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Group Health Plans: Are You Ready for Healthcare Reform?

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As the end of the year approaches, employers are preparing to implement new requirements for calendar-year group health plans under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together Healthcare Reform, or HCR) on January 1, 2011. This LawFlash reviews planning opportunities and required changes, notices, and plan amendments that should be on every plan sponsor's to-do list at the end of 2010.

Planning Opportunities

Will your plan be grandfathered for 2011?

By now, an analysis of the relative advantages and disadvantages of maintaining grandfathered plan status for 2011 should be completed. In order for a coverage option to be grandfathered, it must meet these basic requirements: (1) the coverage option was in existence on March 23, 2010, (2) at least one employee was covered on that date and at least one employee continues to be covered, and (3) no impermissible changes have been made to the coverage option.

Electing to remain grandfathered for 2011 will enable plans to avoid reforms that become effective next year, such as first-dollar preventive care coverage, new nondiscrimination rules, and new internal and external claims procedures. Some employers may choose to have their plans remain grandfathered next year simply to buy more time to come into compliance with HCR. However, the grandfathering rules put serious restraints on an employer's ability to adjust benefits and respond to market conditions. In some cases, insured plans may not have the choice to remain grandfathered because the insurance products they previously used will be changed or eliminated—but note that recent guidance reverses earlier interim final rules and now allows employers to change insurers (while making no other changes) without automatically losing grandfather status.

Even plans that remain grandfathered are required to meet certain new requirements, as described below.

Can you take advantage of exemptions for retiree-only plans, limited-scope dental and vision plans, and supplemental plans?

Certain types of plans that are exempt from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) also are exempt from the group market reforms under HCR, which may present opportunities for employers to peel off certain benefits and thus avoid the new requirements. Separate

plans will require, at a minimum, separate plan documents, summary plan descriptions, and annual filings on Form 5500.

Retiree Plans. Group health plans that have fewer than two participants who are current employees are exempt under HIPAA and also exempt from HCR. As a result, a plan sponsor may avoid the application of many HCR requirements by creating a separate retiree-only plan effective on or before January 1, 2011. Some retiree plans also cover individuals on long-term disability. Recent guidance issued by the Department of Labor (DOL) states that these plans will be treated as exempt retiree-only plans at least until further guidance is issued, which will be prospective only.

Dental and Vision Plans. Limited-scope dental and vision benefits are exempt if they (i) are offered under a separate policy, certificate, or contract of insurance, or (ii) are not an integral part of the group health plan. If dental and vision benefits are provided pursuant to a separate election and at least a nominal employee contribution is charged, the benefits will be considered not integral and will be exempt.

Executive Plans. Also exempt from HIPAA are certain "supplemental plans." HIPAA exempts Medicare supplemental insurance, TRICARE coverage for military personnel, and "similar supplemental coverage" if the benefits are provided under a separate policy, certificate, or contract of insurance. This exception could be significant for an employer that wishes to provide extra health insurance benefits to executives. The federal agencies responsible for enforcing HIPAA have issued safe harbor rules that provide that a supplemental plan will be treated as exempt only if it meets the following conditions:

- It is issued by an entity that does not provide the primary coverage under the group health plan.
- It is specifically designed to supplement gaps in the primary coverage, such as payment of co-payments and deductibles.
- The cost of the supplemental coverage does not exceed 15% of the cost of the primary coverage.
- It does not differentiate among individuals in eligibility, benefits, or premiums based on a health factor.

If supplemental health insurance offered to executives satisfies these requirements, such coverage will not be subject to most of HCR, including the nondiscrimination rules.

Who will be eligible for dependent coverage under your plans?

HCR requires plans that offer coverage for sons, daughters, stepchildren, adopted children, and foster children to offer such coverage until age 26 without regard to support, residency, or other dependency factors. Such coverage may also be provided on a pretax basis through the employer's cafeteria plan until the end of the calendar year in which the child attains age 26. Employers who cover other children, such as grandchildren or nieces and nephews, may continue to impose additional eligibility requirements on those individuals, such as a condition that the individual be a dependent for income tax purposes. Coverage may only be provided on a pretax basis under a cafeteria plan if such other children are tax dependents. Also, employers must decide whether the same or different dependent eligibility requirements will apply for other benefits, such as dental and vision coverage.

Practice pointer: Be certain that your cafeteria plan document allows for payment of coverage for adult children on a pretax basis. If it does not, you must amend the terms of your plan by December 31, 2010. See additional details below.

Will you apply for a waiver for a "mini-med" plan?

Many employers provide part-time and seasonal employees with limited, low-cost medical coverage under what are commonly known as "mini-med" plans. These plans will no longer be permissible under HCR; however, before January 1, 2014, a plan that has annual dollar limits on essential health benefits below the restricted amounts may apply for a waiver if compliance with the new limits would result in a significant decrease in access to benefits under the plan or would significantly increase premiums for the plan. Application for a waiver must be submitted at least 30 days before the start of the plan year.

Changes Required for 2011

All **nonexempt plans** (including grandfathered plans) must make the following changes:

- **Dependent Coverage:** A plan that covers sons, daughters, stepchildren, adopted children, and foster children must cover them until age 26 and must offer a special enrollment period of at least 30 days for adult children who previously aged out of coverage.
- **Lifetime Limits:** Plans may not impose lifetime limits on essential health benefits and must offer a special enrollment period of at least 30 days to individuals who previously lost coverage due to a lifetime limit.
- **Annual Limits:** Plans may not impose annual limits on essential health benefits. This requirement is phased in over the next three years, with minimum annual limits set at $750,000 for 2011, $1.25 million for 2012, and $2 million for 2013.
- **Pre-existing Conditions:** A plan may not impose pre-existing condition limitations on enrollees under age 19. This requirement extends to all enrollees for plan years beginning on or after January 1, 2014.
- **Rescission:** Generally, a plan may terminate coverage retroactively only in the event of fraud or intentional misrepresentation by a participant or a failure to timely pay required premiums. However, in the case of certain administrative delays, such as canceling coverage after termination of employment or after notification of an employee's divorce, recent Q&As indicate that coverage may be canceled retroactive to the date of the termination or divorce.
- **OTC Drugs:** Expenses incurred for over the counter (OTC) drugs on or after January 1, 2011 will not be eligible for reimbursement under a health FSA, HSA, HRA, or Archer MSA, unless the drugs are prescribed. Debit cards may not be used to purchase OTC drugs under the new rule because prescriptions often cannot be substantiated under current debit card systems; however, the IRS has indicated that it will not challenge debit card transactions made through January 15, 2011. Depending upon whether your debit card administrator can differentiate between prescribed OTC drugs and traditional prescriptions, it may even be necessary, absent additional relief, to stop usage of the debit card for ALL drug purchases.
- **Tax Reporting:** Employers are required to report the aggregate cost of employer-provided health coverage on Form W-2. The IRS has announced that compliance with this new reporting requirement will be optional for 2011.

Nongrandfathered plans also must comply with these additional requirements:

- **Patient Protections:** Group health plans that use a network of providers must allow covered individuals to choose their own primary care physicians (PCPs), must allow a child to select a pediatrician as his or her PCP, and must allow a woman to visit a healthcare provider specializing in obstetrics or gynecology without prior authorization or a referral. A plan that provides benefits for services in the emergency department of a hospital must cover emergency services without prior authorization whether the hospital is in network or out of network, subject to cost-sharing requirements on out-of-network services.

- **Preventive Care:** A plan must provide coverage for "recommended preventive services" (as defined in the regulations) without cost-sharing. However, a plan that uses a network of providers is not required to provide coverage for recommended preventive services delivered by out-of-network providers, and may impose cost-sharing requirements for out-of-network services. Also, a plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for recommended preventive services to the extent not specified in the applicable recommendation or guideline.
- **Internal Claims and Appeals:** Currently, health plans must substantially comply with the existing ERISA claims and appeals regulations. Under HCR, nongrandfathered plans must strictly adhere to the existing regulations as well as to a number of new requirements. An enforcement grace period will apply until July 2, 2011 with respect to certain of the new requirements—including the review of urgent care claims within 24 hours, new content for notices of adverse benefit determination, and the strict adherence standard—to give plans time to make necessary procedural and systems changes. Model claim denial notices have been issued by the Department of Labor (DOL); the agency is expected to issue model claims and appeals language soon.
- **External Review:** Insured plans that are subject to a state external review process that meets the HCR requirements must comply with that process. Other plans must comply with a federal external review process. An interim enforcement safe harbor has been established for nongrandfathered self-insured plans subject to the federal external review process. If such a plan either complies with the safe harbor procedures outlined in DOL Technical Release 2010-01, or voluntarily complies with an available state external review process, enforcement action will not be taken against the plan during the interim enforcement period.
- **Nondiscrimination:** Self-insured medical plans are prohibited from discriminating in favor of highly compensated employees under current law. HCR extends that prohibition to insured plans, although different penalties apply if the rules are violated. The application of nondiscrimination rules to insured plans means the end of executive health plans that cannot maintain grandfathered status, unless such plans can be considered exempt supplemental plans under HIPAA, as explained above.

New Disclosure Requirements

Under ERISA, a summary plan description (SPD) explaining the benefits provided under an employee benefit plan must be distributed to plan participants. Changes to health benefits made as a result of HCR should be described in revised SPDs or summaries of material modifications within the usual time frames prescribed under ERISA. HCR establishes a new requirement that health benefits be described in a "culturally and linguistically appropriate manner." We anticipate future guidance on this provision that will determine its impact on employee communications.

New notices are required under HCR, as follows:

- **Notice of Grandfathered Plan Status:** In order to maintain grandfathered status, a statement that the plan believes it is grandfathered must be included in any materials describing health plan benefits (e.g., enrollment materials, SPDs, schedules of benefits). Contact information for questions and complaints must also be provided. Model language is provided in the regulations.
- **Special Enrollment Notice for Adult Children:** A plan that covers sons, daughters, stepchildren, adopted children, and/or foster children that previously cut off coverage prior to age 26 must provide written notice to any adult child that aged out of the plan that he or she can once again enroll in the health plan during a special enrollment period. A model notice has been issued by the

DOL. As under HIPAA, the employee-parent also will be eligible to enroll or change benefit options (e.g., switch from single to family coverage) during the special enrollment period.

- **Special Enrollment Notice for Individuals Who Previously Reached a Plan's Lifetime Limit:** A plan that imposed a lifetime limit on essential health benefits must provide written notice that the lifetime limit no longer applies and that individuals can once again enroll in the health plan during a special enrollment period. The notice may be included with other enrollment materials as long as it is prominent. A model notice has been issued by the DOL. As under HIPAA, if the individual who was excluded was a dependent, the employee also will be eligible to enroll or change benefit options during the special enrollment period.
- **Notice of Right to Choose Provider:** A plan that requires an enrollee to designate a PCP must provide notice of the plan's terms regarding the designation. The notice must be included with the SPD or other similar description of benefits under the plan. Model language is provided in the regulations.

Required Cafeteria Plan Amendments

Employers that wish to provide pretax health and welfare benefits to their employees must maintain a cafeteria plan under Section 125 of the Internal Revenue Code. A cafeteria plan must be in writing and must be adopted on or before the date it is to become effective. Cafeteria plan amendments generally must be adopted prospectively, except where the IRS issues specific guidance permitting retroactive amendment for certain provisions.

The following cafeteria plan amendments are required as a result of HCR:

- **Dependent Coverage:** Cafeteria plans that implemented the new coverage rules for adult children early during 2010 may be amended retroactively pursuant to IRS guidance, as long as the amendment reflecting such changes is adopted no later than December 31, 2010. All cafeteria plans must be amended before January 1, 2011 to reflect changes related to dependent coverage, pretax contributions, and special enrollment periods for the new plan year.
- **OTC Drugs:** IRS guidance provides that cafeteria plans may be retroactively amended to reflect the new OTC drug rules, as long as the amendment is adopted by June 30, 2011.
- **Limit on Health FSA Contributions:** Currently, there is no limit on health FSA contributions. The maximum annual contribution to a health FSA for 2013 will be $2,500, after which the limit will be indexed for inflation. This amendment must be adopted no later than December 31, 2012.
- **Automatic Enrollment:** HCR requires employers with more than 200 full-time employees to automatically enroll their full-time employees in the lowest-cost coverage option under their health plans if the employees do not otherwise enroll or opt out. This requirement will become effective as of the date specified in implementing regulations to be issued by the DOL; cafeteria plans will need to be amended to reflect this change.

CHIPRA Special Enrollment Rights and Notice

Employers are reminded that an annual notice is required under the Children's Health Insurance Program Reauthorization Act (CHIPRA). Effective April 1, 2009, a 60-day special enrollment opportunity is required to be offered when an employee or eligible dependent (1) is covered under a Medicaid plan or state children's health insurance program (CHIP) and loses eligibility under that plan, or (2) becomes eligible for premium assistance under a CHIP or Medicaid plan that can be used toward the cost of an employer plan. For calendar-year plans, the initial CHIPRA notice must be provided by January 1, 2011

to all employees who reside in the 40 states that offer premium assistance. The CHIPRA notice must be a separate, prominent document written in a manner that ensures that an employee who may be eligible for premium assistance could reasonably be expected to appreciate its significance. The DOL has provided a model notice and recently updated the model. Cafeteria plans that were not previously amended to reflect the CHIPRA special enrollment periods should be amended now.

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If you need assistance with, or additional information about, group health aspects of Healthcare Reform, please contact one of the attorneys listed below.

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