

The government continues to keep HR managers busy by issuing new rules on almost a weekly basis. Last week the government issued 55 pages of regulations on a number of topics regarding health care reform. Therefore, I will spend the bulk of this newsletter on the highpoints of the new regulations. But I do want to touch on a couple of other subjects also.

Cost of COBRA Premiums Subsidy

Congress, at least for the moment, has decided not to extend the COBRA (and Ohio Mini-COBRA) premiums subsidy. Perhaps when the elections get closer in November Congress may have a change of heart and may reinstate the premium subsidy. Anyway, the subsidy has cost the American taxpayer a shade over \$ 2 billion for 2009 for approximately 2 million households according to U.S. Treasury Department.

<http://www.ustreas.gov/offices/tax-policy/library/COBRAInterimReport.pdf>

Additionally over 20,000 individuals challenged the employer's subsidy denial and the government overturned and approved about 13,000 appeals.

Employers Thinking on Health Care Reform

If health care reform has you scratching your head, you are not alone. The following is an in depth survey about what other employers are considering doing as a result of health care reform.

<http://www.iscebs.org/PDF/surveys/HealthCareReform100616.pdf>

I suggest you review the survey because it may give you some ideas on how to deal with the new rules.

Government Expands FMLA

The FMLA requires larger employers (i.e. those with 50 or more employees) to provide certain employees up to 12 weeks of unpaid leave to care for a child. The FMLA has been around for over 15 years. The Department of Labor has issued a bulletin that says an employee is entitled to a FMLA leave as long as the employee bears the day to day responsibility for the care or financial support of the child. This means that the employee does not have to be legally responsible or biologically related to the child for the employee to be eligible for a FMLA leave.

http://www.dol.gov/whd/opinion/adminIntrprtn/FMLA/2010/FMLAAI2010_3.pdf

What this means is that employees will be able to request a FMLA leave to take care of their domestic partners' children.

Grandfathered vs. Non-Grandfathered Plans

As we reported in the last newsletter, the government issued rules governing when a plan will lose its grandfathered status under health care reform. In my opinion, few

plans will be able to retain their grandfathered status over time. Plan sponsors want to change their plans for a number of reasons. However, the rules are written so that almost any real change will cost the plan its grandfathered status. I am attaching a number of articles that talk about the grandfathered status rules.

<http://www.troutmansanders.com/compadvisory0618/>

<http://tinyurl.com/38kx7x6>

<http://tinyurl.com/2do7u8o>

There are a ton of articles on this topic but these three are some of the better ones and it is worthwhile to read them.

New Patients' Bill of Rights

The government (i.e. the Department of Health and Human Services, Department of Labor and IRS) issued 55 pages of regulations on June 28, 2010, addressing a number of topics under health care reform. Unless otherwise indicated the effective date for these provisions is plan years beginning on or after September 23, 2010. The following is a brief summary of those rules.

Annual \$ Limits

Effective January 1, 2014, plans no longer will be permitted to have annual limits on "essential health benefits." This means that until that time a health plan can, in fact, have annual limits on "essential health benefits" which, by the way, have not yet been defined. While still not defined, the government has listed the annual limits for these essential health benefits. The annual limits are:

1. Between September 23, 2010 and September 23, 2011 - \$ 750,000.
2. Between September 23, 2011 and September 23, 2012 - \$ 1.25 million
3. Between September 23, 2013 and December 31, 2013 - \$ 2 million

As we indicated in the last newsletter, a health plan will lose its grandfathered status if benefits are reduced or taken away. This means if the plan did not have annual limits on essential health benefits as of March 23, 2010 and annual limits are implemented; the plan will lose its grandfathered status. Additionally, as you can see the limits are pretty high and it is questionable whether the carriers, in the case of fully insured plans, will bother keeping track of these limits or simply say all the essential health benefits are unlimited effective now. The more relevant question for employers may be "What is the cost increase for this unlimited coverage?" In other words, how much are the premiums going to go up because of this new rule?

Of course plans can continue to impose annual and lifetime limits on non-essential health benefits. Additionally plans can exclude benefits for particular conditions. However, if the plan previously provided benefits for that condition and then eliminated those benefits, the plan would lose its grandfathered status. These annual and lifetime limits do not apply to Health FSAs, HSAs and HRAs that are part of the “main” health plan or if the HRA only covers retirees. However, a standalone HRA may be subject to these rules. If that is the case no employer would sponsor a standalone HRA unless (1) it is grandfathered or (2) it does not provide any essential health benefits. The government has asked for comments on how the rules should be applied to standalone HRAs.

Lifetime \$ Limits

This restriction is pretty easy to understand. Basically no lifetime limits on essential health benefits. The rules require all plans (i.e. insured and self-funded) to send notices to individuals whose coverage ended because they previously reached the plan’s maximum benefit limit.

Choice of Doctors

Although health care reform does not require the plans to accept any willing provider, once the provider has been accepted by the plan (i.e. is an in-network provider), the plan cannot discriminate against the provider. Basically this means that if the plan is non-grandfathered and requires the person to select a primary care physician, then the plan must let the person select any in-network primary care physician accepting patients. Additionally, non-grandfathered plans must permit direct access to in-network OB-GYNs without prior authorization.

Emergency Care Out-of-Network Providers

Non-grandfathered plans cannot require prior approval or impose higher cost sharing provisions for out-of-network emergency care providers as long as the care is for an emergency medical condition. However, the out-of-network provider can balance bill the patient under certain circumstances.

Pre-Existing Condition Limitations

All plans (i.e. grandfathered and non-grandfathered) cannot impose any pre-existing condition limitation as of January 1, 2014. Prior to that date all plans cannot impose any pre-existing condition limitation on individuals under age 19. Note that HIPAA has similar (but not identical) restrictions. One key difference between these is, under the new rules, the plan cannot reduce or deny benefits for a pre-existing condition even if the person has a 63 day break in coverage.

Although the person will have to wait until the next open enrollment period to become covered (unless there is a special enrollment period event), it certainly seems that a person can wait until they have a need (i.e. medical condition) and then enter the plan. It is kind of like waiting for the house to catch on fire and then buying a home owner policy.

This is a big concern for the insurance industry. They argued that if they are required to accept everyone, then everyone should be required to have health insurance. Beginnings in 2014 penalties apply to most individuals for not having coverage. However, as a practical matter, the penalties are pretty low. Therefore, the "bottom line" is that the carriers will be required to cover anyone who applies for coverage and the carriers will not be able to exclude benefits for pre-existing conditions. On the other hand, individuals will not be penalized very much for not having coverage. Unfortunately, this could have a dramatic impact on the carriers and could ultimately lead to higher premiums.

Prohibition on Rescissions

This precludes the plan from rescinding coverage unless there has been fraud or an intentional misrepresentation of a material fact. This really has not been much of an issue with respect to group plans. However, the new rules apply to individual coverage where this practice has been more prevalent.

The government has issued a fact sheet regarding the new rules.

http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html

The amount of rule-making by the government has been unprecedented and it shows no sign of slowing down. It is clear the Obama administration wants the government to take a larger role in the health care arena. Many people believe President Obama's end game is to have a single payer system and that all these rules are steps in that direction. However, most of the new rules (i.e. the health care exchanges, individual mandates and the employers' play or pay provisions) do not kick in until 2014. That means we will have two Congressional elections and one Presidential election prior to that date. Obviously no one can assume the rules will be repealed. On the other hand, a lot can happen politically between now and then. The only thing that will remain constant is that there will be a lot of change during this time.