An ALM Publication

CORPORATE COUNSEL

DECEMBER 2010

Special Advertising Section

OUTSIDE PERSPECTIVES

Employers And Health Reform: Do You Know What Your Current Obligations Are?

Rhonda D. Orin

ALTHOUGH MANY CHANGES THAT flow from the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively, "PPACA"), will not phase in for years, others took effect on September 23, 2010. A short description of the provisions that took effect on that date, as well as regulations issued recently by various agencies, is provided below.

Annual and Lifetime Limits

One of the most significant new provisions regards lifetime and annual limits for "essential health benefits" for participants and beneficiaries. Lifetime limits are precluded completely. For plan years beginning on or after September 23, 2010, group health plans and insurance companies may not establish annual limits under $750,000. This ceiling increases to $1.25 million for plan years beginning on or after September 23, 2011 and to $2 million for plan years beginning on or after September 23, 2012. From January 1, 2014 forward, any annual limit is precluded.

Prohibition on Rescission

Also important is a new prohibition on arbitrary rescissions, as when an insurance company retroactively discovers errors in a policyholder's original application. PPACA restricts the rights of group health plans and insurance companies to rescind coverage and requires them to provide advance notice of cancellation. Specifically, a plan may rescind coverage only in cases of fraud or intentional misrepresentation and upon 30-days notice. Interim regulations provide that rescissions constitute "adverse benefit determinations" subject to the rules regarding denied claims.

Emergency Services

Group health plans and insurance companies that provide emergency service benefits must not require pre-authorization or impose different cost-sharing amounts for out-of-network emergency service providers. Recently issued interim regulations provide a detailed description of the cost-sharing analysis.

Preventive Care

Another new provision regards preventive care. Group health plans and insurance companies must provide coverage for preventive care, such as the flu and other vaccines and screening for various medical conditions. Unless plans are grandfathered, this care must be provided without cost-sharing, provided that the care is rendered by in-network providers. A current list of preventive care services may be found at http://www.healthcare.gov.

Coverage for Adult Children

Considerable attention has been paid to a new provision regarding coverage for adult children. Group health plans and insurance companies are required to provide coverage for adult children up to age 26. Both married and unmarried children qualify for this coverage, although not their spouses or dependents. This provision applies to existing employer plans unless the child has an offer of coverage through another employer. At least for now, employers are allowed to rely on the participant's representations as to the employment status of their qualified adult children; formal verification is not required.

Pre-Existing Conditions for Children Under 19

Group health plans and insurance companies are prohibited from implementing exclusions for pre-existing conditions for children under age 19. This prohibition extends to grandfathered plans and issuers, except for issuers of stand-alone retiree-only health plans in the private market.

Claim Appeals Procedures

Group health plans and insurance companies must establish an internal claims appeals procedure that includes an external review process. At least for now, this provison does not apply to grandfathered, self-funded plans. The external review will be done by an independent entity and the health plan or issuer will pay the costs.

Significantly, the external review will be on a "de novo" basis, meaning that the reviewer will look at all evidence with a fresh eye, including evidence that was not considered during the initial determination. Until now, reviews of claims decisions, even by the courts, had essentially been limited to assessing whether the evidence before the plan was sufficient to support the coverage determination. Reviewers were not free to alter validly supported determinations even if they would have decided the claims differently.

Outstanding questions exist about when the external reviewers will be subject to appeal to the courts and, during such appeals, what legal standards will be applied. The judicial precedent that currently limits courts to discretionary reviews, except in cases of conflict of interest, arises out of the principle of according deference to decisions made by plans. There is no such precedent with regard to decisions made by external review organizations.

Recently issued interim regulations modify existing Department of Labor regulations regarding claims and appeals procedures for employee benefit plans. Most significantly, if a plan fails to strictly comply with the new requirements regarding the claims appeals procedure, the claimant will be deemed to have exhausted his or her administrative remedies and be permitted to seek judicial review. In addition, if a claimant's internal appeal is denied, the interim regulations provide guidance on the external review process. For self-insured plans, a federal external review process may apply if the applicable state has not adopted an acceptable external review process.

What If Your Plan is "Grandfathered"?

Certain health plans are considered "grandfathered" plans under the PPACA, and may be subject to less than all of the above required changes. Grandfathered plans are those plans that were in existence as of March 23, 2010 (the date of PPACA's enactment). Recently issued interim regulations provide details regarding when a plan has "grandfathered" status, a highly nuanced topic beyond the scope of this overview.

Grandfathered plans must comply with certain of the requirements under PPACA, including: (1) prohibition on pre-existing condition exclusions; (2) coverage for adult children under the age of 26 (except for adult children eligible for employer-sponsored coverage); (3) restrictions on annual and lifetime limits for "essential health benefits"; (4) prohibition on rescissions of coverage except in cases of fraud or intentional misrepresentation and prohibition on cancellation of coverage without prior notice; (5) for flexible spending accounts, over-the-counter drugs no longer qualify for reimbursement; (6) health insurance companies offering group health insurance must provide an annual report on the percentage of premiums spent on non-claims, and if the amount spent on non-claims exceeds a certain percentage, the insurance company must provide an annual rebate to all enrollees; and (7) advance notice of material plan modifications.

Changes That Take Effect as of January 1, 2011

Finally, as of January 1, 2011, employers that sponsor health care plans will be required to report the aggregate cost of health care coverage on employees W-2 forms. The aggregate cost is to be calculated using the cost of coverage rules in COBRA. Employers should be prepared to provide this information for former employees in cases in which the employee receives continuation health care coverage. While employers should maintain their records throughout 2011 with this requirement in mind, its impact will not be felt until early 2012, when the W-2s for the 2011 tax year are due.

These reporting obligations apply to insurance companies as well. Starting in 2011, insurance companies that cover fully insured plans must report annually to the Department of Health & Human Services and identify amounts spent on claims versus non-claims. The amount spent on claims, known as the Medical Loss Ratio or MLR, must be at least 85 percent for large group-market insurance companies. Individual and small-market insurance companies must have MLRs of at least 80 percent. Notably, insurance companies that do not meet these MLRs will owe rebates to enrollees.

Rhonda D. Orin is the managing partner of the Washington, D.C. office of Anderson Kill. Ms. Orin has extensive experience in recovering insurance proceeds for policyholders across the country. Ms. Orin also has a cutting-edge practice in representing employers with self-funded and fully insured health plans, especially as to their evolving obligations due to health reform. Ms. Orin can be reached at rorin@andersonkill.com or (202) 416-6500.

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