

I have been practicing in this area for some time and the pace of new developments has never been faster or the complexity greater. Unfortunately there is no sign of things slowing down or getting easier to understand.



New COB Issues

The Patient Protection and Affordable Care Act (the “PPACA”) and Ohio law requires health plans to cover adult children. The child’s marital or employment status is irrelevant under the PPACA. Therefore plans will begin covering children who are married and/or working. This will raise new issues with the plan’s coordination of benefit (“COB”) provisions.

In the case of a fully insured plan or self funded health plan not covered under ERISA, the state rules governing COB will control. However, majority of self funded plans are covered under ERISA and those plans will have some flexibility in drafting the plan’s COB provisions. In the past, most plans terminated the child’s coverage when the child got married. Now that that is no longer the case, plan sponsors should update the COB language to address married children. Since this is relatively new territory, plan sponsors may want to consider the following COB procedures directed towards adult children who are married and/or working full time.

1. The plan that covers the individual as an employee is primary to the plan that covers the individual as a spouse or dependent;
2. The plan that covers the individual as a spouse is primary to the plan that covers the individual as a dependent.

This language says that if the adult child is working and is covered by his or her employer's health plan, then the plan sponsored by the child's employer will always be primary. If a child is married and covered under his or her spouse's plan and parent's plan, then the plan sponsored by the spouse's employer will be primary and the plan sponsored by the parent's employer will be secondary.

In short, if you sponsor a self funded health plan, you should check with your TPA on how best to handle the COB provisions. Obviously any changes should be approved by the stop loss carrier.

Form 5500s

This is just a reminder that the 2009 annual filing reports (i.e. Form 5500s) for calendar year plans are due July 31, 2010. Failure to file the forms on time can result in penalties of up to \$ 300 per day up to \$ 30,000 per year per filing. If you can not meet the filing deadline you can file for an automatic 2 ½ month extension by filing Form 5558 before the original due date for the Form 5500.

As you know by now, the government has implemented the EFAST 2 system which requires all the forms be submitted electronically. My experience is that completing the forms is not any more difficult. However, actually submitting them to the government can be challenging at times. Basically, you have to register with the Department of Labor and obtain a "PIN" and User ID. You then have to enter the numbers on the forms and submit them to the government. If you are not used to "signing" documents electronically it can be frustrating the first time but once you go through the process it is not that difficult.

One of my concerns is now that the system is more automated the government is better able to cross check for non-filers. Most employers use a vendor to administer their retirement plans. Those vendors usually do a pretty good job with the Form 5500 for the retirement plans. That is, most employers remember to file the Form 5500 for the retirement plan. However, some employers forget to file the forms for the health, dental, life, disability plans.

I can envision the government checking to see that employers who file the forms for retirement plans also file the forms for the health and other plans. For example, an employer with 300 employees in a 401K plan files the Form 5500 for the 401K plan each year but does not file any other forms. It is very unlikely that an employer that large does not also offer health benefits and yet this employer is not filing any other Form 5500s. With the growing deficit I can see the government cross checking the Form 5500s and then contacting the employer and assessing a penalty for not filing all the Form 5500s.

Document Retention

I get this question a lot; how long should I keep plan documents? As a rule of thumb, ERISA requires you keep all documents for at least eight years. However, that is not the end of the discussion. In addition to the ERISA requirements, someone could file a lawsuit for benefits. In that case the statute of limitations applicable to the particular lawsuit would apply. The statute of limitations applicable to a lawsuit is based on the jurisdiction and the basis of the lawsuit. Unfortunately the statute of limitations can be quite long.

For example, in Ohio if the lawsuit is based on a breach of contract, the statute of limitations can be up to 15 years. As a practical matter, it is doubtful that someone would wait that long to file suit. Nevertheless, technically speaking, it is possible someone could file a lawsuit over a claim many years later.

I am attaching an article discussing this topic. Note that the article on time limits starts half way down the page. That is, it is the second article on the page.

<http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-july-2010/>

When it comes to document retention, the longer the better. At a bare minimum you should keep the records at least eight years. With today's technology you may want to consider converting the paper into electronic format. Once that is done keeping the documents almost indefinitely is not that difficult.

HITECH – Again?

The Health Insurance Portability and Accountability Act (“HIPAA”) was enacted in 1996 and one of the major components of the new law was to help protect individual health information called PHI. HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act of 2010 (“HITECH”) to further protect PHI. The Department of Health and Human Services issued proposed rules further explaining the HITECH provisions. The following articles talk about the proposed changes:

http://www.alston.com/files/Publication/a06963c0-d3dd-4aac-b682-51a1cb489a15/Presentation/PublicationAttachment/9e4ef5aa-9d0c-44de-9f0b-53c6a664d12b/HIPAA_HITECH.pdf

and

<http://benefitslink.com/articles/guests/washbull100719a.html>

I would not spend a lot of time on the rules because (1) they only are in proposed format and (2) if and when they are adopted they have a deferred effective date.



Show Me the Money!!!

Now that health care reform has passed and putting aside the complexity, the big question is how much is this all going to cost. I am sure if you ask 100 economists, you will get 100 different answers from costs will go down to they will skyrocket. The following is an article that talks about the impact of health care reform on small groups in both the short and long term.

<http://www.urban.org/uploadedpdf/412128-PPACA-impact.pdf>

According to this article providing unlimited lifetime maximum will increase premiums 1/2 of 1% and covering adult children will cost .5 to 1.2 percent. These numbers sound low to me.

No COBRA Subsidy

The latest extension to jobless benefits does not include money for the COBRA (and Ohio's Mini COBRA) premium subsidy. Congress caved in to the public's demand to reduce government spending and passed an extension for unemployment benefits but the bill does not extend the premium subsidy. This means that individuals terminated after May

31, 2010, will not be eligible for the subsidy. Of course anyone receiving the subsidy can continue receiving the subsidy until it expires.



Patients' Bill of Rights

We reported late last month that the government (i.e. the Department of Health and Human Services, Internal Revenue Service and the Department of Labor) issued interim final regulations - 190 pages of them! The regulations have been dubbed the new "Patient's Bill of Rights" and discuss a number of topics like the prohibition on annual and lifetime benefits, the new and improved rules governing pre-existing conditions and other patient protections. The following article talks about the new rules.

<http://healthcareemploymentcounsel.com/employee-benefits/federal-laws/the-newest-ppaca-regulations-what-you-need-to-know/>

Many people believe the Patient Protection and Affordable Care Act ("PPACA") is not health care reform but is really insurance reform. The interim final regulations add credence to that accusation. If you are maintaining a fully insured plan, the carrier will be responsible for compliance. If you have a self funded plan you should check with your TPA to make sure they are on top of the changes.



Preventive Services

One of the complaints against the health care system is that it does not provide enough preventive care. The argument goes that if people take better care of themselves, they will avoid costly treatments down the road. Therefore, one of the goals of health care reform was to make Americans healthier. To that end, non-grandfathered health plans have to provide first dollar coverage for preventive services provided by in network providers for plan year beginning on or after September 23, 2010 (i.e. January 1, 2011 for calendar year plans). The government released regulations explaining this requirement. The following is a link to the government's press release and regulations:

<http://www.hhs.gov/news/press/2010pres/07/20100714a.html>

Basically there is an independent panel of experts that will determine what constitutes preventive services. The following law firm articles explain the rules in detail:

<http://www.sutherland.com/files/News/59bb36e8-b56f-44a3-bede-61038af39177/Presentation/NewsAttachment/365d77ff-dccc-461b-9124-6324d9337641/EMPBEN%20Alert%207.21.10.pdf>

and

<http://www.jacksonlewis.com/legalupdates/article.cfm?aid=2114>

Again, in the context of a fully insured plan, the carrier will make the changes. Self funded plans will have to look to the TPA for help and, as always, the question becomes how much are the changes going to cost?



New Appeal Procedures

The administration cited several instances during the health care reform debate where individuals had been treated poorly by the carrier. To address this perceived injustice the PPACA now provides participants in non-grandfathered plans with both internal and external appeal procedures. The procedures are to be standardized and will give individuals the ability to appeal an adverse decision to an independent reviewer.

As a practical matter, the new rules will have a greater impact on self funded health plans. Participants in fully insured plans in Ohio already have the ability to have an external review. However, the new rules now require self funded non-grandfathered health plans to allow for external reviews.

<http://www.dol.gov/ebsa/newsroom/fsaffordablecareact.html#f1>

One of the biggest changes is that the plan will have to continue coverage during the appeal process. This requirement will probably speed up the process since it will be in the plan's best interest to bring the matter to closure. This is a good thing for everyone.

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