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Healthcare Reform Update

Further expansion and clarification of sections of the Healthcare Reform and the Q & A from previous issues of Vista's includes the following updates related to:

1. Reinsurance Program for Early Retirees
2. Market Reform/Plan Design Requirements

As you may recall from previous information, insurance exchanges are scheduled to commence operation in many states in 2014. In Colorado, a series of forums are being scheduled to discuss the nature of, funding for, functional responsibilities of, structure of and overall scope of activity and authority that will be ceded to the exchange. The implementation of exchanges will affect how many consumers and employers with fewer than 50 employees access information about health coverage, understand the choices and options and feel comfortable selecting and enrolling in a plan they feel is best for their family or organization. This will be no easy task. We plan to participate in the forums and do our best to ensure the structure, process and consumer friendly access does not get bogged down with bureaucracy and excess cost.

We encourage your attention to, and participation in, these discussions. So much of the specific impact of the bills is yet to be defined. We must stay vigilant in understanding and participating in the discussion, and eventual implementation of rules and regulations. There is much at stake for all of us.

Reinsurance Program for Early Retirees



1. Are there any stipulations that would prevent an employer who offers early retirement options only to their officers from being able to apply for funding via the Early Retiree Reinsurance Program?

The Early Retiree Reinsurance Program does not restrict program eligibility based on the categories of employees who are offered early retirement. (FAQ added 8-20-10.)

Market Reform/Plan Design Requirements

1. On Section 1302, page 62 of the bill, in (2), the Annual Limits on Deductible section, does not explicitly reference an effective date for the \$2,000 / \$4,000 amounts. When does this limitation become effective?

This question references the annual limitations on deductibles for employer-sponsored coverage in the small group market (100 or fewer employees) in Section 1302 (c)(2) of PPACA. No effective date is specified in the statute for this provision, which makes the answer to this question unclear. However we would anticipate, based on the appearance of this provision in the Subtitle dealing with Exchanges and the fact that the indexing mechanism for the provision references calendar years after 2014, that regulators would interpret this limit on deductibles as being effective in 2014. Keep in mind, though, that there is presently no definitive answer in the absence of specific regulatory guidance. (FAQ added 8-20-10.)

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2. Per the most recent FAQs (V12), question 64 states that the 90-day max waiting period takes effect 2014. However, question 143 states that the 90 day max waiting period applies, per grandfathered rules, 9/23/10 (see below). If we are interpreting something incorrectly, please let us know.

You are correct – 2014 is the effective date of the 90 day maximum waiting period. The response to Question 143 (now numbered Question 156) has been revised to specify that the waiting period provision is among the reforms that go into effect in 2014 rather than plan years starting after September 23, 2010. (FAQ added 8-20-10.)

3. On CIAB's FAQ document, certain questions reference a requirement to extend dental and vision coverage to over age dependents, if such coverage is offered to other dependent children. However, an employee in one of our other offices posed this question to an attorney they have on retainer, and was given a different answer. As you can imagine, we're now scratching our heads wondering what to tell our clients. Would you pose this to Steptoe to see what they come back with – do they still firmly believe in their original interpretation? Are there specific regs / text they could reference?



We believe the confusion about this issue arises from the intersection of the preamble to the grandfather rules which provides that the PPACA reforms do not apply to

“excepted benefits” like stand-alone dental and vision, and the provision in the dependent coverage regulations that prohibits plans from discriminating in the benefits offered to one group of dependents versus the overage dependents. The relevant text of the dependent coverage rule includes the following in the rule’s preamble: “for children under age 26, the plan cannot vary benefits based on the age of the child” (75 Fed. Reg. 27122, 27124 (May 13, 2010)), and “the child [eligible for the rule’s special enrollment relief] must be offered all the benefit packages available to similarly situated individuals who did not lose coverage

by reason of cessation of dependent status” (id. at 27125). And in the regulations themselves: “Uniformity irrespective of age. The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older)” (id. at 27134, 27136, 27138, to be codified as 54 C.F.R. § 54.9814T (d); 29 C.F.R. § 2590.715-2714 (d); and 45 C.F.R. § 147.120 (d)); and “the child [as a special enrollee] must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package.” (75 Fed. Reg. at 27135, 27137, 27139 (to be codified as 54 C.F.R. § 54.9814T (d); 29 C.F.R. § 2590.715-2714 (f) (4); and 45 C.F.R. § 147.120 (f)(4)).

In attempting to harmonize the exemption for excepted benefits and the non-discrimination aspect of the dependent coverage rule, reasonable minds can certainly differ. The most important point to be aware of is that this issue has not been addressed in regulatory guidance, and there is some risk should plans elect to interpret the dependent coverage rule as not requiring them to offer older dependents dental and vision if such coverage is offered to younger ones. The conservative approach, of course, would be to offer the same benefits to all dependents under 26 until the question is resolved by regulators. But it is up to plans and their advisors whether they wish to take this approach. (FAQ added 8-20-10.)

4. My understanding is that if you decided voluntarily not to enroll your child for whatever reason, this is NOT an opportunity to add them now UNLESS they WERE originally enrolled and lost coverage due to ageing out of the plan or no longer being FT students. Please confirm.

The special enrollment opportunity is only for those children who had been excluded from coverage because of age before the effective date of the rule – that is, for a child whose coverage ended, or who was denied coverage, or who was ineligible for coverage, because the availability of coverage under the plan ended before age 26. (FAQ added 8-20-10.)



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5. With respect to the answer immediately above, can they expand on their source, please? “Our understanding” sounds like an assumption? Outside of self-funded plans, we’re not sure what “current non-discrimination rules” they might be referring to (HIPAA wellness incentive non-discrimination rules are a different topic). This answer also doesn’t reference the fact that offering premium discounts and/or benefit enhancements under bona-fide wellness programs are still allowed (even encouraged) despite this prohibition.

Prior to the enactment of PPACA, Public Health Service Act Section 2702 (b) prohibited group health plans and issuers offering group coverage from varying premiums for similarly situated individuals based on an individual’s health status, outside the context of a wellness program. PPACA maintains this prohibition in new PHS Act Section 2705, and also codifies the regulatory provisions setting forth the requirements for wellness programs to offer premium discounts and the like. Accordingly, there has not been a substantive change in the law – premiums cannot be varied based on BMI or other health status-related factors, unless done in the context of a wellness program that complies with the statute’s requirements. (FAQ added 8-20-10.)

6. What is the penalty if a group chooses not to make the necessary changes to be compliant with the health reform legislation on their first anniversary date after 9/23/2010? What will the penalty be?

With respect to the market reforms (e.g., prohibition on lifetime limits, coverage of adult children to age 26, coverage of participation in government-approved clinical trials) that were incorporated by PPACA into the Public Health Service Act, the penalty for failure to implement applicable changes is \$100 per day per violation, and violations can be defined as being by beneficiary. Also bear in mind that because plans will have a legal requirement to make

certain changes for plan years starting after September 23, 2010, such as eliminating lifetime limits, a plan beneficiary may have a legal claim that such limits or other non-compliant terms do not apply to plan years that commence after that date even if the plan has not been revised to reflect the new legal requirement. (FAQ added 8-20-10.)



Please contact your Van Gilder team with any questions or concerns.

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 PHS Act. 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.