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Healthcare Reform Update

Considerable discussion, some view it as debate, continues on surrounding the rules, regulations and procedures under the PPACA and HCEARA(Healthcare reform bills). At Van Gilder, we continue to gather information with the hope of imparting those interpretations as they evolve. We also like the format of responding to questions related to specific employer or employee situations with answers developed by law firm, Steptoe & Johnson LLP. In this issue, as well as next month's issue, we will actually update some of the sections under the bills that have been further refined and/or defined. As always, should you have questions or need additional information concerning this update, or in general related to Healthcare Reform, please contact your Van Gilder team. Our goal is to bring you the current thinking and learned interpretation from the legal team that is acutely focused on this daunting change affecting all of us.

"Grandfathered" Plans/CBAs

1. If you are supposed to look back to the 12 months preceding the change that has been or will be made to the plan [to make calculations regarding changes in co-pays, etc. that involve a comparison to the rate of medical inflation] what do you do if the change to the plan is for 1/1/2011 and we are currently discussing changes for 1/1/2011 and obviously we do not have 12 months of prior yet. Do you look at the 12 months prior to when you are deciding what change to make?

There appears to be a slight conflict between what the rule itself states and the examples of calculating medical inflation that are provided in the rule, and we concur that this creates confusion because a plan would be examining the potential impact of cost-sharing increases before the effective date of the change, and thus, before there would be a full 12 months worth of medical inflation data ending on the effective date of the change. Since the actual rule states that the change in the medical inflation rate is to be calculated by subtracting the medical inflation rate published for March 2010 from the index amount "for any month in the 12 months before the new change is to take effect," (the italics are ours), a reasonable interpretation of the rule would be to take the highest monthly index amount from the 12 month period preceding January 1, 2011 – that is, from January 1, 2010 up to the time the plan is evaluating the change. (FAQ added 8-20-10)

2. Our client currently offers a plan that is partially self-funded, this is their core medical policy. It is currently a $2,500/$5,000 deductible. This plan is not changing at all. However, on top of this plan, the employer offers a 'wellness incentive' giving the employee the option to lower their deductible by meeting certain requirements that are tied to living a healthy lifestyle. This 'wellness incentive' is currently in the form of a fully insured supplemental policy (through BeniComp).

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The client is considering changing the funding of this 'wellness incentive' to a self-funded arrangement with a new administrator. However, the lifestyle requirements and credits that the employees may earn will not change. With regard to the supplemental plan, will the client lose Grandfathered Status if they decide to a) change carriers, b) change the way they finance it, or c) just eliminate it altogether?

The grandfather rules allow plans to change from an insured funding arrangement to self-insured without losing grandfathered status, and also permit self-funded plans to change administrators without losing grandfathered status.

As for the impact of eliminating the supplemental policy, the grandfather rules state that changes other than those described in the rules will not affect grandfather status, and since the rules do not prohibit changes to wellness programs, the elimination of the program should not affect the core medical plan's grandfathered status.

The grandfather rules do, however, preclude insured plans from changing carriers; a change in carriers would cause loss of grandfathered status. But we note that there is a separate and more fundamental issue here: whether the reforms required by PPACA – and therefore, the grandfather rules – apply to the "supplemental" plan in this example at all. We would argue that the statute does not, because (1) PPACA applies to "group health plans" and "group health insurance coverage," as those terms are defined in the Public Health Service Act; (2) the PHSA provides that "group health plans" and "group health insurance coverage" do not include "excepted benefits;" and (3) very reasonable arguments can be made that supplemental policies like the one in this example are excepted benefits. If wellness incentives such as this supplemental plan are excepted benefits, a change in carrier would not affect grandfathered status (and neither would changes in funding arrangements). But since regulators have not directly addressed the status of wellness plan-related benefits or supplemental benefits, we would caution that any such change may carry risk and should not be undertaken without the advice of the plan's advisors. (FAQ added 8-20-10)

3. If a self-insured plan changes provider networks, would the plan lose grandfathered status? A few of my colleagues say they have reviewed articles on the internet that this would cause a loss of status, but there is also a lot of bad information floating around….. please clarify for us.

The interim final rule on grandfathering does not prohibit plans from making changes to their provider networks, although this is an issue for which the regulatory agencies have requested specific comment, which means the regulators' position could change in the final rule. Plans that are considering making changes to their provider networks should monitor the regulatory proceedings on grandfathering to ensure that they are in compliance with any final determination made by the agencies. (FAQ added 8-20-10)

4. An employer going through rapid growth due to a temporary contract can not afford to make the same contributions (50% across the board, employee and dependants) to the health plan for the new workers for the temporary contract, and also needs to maintain minimum participation in these lower skilled / paid workers, so they want to grandfather the existing employees as a closed class and pay 75% Single Only, no contribution for dependants on new hires. 1.) Will this change cause them to lose Grandfathered Status under Healthcare Reform? 2.) If this takes away grandfathered status, can this arrangement pass the non-discrimination test that the loss of grandfathering will bring at renewal? 3.) Could they open a NEW PLAN, maintain the existing plan and its Grandfathered status, and put the new employees in the new (non-grandfathered) plan at a 75% contribution for employee only in plan 2?

The answers to each question are as follows:

1) If the employer created a new and separate plan for the new hires and made a contribution for that plan different from the contribution it makes to the existing plan, the establishment of such a new plan should not cause loss of grandfathered status for the old plan, so long as the employer takes care not to make any changes to the old plan that exceed what is permitted under the grandfathering rules. Close attention should be paid to ensure that only new hires are placed in the new plan, because the act of moving an existing employee from a grandfathered plan with more generous benefits to a plan with less generous benefits can trigger loss of grandfathered status for the old plan.

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2) The bigger question in this situation would be whether the new plan could pass the Section 105(h) non-discrimination test. (Keep in mind that if the plan is self-insured, it must comply with the rules prohibiting discrimination in favor of highly compensated employees regardless of whether it is grandfathered.) Very generally, the Section 105(h) test requires that you cover 80% of all employees (which this arrangement would likely fail given that it probably would not be covering that high a percentage of employees), or you would have to pass the alternative "nondiscriminatory classification test" that is based mainly on facts and circumstances. A general formulation of that test requires that the compensation for non-participants be essentially the same as compensation for participants, that the plan covers employees in all compensation ranges, that lower and mid-level employees are covered in more than nominal numbers, and that the classification of eligible employees is not discriminatory in favor of officers, shareholders or the highly compensated. The IRS also looks at the relative percentages of high and lower paid employees who are participating. The IRS has not focused on this test for a long time (but will likely have to do so in the future) so it is hard to say what types of evidence they might want an employer to provide.

Employer Mandate Issues

1. I have a question regarding the impact of health care reform. I have a family owned construction company based in Kansas City, Missouri. They have 15 full time, non-union employees who have their own group plan. In addition, the company pays into the union health plan based on hours worked. They have 60-80 union employees throughout the course of the year. Would they be treated as under 50 or more than 50 for the health care reform? If they would be treated as over 50, is there any way they can stay as an under 50 group and avoid the PPACA employer mandate?

If an employer has at least 50 employees, counting full-time employees (i.e., those working an average of 30 or more hours per week) and full-time equivalents (i.e., adding up all the hours worked in a month by any part-time employees and dividing that number by 120), the employer would be considered a "large employer," to whom the employer mandate will apply. The fact that some employees may be non-union, and some may be union employees, does not factor into the calculation of employer size for purposes of the employer mandate. The one caveat to the 50 employee benchmark is if the employer only exceeds 50 employees due to employment of seasonal workers, which applies if the workforce is more than 50 full-time employees for 120 or fewer days in a calendar year. "Seasonal" employees are ones who work fewer than 120 days per year for the employer and who also meet the definition of "seasonal" employee that the DOL is expected to issue in future regulations. (FAQ added 8-20-10)

This document is comprised of questions received from Council members and answered by The Council's attorneys at Steptoe & Johnson LLP. All section references are to the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) ("PPACA") or the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) ("HCEARA"), as indicated in each response. Many of the changes in the legislation are in the form of amendments to the Public Health Service Act. References to that Act in this document will be to PHSA. Please keep in mind that the information provided here is not intended to be, and should not be construed, as a legal opinion or advice. It is recommended that you consult with your own attorney or other adviser relating to your specific circumstances or those of any organization you advise.