, if an item or service described above is not billed/tracked separately from an office visit, whether the plan may impose cost-sharing requirements for the office visit depends on the primary purpose of the visit:

- If the primary purpose of the office visit is not the delivery of an item or service described above, cost-sharing requirements for the office visit may be imposed.
- If the primary purpose of the office visit is the delivery of an item or service described above, cost-sharing requirements for the office visit may not be imposed.

The Interim Final Rule does not prohibit cost-sharing requirements for items/services described above that are delivered by an out-of-network provider.

Citation: Federal Register, Vol. 75, No. 137 (July 19, 2010), pp. 41726-42760.

Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

DHHS, DOL, and DOT recently issued Final and Proposed Rules regarding pre-existing condition exclusions, lifetime and annual limits, rescissions and patient protections.

Pre-Existing Condition Exclusions

This rule applies to grandfathered plans. With respect to plan years beginning on or after January 1, 2014, a group health plan may not impose any pre-existing condition exclusion (A pre-existing condition exclusion means a limitation or exclusion of benefits, including denial of coverage, based on the fact that the condition was present before the effective date of coverage/denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date). The prohibition of pre-existing condition exclusions applies earlier for children. Specifically, enrollees, including applicants for enrollment, who are under 19 years of age for plan years beginning on or after September 23, 2010 may not be subject to a pre-existing condition exclusion.

Lifetime and Annual Limits

This rule applies to grandfathered group plans.

- For plan years beginning on or after September 23, 2010, group health plans may not establish a lifetime limit on the dollar amount of "essential health benefits." With respect to individuals whose coverage or benefits ended due to reaching a lifetime limit who would be eligible for benefits on the first day of the first plan year beginning on or after September 23, 2010 (because the lifetime limitation no longer applies), such individual must be given written notice that the lifetime limit no longer applies and that the individual is once again eligible for benefits under the plan. The individual must be given at least 30 days to enroll. Any individual enrolling in a group health plan under these circumstances must be treated as a special enrollee. As such, the individual must be offered the same benefits available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit.
- For plan years beginning on or after January 1, 2014, group health plans may not establish an annual limit on the dollar amount of "essential health benefits." This does not apply to health flexible spending arrangements as defined in Section 106(c)(2) of the Internal Revenue Code. With respect to plan years beginning on or after September 23, 2010 and prior to January 1, 2014, a group health plan may establish an annual limit on the dollar amount of essential health benefits, provided that the limit is no less than:
  (i) $750,000 (for plan years beginning on or after September 23, 2010, but before September 23, 2011);
  (ii) $1,250,000 (for plan years beginning on or after September 23, 2011, but before September 23, 2012); and

(iii) $2,000,000 (for plan years beginning on or after September 23, 2012, but before January 1, 2014).

Rescission

This rule applies to grandfathered group plans.

- For plan years beginning on or after September 23, 2010, a group health plan may not rescind coverage (a rescission is a cancellation or discontinuance of coverage that has retroactive effect) unless the individual (or a person seeking coverage on behalf of the individual) engages in fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan. The plan must provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded.

Patient Protections

This rule does not apply to grandfathered plans. For plan years beginning on or after September 23, 2010:

- If the plan requires designation of a participating primary care provider, any participating primary care provider who is available to accept the individual may be designated.
- If the plan requires designation of a participating primary care provider for a child, any participating physician who specializes in pediatrics and is available to accept the individual may be designated.
- A group health plan may not require authorization or referral by the plan, or any person (including the primary care provider) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.
- Notices describing the above requirements must be included whenever the plan provides a participant with a summary plan description. Model language is included in the Interim Final Rule at 45 C.F.R. § 147.138(a)(4)(iii).
- If a group health plan provides benefits with respect to hospital emergency department services, the plan must cover emergency services in the following manner:
  (i) Without the need for any prior authorization, even if the emergency services are provided out-of-network;
  (ii) Without regard to whether the healthcare provider furnishing the emergency services is a participating network provider;
  (iii) Without imposing any administrative requirement or limitation on coverage that is more restrictive on out-of-network providers than in-network providers;

(iv) Without implementing a higher co-payment or co-insurance rate for out-of-network providers than in-network providers (but additional costs to the plan for services by an out-of-network provider may be transferred to the participant); and

(v) Without regard to any other term or condition of coverage, other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted by federal laws, or applicable cost-sharing.

Citation: Federal Register, Vol. 75, No. 123 (June 28, 2010), pp. 37188-37241.

Grandfathered Health Plans

Several of the provisions of the PPACA do not apply to "grandfathered" health plans. DHHS, DOL, and DOT have implemented an Interim Final Rule and Proposed Rule concerning grandfathered status under the PPACA.

- Grandfathered health plan coverage means coverage provided by a group health plan in which an individual was enrolled on March 23, 2010. A group health plan does not lose its grandfathered status merely because one or more (or even all) individuals who were enrolled on March 23, 2010 cease to be covered, as long as the plan has continuously covered someone since March 23, 2010.
- Subject to special rules for collectively bargained plans, if an employer enters into a new policy, certificate, or contract of insurance after March 23, 2010 (because, for example, the previous coverage was not renewed) the new policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in the group plan.
- To maintain status as a grandfathered health plan, in any materials provided to a participant or beneficiary describing the benefits provided under the plan, the plan must include a statement that the plan believes it is a grandfathered health plan. Model language is provided at 45 C.F.R. § 147.140.
- To maintain status as a grandfathered health plan, a group plan must maintain records documenting the terms of the plan in effect on March 23, 2010.
- If an individual is enrolled in a grandfathered plan on March 23, 2010, grandfathered health plan coverage includes coverage of family members who enroll after March 23, 2010.
- A grandfathered plan that provided coverage on March 23, 2010 that maintains its status as a grandfathered health plan is considered grandfathered health plan coverage for new employees and their families who enroll in the plan after March 23, 2010.
- The Interim Final Rule includes "anti-abuse rules." For example, if the main purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan. Moreover, transferring employees from one plan to another may cause a plan to lose it grandfathered status if there was no bona fide employment reason to

transfer the employees (changing the terms or cost of coverage is not considered a bona fide employment reason).

- With respect to collectively bargained plans ratified before March 23, 2010, coverage is grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates.
- Situations in which a group health plan will cease to be a grandfathered health plan include:
  - (i) Elimination of all or substantially all benefits to diagnose or treat a particular condition.
  - (ii) Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's co-insurance requirement).
  - (iii) Any increase in a fixed amount cost-sharing requirement other than a co-payment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the "maximum percentage increase" (defined as "medical inflation," expressed as a percentage, plus 15 percentage points, with "medical inflation" being defined as the increase since March, 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100).
  - (iv) Any increase in a fixed amount co-payment if the total increase in the co-payment measured from March 23, 2010 exceeds the greater of: (A) $5.00 times "medical inflation" plus $5.00; or (B) the "maximum percentage increase" determined by expressing the total increase in the co-payment as a percentage.
  - (v) The employer or employer organization decreases its contribution rate based on cost of coverage (as defined in the regulations) toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010, or, if the contribution rate is based on a formula, the employer or employer organization decreases its contribution rate based on a formula toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.
  - (vi) A plan that did not impose an overall annual or lifetime limit on March 23, 2010 subsequently imposes an overall annual limit on the dollar value of benefits.
  - (vii) A plan that imposed an overall lifetime limit on benefits but no annual limit as of March 23, 2010 subsequently adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit in effect on March 23, 2010.
  - (viii) A plan that imposed an overall annual limit on benefits as of March 23, 2010 subsequently decreases the dollar value of the annual limit.

One Indiana Square, Suite 1800,
Indianapolis, IN 46204-4208
www.woodmclaw.com
PH: 317.639.6151 | 1.888.639.6151

- For employers who made changes to their group health plan that would otherwise jeopardize its grandfathered status, there are certain transitional rules depending on whether changes were made prior to or after March 23, 2010. With regard to changes made prior to March 23, 2010, the following changes will be considered part of the plan on March 23, 2010, and, therefore, will not cause a plan to lose grandfathered status:
  - (i) Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010;
  - (ii) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a state insurance department; or
  - (iii) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.
- With regard to changes made after March 23, 2010 and adopted prior to June 14, 2010, the changes will not cause the plan to lose its grandfathered status if the changes are revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010 and the terms of the plan, as modified, would not cause the plan to lose grandfathered status. Changes are considered adopted prior to June 14, 2010 if:
  - (i) The changes are effective before that date;
  - (ii) The changes are effective on or after that date pursuant to a legally binding contract entered into before that date;
  - (iii) The changes are effective on or after that date pursuant to a filing before that date with a state insurance department; or
  - (iv) The changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

Citation: Federal Register, Vol. 75, No. 116 (June 17, 2010), pp. 34538-34570.

<u>Dependent Coverage of Children to Age 26</u>

DHHS, DOL and DOT have issued an Interim Final Rule and Proposed Rule concerning the PPACA's provisions regarding dependent coverage of children to age 26.

- Except for special rules that apply to grandfathered plans, described below, for plan years beginning on or after September 23, 2010, a group health plan that makes dependent coverage of children available must make such coverage available for children until they reach 26 years of age. With respect to a child who has not reached the age of 26, a plan may not define "dependent" for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. For example, the plan may not deny or restrict coverage for a child who has not reached the age of 26 based on the presence or absence of the child's financial dependency, residency with the participant or with any other person, student status, employment, or any combination of those factors. Terms of dependent coverage may not vary based on age.

- With respect to individuals whose coverage ended by reason of reaching a dependent eligibility threshold in an earlier version of the plan, the group health plan must give the child notice and at least 30 days to enroll. Any child so enrolling must be treated as a special enrollee. As such, the child must be offered all the benefit packages available to similarly situated individuals who did not lose coverage because of losing dependent status.
- For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent. For plan years beginning on or after January 1, 2014, a grandfathered plan that offers dependent coverage must cover dependents to age 26.

Citation: Federal Register, Vol. 75, No. 92 (May 13, 2010), pp. 27122-27140.

Early Retiree Reinsurance Program

DHHS issued an Interim Final Rule concerning the PPACA provisions providing for an early retiree reinsurance program. Employers whose group health plans provide health benefits to early retirees and who want to participate in this program must apply to the DHHS to participate. If approved, employers and plans may submit claims to DHHS for approval of partial reimbursement of health care costs.

Citation: Federal Register, Vol. 75, No. 86 (May 5, 2010), pp. 24450-24470.

By: Gregory P. Kult
317.860.5341 (direct)
317.639.6151 (firm)
877.639.6151 (toll free)
gkult@woodmclaw.com

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