

Employers: Prepare Now for the Impact of Health Care Reform in 2011

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It's that time again – open enrollment season for employer's group health plans. Due to the enactment of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together, the "Health Care Reform Legislation") in March of this year, the open enrollment season for 2011 group health benefits is guaranteed to be challenging for employers. For the many employers in the U.S. that run their group health plans on a calendar year cycle – January 1 to December 31 – several changes mandated by the Health Care Reform Legislation will become effective on January 1, 2011.

The Health Care Reform Legislation, passed using the controversial reconciliation process, provided only minimal guidance regarding many of its provisions, leaving most of the details to implementing regulations. Over the past several months, the Department of Health and Human Services ("HHS"), the Department of the Treasury (the "Treasury"), and the Department of Labor (the "DOL") have been steadily issuing these implementing regulations and other guidance on various aspects of the Health Care Reform Legislation. These regulations and guidance contain a myriad of employer obligations under the Health Care Reform Legislation, some of which will require almost immediate attention from employers with group health plans.

Get Ready Now – Health Care Reform Legislation Changes Effective in 2011

Many changes under the Health Care Reform Legislation become effective for plan years beginning on or after September 23, 2010 – January 1, 2011 for calendar year plans. Some of the most significant of these changes are highlighted below.

- *Dependent Coverage to Age 26.* Group health plans offering dependent coverage will be required to provide coverage for participants' adult children up to age 26, regardless of residency and marital status.¹
- *Prohibition on Pre-Existing Condition Exclusions for Children under Age 19.* Group health plans will be prohibited from imposing pre-existing condition exclusions on children under the age of 19.² (Effective January 1, 2014, group health plans will be prohibited from imposing pre-existing condition exclusions on any individuals.)³
- *Elimination of Lifetime Limits.* Group health plans will be prohibited from imposing lifetime limits on the dollar value of benefits for any participant or beneficiary.⁴
- *Restrictions on Annual Limits.* Group health plans will be prohibited from imposing annual limits on the dollar

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value of benefits for any participant or beneficiary, subject to an exception that group health plans may impose "restricted" annual limits on "essential health benefits" prior to 2014.⁵

- *New Rules Regarding Rescissions.* Group health plans will be prohibited from rescinding a participant's coverage, except where the individual has performed an act or practice constituting fraud or has made an intentional misrepresentation of material fact as prohibited under the terms of the plan.⁶
- *Preventative Services with No Cost-Sharing.* Group health plans will be required to cover, without any cost-sharing (e.g., co-payments, coinsurance, or deductibles), certain recommended preventative care services and items.⁷
- *Claims Appeal Process Changes.* Group health plans will be required to implement an internal and external claims appeal process, including specific employee notifications regarding such processes.⁸
- *Requirement to Provide "Patient Protections."* Group health plans will be required to (1) allow participants to select any available participating primary care provider or pediatrician, (2) permit participants to obtain OB/GYN care without pre-authorization, (3) eliminate pre-authorization requirements for emergency services, and (4) eliminate higher cost-sharing amounts for out-of-network emergency care or provider services.⁹
- *Nondiscrimination Testing for Fully-Insured Plans.* Fully-insured group health plans will be required to comply with the existing nondiscrimination rules for self-funded group health plans under Section 105(h) of the Internal Revenue Code of 1986, as amended (the "Code").¹⁰

- *Prohibition on Reimbursement of Over-the-Counter Drugs without a Prescription.* Tax-favored health accounts (e.g., health flexible spending accounts, health reimbursement arrangements, and health savings accounts) may not reimburse costs for over-the-counter ("OTC") medicines or drugs unless (1) the individual obtains a prescription for the OTC medicine or drug, or (2) the medicine or drug is insulin. This rule becomes effective on January 1, 2011 regardless of whether an employer uses a non-calendar plan year or has implemented a grace period.¹¹

Grandfathered Health Plan Status – What Is It and How It Can Help Your Group Health Plan

Certain changes under the Health Care Reform Legislation do not apply to "grandfathered health plans" – health plans in which at least one individual was enrolled on March 23, 2010.¹² For instance, the requirement to provide preventative services with no cost-sharing, the claims appeal process changes, and the application of the Code Section 105(h) nondiscrimination rules to fully-insured plans do not apply to grandfathered health plans.

However, many other changes under the Health Care Reform Legislation will apply *regardless* of grandfathered health plan status. These include the requirement to provide dependent coverage for adult children to age 26, the prohibition on pre-existing condition exclusions, the restrictions on annual and lifetime limits, and the new rules regarding rescission of health coverage.

In June, HHS, the Treasury and the DOL jointly-issued interim final regulations addressing grandfathered health plan status and identifying the changes that will (and will not) cause a health plan to lose grandfathered status. Many of the changes that will result in a loss of grandfathered health plan status involve increases in employees' cost of

coverage. For example, under the regulations addressing grandfathered status, co-insurance percentages cannot be increased by any amount, fixed dollar cost-sharing amounts cannot be increased by more than 15% beyond the increase in the medical inflation rate, and co-payments cannot be increased beyond the greater of (1) 15% plus medical inflation or (2) \$5 increased by medical inflation.¹³ As a result, employers who wish to retain grandfathered health plan status will have limited flexibility to change the cost structure of their group health plans.

Now Is the Time to Make Decisions Regarding Grandfathered Health Plan Status

At this juncture, employers should weigh the advantages and disadvantages of retaining grandfathered status for their group health plans for the 2011 plan year, while keeping in mind that retaining grandfathered status may not be feasible or reasonable in certain circumstances. Employers should review their current plan designs and consider (1) what Health Care Reform Legislation changes will be required to be implemented if grandfathered status is lost, (2) the cost for implementing such changes, and (3) whether these costs will be more burdensome than the lack of flexibility in plan design associated with retaining grandfathered status. It is important to note that federal regulators will continue to issue regulations and guidance on various aspects of the Health Care Reform Legislation in the upcoming months. In light of the substantial employer obligations contained in the regulations issued thus far, the benefit of retaining grandfathered health plan status may not be fully appreciated at this time. Determining the true benefit of grandfathered status will be a unique process for each employer and each group health plan. Importantly, once grandfathered status is lost, it cannot be reinstated, so the decision process must be undertaken with great care.

Communicating Plan Design Changes

Communication regarding employer-provided health benefits is becoming increasingly important, especially in connection with the Health Care Reform Legislation changes. To effectively communicate these changes to employees, employers will need to update enrollment materials and participant communications, including plan documents and summary plan descriptions ("SPDs"), for the upcoming 2011 plan year. The Health Care Reform Legislation and its implementing regulations contain several specific employer communication obligations, the most significant of which are summarized below.

- *Notice Regarding Grandfathered Status.* If an employer intends to retain grandfathered status for its health plan, the employer must provide plan participants with a statement that the plan intends to retain such status and that certain Health Care Reform Legislation changes do not apply to the plan.¹⁴ Sample language has been issued to satisfy this disclosure requirement.¹⁵
- *Special Enrollment and Plan Amendments Regarding Dependent Coverage to Age 26.* Adult children who become eligible to enroll in a group health plan because of the expanded dependent coverage requirement for adult children must be provided written notice of their enrollment rights.¹⁶ The DOL has issued a model notice to satisfy this disclosure requirement.¹⁷ In addition, plan documents and SPDs must be amended to remove qualifiers such as financial dependency, residency, and age (under age 26), from the plan's definition of "dependent."¹⁸
- *Special Enrollment and Plan Amendments Regarding Lifetime Limits.* Individuals who had reached a lifetime limit under a group health plan, and who are otherwise still eligible for

coverage under the plan, must be provided with written notice that the lifetime limit no longer applies and that they are eligible for coverage.¹⁹ The DOL has issued a model notice to satisfy this disclosure requirement.²⁰ In addition, plan documents and SPDs must be amended to remove lifetime limits.

- *Notification and Plan Amendments Regarding "Patient Protections."* If the plan is not a grandfathered health plan, plan participants must be provided with a notice describing the right to select any available participating primary care provider or pediatrician, and the right to obtain OB/GYN care without pre-authorization.²¹ The DOL has issued a model notice to satisfy this disclosure requirement.²² In addition, plan documents and SPDs must be amended to include these "patient protections."
- *Plan Amendments Regarding Annual Limits.* Plan documents and SPDs must be amended to remove annual limits that do not meet the "restrictions" applicable to "essential health benefits."²³
- *Plan Amendments Regarding Pre-Existing Condition Exclusions.* Plan documents and SPDs must be amended to eliminate pre-existing condition exclusions for children under age 19.²⁴
- *Plan Amendments Regarding Rescission.* Plan documents and SPDs must be amended to incorporate the new rules regarding rescission (*i.e.*, that rescissions are only permitted in cases of fraud or intentional misrepresentation of a material fact).²⁵
- *Plan Amendments Regarding Preventative Services.* If the plan is not a grandfathered health plan, the plan document and SPD must be amended to eliminate any applicable cost-sharing requirements (*e.g.*, co-payments, coinsurance, or deductibles) for certain

recommended preventative care services and items.²⁶

- *Plan Amendments Regarding Claims Appeal Process Changes.* If the plan is not a grandfathered health plan, the plan document and SPD must be amended to reflect the internal and external claims appeal process changes.²⁷
- *Plan Amendments Regarding the Reimbursement of OTC Drugs.* Plan documents and SPDs for health flexible spending accounts, health reimbursement arrangements, and health savings accounts must be amended to reflect the new requirements regarding OTC medicines and drugs.²⁸ In addition, cafeteria plan documents must be amended to include these requirements.²⁹ The Internal Revenue Service has indicated that cafeteria plans may be amended retroactively to December 31, 2010 to reflect the new rules regarding OTC medicines or drugs, so long as such amendments are adopted no later than June 30, 2011.³⁰

Conclusion

With the multitude of changes under the Health Care Reform Legislation, employers are understandably overwhelmed and confused about their new obligations under the Health Care Reform Legislation. At the same time, employees are becoming increasingly focused on their employer-provided health benefits in light of the Health Care Reform Legislation.

Among all of the required disclosures and participant communications mandated by the Health Care Reform Legislation, employers should also consider providing additional information about health care reform, including materials provided by its health care advisors and administrators, and links to government resources

such as www.healthcare.gov (a website developed by HHS providing general and specific information about the Health Care Reform Legislation). As employers prepare these disclosures and communications, they should take this opportunity to communicate not just the changes required in 2011 because of the Health Care Reform Legislation, but also consider using this opportunity to explain the true cost and value of employer-provided health care coverage to their employees. Health care reform is coming; employers should consider taking advantage of employees' interests in the topic to promote employer goodwill while meeting their legal obligations under the Health Care Reform Legislation.

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amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, § 2301(b), 124 Stat. 1029, 1082.

² Public Health Service Act § 2704, 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-4), *amended and redesignated by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1201(a)(A), 124 Stat. 119, 154 (2010); the Affordable Care Act § 1253, 124 Stat. 162, redesignated as § 1255 by the Affordable Care Act, § 10103(f), 124 Stat. 895.*

³ Patient Protection and Affordable Care Act, P.L. 111-148, § 1253, 124 Stat. 119, 162 (2010), *amended by Act § 10103(e), 124 Stat. 895, redesignated as § 1255 by the Affordable Care Act § 10103(f), 124 Stat. 895.*

⁴ Public Health Service Act § 2711(a)(1), 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-11), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1001(5), 124 Stat. 119, 131 (2010), amended by the Affordable Care Act, § 10101(a), 124 Stat. 883.*

⁵ *Id.*

⁶ Public Health Service Act § 2712, 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-12), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1001(5), 124 Stat. 119, 131 (2010).*

⁷ Public Health Service Act § 2713(a), 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-13), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1001(5), 124 Stat. 119, 131 (2010).*

⁸ Public Health Service Act § 2719, 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-19), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1001(5), 124 Stat. 119, 137-138 (2010), amended by the Affordable Care Act, § 10101(g), 124 Stat. 887-888.*

⁹ Public Health Service Act § 2719A, 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-19a), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 10101(g), 124 Stat. 119, 888-890 (2010).*

¹⁰ Public Health Service Act § 2716(a), 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-16), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1001(5), 124 Stat. 119, 135 (2010), amended by the Affordable Care Act, § 10101(d), 124 Stat. 884.*

¹¹ I.R.C. § 106 (2006) (to be codified at I.R.C. § 106(f)), *amended by the Patient Protection and Affordable Care Act, P.L. 111-148, § 9003(c), 124 Stat. 119, 854 (2010).*

¹² Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a

¹ Public Health Service Act § 2714, 42 U.S.C. 200, et. seq. (2006) (to be codified at 42 U.S.C. 300gg-14), *added by the Patient Protection and Affordable Care Act, P.L. 111-148, § 1001(5), 124 Stat. 119, 132 (2010),*

Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34558 (proposed June 16, 2010) (to be codified at 26 C.F.R. § 54.9815-1251T(a)(1)(i)).

¹³ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34560 (proposed June 16, 2010) (to be codified at 26 C.F.R. § 54.9815-1251T(g)(1)(ii)-(iv)).

¹⁴ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34558 (proposed June 16, 2010) (to be codified at 26 C.F.R. § 54.9815-1251T(a)(2)(i)).

¹⁵ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34558 (proposed June 16, 2010) (to be codified at 26 C.F.R. § 54.9815-1251T(a)(2)(i)).

¹⁶ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Dependent Coverage of Children Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27122, 27135 (proposed May 13, 2010) (to be codified at 26 C.F.R. § 54.9815-2714T(f)(2)).

¹⁷ Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26, Department of Labor, <http://www.dol.gov/ebsa/dependentsmodelnotice.doc> (last visited September 10, 2010).

¹⁸ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Dependent Coverage of Children Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27122, 27134 (proposed May 13, 2010) (to be codified at 26 C.F.R. § 54.9815-2714T(b)).

¹⁹ Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37224 (proposed June 28, 2010) (to be codified at 26 C.F.R. § 54.9815-2711T(e)(2)).

²⁰ Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity, Department of Labor, <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc> (last visited September 10, 2010).

²¹ Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual

Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37224, 37226-37227 (proposed June 28, 2010) (to be codified at 26 C.F.R. § 54.9815-2719AT(a)(4)).

²² Patient Protection Model Disclosure, Department of Labor, <http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc> (last visited September 10, 2010).

²³ Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37223-37224 (proposed June 28, 2010) (to be codified at 26 C.F.R. § 54.9815-2711T(d)).

²⁴ Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37223 (proposed June 28, 2010) (to be codified at 26 C.F.R. § 54.9815-2704T(a), (b)(2)).

²⁵ Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37225 (proposed June 28, 2010) (to be codified at 26 C.F.R. § 54.9815-2712T(a)).

²⁶ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41756 (proposed July 19, 2010) (to be codified at 26 C.F.R. § 54.9815-2713T(a)(1)).

²⁷ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41756 (proposed July 23, 2010) (to be codified at 26 C.F.R. § 54.9815-2719T(a)(1)).

²⁸ I.R.S. Notice 2010-59.

²⁹ Id.

³⁰ Id.