In This Issue:

Benefits Bulletin

Health Care Reform Timeline

FMLA Fraud – An Employer Concern

New Requirements for Mental Health and Substance Use Disorder Coverage

RJ Ahmann Company
7555 Market Place Drive
Eden Prairie, MN 55344
Phone: 952-947-9700
Fax: 952-947-9793
www.rja.com

Health Care Reform Timeline

On March 23, 2010, President Obama signed into law the health care reform bill, the Patient Protection and Affordable Care Act. This legislation, along with the Health Care and Education Reconciliation Act of 2010, makes sweeping changes to the U.S. health care system. These changes will be implemented over the next several years.

2010

Expanded Insurance Coverage

- **Extended Coverage for Young Adults.** Group health plans and health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children must make coverage available for adult children up to age 26. There is no requirement to cover the child of a dependent child. This requirement will apply to grandfathered and new plans.
- **Access to Insurance for Uninsured Individuals with Pre-Existing Conditions.** The health care reform bill provides for the establishment of a temporary high risk health insurance pool program to provide health insurance coverage for certain uninsured individuals with pre-existing conditions. The program will end when the health insurance exchanges, set to be established in 2014, are operational.
- **Identifying Affordable Coverage.** The Secretary of Health and Human Services is required to establish an Internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website will also include information for small businesses about available coverage options.
- **Reinsurance for Covering Early Retirees.** The new law requires the establishment of a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program will end on January 1, 2014.

Health Insurance Reform

- **Eliminating Pre-Existing Condition Exclusions for Children.** Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children. This provision will apply to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.
- **Coverage of Preventive Health Services.** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive services. These plans also may not impose cost sharing requirements for preventive services.
- **Prohibiting Rescissions.** The health care reform law is designed to prohibit abusive rescissions of coverage by insurance companies when an individual gets sick as a way of avoiding covering the cost of the individual's health care needs. Group health plans and health insurance issuers offering group or individual insurance coverage may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be cancelled without prior notice to the enrollee. This provision applies to all new and existing plans.
- **Limits on Lifetime and Annual Limits.** In general, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or impose unreasonable annual limits on the

dollar value of benefits for any participant or beneficiary. This requirement applies to all plans. Annual limits will also be prohibited beginning in 2014.

Health Plan Administration

- **Improved Appeals Process.** Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, plans and issuers must:
  - have an internal claims process in effect;
  - provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes; and
  - allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

The internal claims process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001. Plans and issuers must also implement an external review process that meets applicable state requirements and guidance that is to be issued.

- **Nondiscrimination Rules for Fully-Insured Plans.** Fully-insured group health plans will now have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This section does not appear to apply to grandfathered plans.

Medicare/Medicaid

- **Rebates for the Medicare Part D "Donut Hole."** Currently, there is a gap in Medicare prescription drug coverage. The coverage gap falls between $2,830 and $6,440 in total drug spending. The health care reform bill provides a $250 rebate check for all Medicare Part D enrollees who enter the "donut hole." Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020.
- **Medicaid Flexibility for States.** States are given a new option under the health care reform law to cover additional individuals under Medicare. States will be able to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL).

Fees and Taxes

- **Small Business Tax Credit.** The first phase of the small business tax credit for qualified small employers begins in 2010. These employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. When health insurance exchanges are operational, tax credits will increase, up to 50 percent of premiums.

2011

Expanded Insurance Coverage

- **Voluntary Long-Term Care Insurance Options.** The health care reform law creates a long-term care insurance program for adults who become disabled. Participation will be voluntary and the program is to be funded by voluntary payroll deductions to provide benefits to adults who become disabled.

Health Plan Administration

- **Improving Medical Loss Ratios.** Health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.
- **Reporting Health Coverage Costs on Form W-2.** Beginning in 2011, employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2.
- **Standardizing the Definition of Qualified Medical Expenses.** The health care reform law conforms to the definition of "qualified medical expenses" for HSAs, FSAs and HRAs to the definition used for the itemized tax deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses. Costs for over-the-counter medications obtained without a prescription would not qualify.
- **Cafeteria Plan Changes.** The new law creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This plan is designed to ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees.

Medicare/Medicaid

- **Medicare Part D Discounts.** In order to make prescription drug coverage more affordable for Medicare enrollees, the new law will provide a 50 percent discount on all brand-name drugs and biologics in the "donut hole." It also begins phasing in additional discounts on brand-name and generic

drugs to completely fill the donut hole by 2020 for all Part D enrollees.

- **Additional Preventive Health Coverage.** The new law provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminates cost-sharing for preventive services beginning in 2011.

Fees and Taxes

- **Increased Tax on Withdrawals from HSAs and Archer MSAs.** The health care reform law will increase the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.

2013

Health Plan Administration

- **Administrative Simplification.** Beginning in 2013, health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.
- **Limiting Health Flexible Savings Account Contributions.** The new health care law will limit the amount of contributions to health FSAs to $2,500 per year, indexed by CPI for subsequent years.

Fees and Taxes

- **Eliminating Deduction for Medicare Part D Subsidy.** Currently, employers that maintain prescription drug plans for their Medicare Part D eligible retirees are entitled to a tax deduction. This deduction will be eliminated in 2013.
- **Increased Threshold for Medical Expense Deductions.** The health care reform law increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- **Additional Hospital Insurance Tax for High Wage Workers.** The new law increases the hospital insurance tax rate by 0.9 percentage points on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).
- **Medical Device Excise Tax.** The law also establishes a 2.3 percent excise tax on the first sale for use of a medical device. Eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use are excepted from the tax.

2014

Coverage Mandates

- **Individual Coverage Mandates.** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at $95 per person for 2014 and increase each year. The penalty amount increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of $2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
- **Employer Coverage Mandates.** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if one employee receives a government subsidy for health coverage. The penalty amount is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.

Health Insurance Exchanges

The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. Large employers with over 100 employees are to be allowed into the exchanges in 2017. Workers who qualify for an affordability exemption to the coverage mandate, but do not qualify for tax credits, can use their employer contribution to join an exchange plan.

Health Insurance Reform

Additional **health insurance reform** measures will be implemented beginning in 2014. Specifically, health insurance companies will not be permitted to:

- Refuse to sell or renew policies due to an individual's health status;
- Exclude coverage for treatments based on pre-existing health conditions;
- Charge higher rates due to heath status, gender or other factors (premiums will be able to vary based only on age (no more than 3:1), geography, family size, and tobacco use);
- Impose annual limits on the amount of coverage an individual may receive; or
- Drop coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

Fees and Taxes

- **Individual Health Care Tax Credits.** The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.
- **Small Business Tax Credit.** The second phase of the small business tax credit for qualified small employers will be implemented in 2014. These employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
- **Health Insurance Provider Fee.** The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2018

High-Cost Plan Excise Tax

A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance (also known as a "Cadillac tax"). The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider" which can be the insurer, the employer, or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

FMLA Fraud – An Employer Concern

Every year the Family and Medical Leave Act (FMLA) helps employees across the nation manage serious health issues and care for ill family members. With this comes a major frustration for employers – the suspected abuse or direct appearance of an employee using this leave inappropriately under FMLA. In fact, suspected employee abuse is the number one FMLA-related concern for employers – with more than 60 percent believing they have granted unfounded leave to employees in the past.

Signs Indicating Possible Abuse

- Frequent leave requests immediately preceding or following a weekend
- FMLA leave requests after denial of vacation on the same or similar days
- Very sudden or abrupt leave requests
- Increase in the number of leave requests
- Complaints from other employees that an individual is abusing leave
- Sightings of an employee on leave engaged in strenuous activities, or activities indicating the employee is capable of performing his/her job
- Repeated injuries/re-injuries shortly after returning from leave

Tips to Prevent and Head Off Abuse

- Require employees to use all paid leave before taking unpaid FMLA. Employees are less likely to abuse FMLA if they have to use up vacation time before doing so.
- Obtain medical certification directly from the doctor. The Seventh Circuit Court has held that an employer does not interfere with FMLA rights by requiring that the completed certification form be faxed or mailed directly by the doctor.
- Require medical certifications within 15 days of taking leave. Employers that are specific about the documentation needed to take FMLA leave as well as the penalties for not complying have a much easier time taking action if the employee fails to do so.
- Have employees provide notice for expected FMLA leave. Requiring advance notice gives the employer the time to plan around future absences, minimizing abuse.
- Establish attendance and call-in policies for all leave. Consistent enforcement of leave policies, including FMLA, can be designed to prevent fraud.
- Utilize private investigators if necessary. Courts have been reluctant to rule against an employer for terminating an employee when he/she is caught directly engaging in fraud.
- Obtain "fitness for duty" certifications for employees when they return from FMLA leave. However, this cannot be required of an employee if returning from intermittent FMLA leave.
- Establish a policy prohibiting an employee from working a second job while on FMLA leave. Note that the Sixth Circuit Court in 2003 ruled that there may be instances when an employee can lawfully take FMLA leave from an employer and still work a second job, and some state FMLA laws may also allow this practice.

Ways to Obtain Additional Medical Information if Fraud is Suspected

- Employers can directly contact employees' health care providers without the employees' permission to make certain that the health care provider is the person who actually signed the certification form.
- Clarifications regarding certification forms can be acquired from the health care provider, but only within the confines of the privacy rules of the Health Insurance Portability and Accountability Act.
- An employer may request the opinion of a second or third health care provider designated or approved by the employer, but not employed regularly by them. This will be at the employer's own expense.
- An employer is not required to obtain additional opinions and may deny the FMLA leave without a second or third opinion when the employer has

credible reason to doubt the validity of the certification.

- An employer may request a recertification of the medical condition associated with the employee's absence every six months. If the employer has reason to doubt the employee's stated reason for leave, it may request recertification in 30 days or even less.

In order to minimize FMLA fraud in the workplace, measures can be taken by the employer without violating an employee's FMLA rights. By detecting possible signs of abuse, using tips to prevent abuse and obtaining additional medical information when fraud is suspected, you take effective steps as an employer toward eliminating FMLA abuse at your workplace.

New Requirements for Mental Health and Substance Use Disorder Coverage

On February 2, 2010, interim final rules regarding coverage for treatment of mental health and substance use disorders were issued. The new rules implement the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and apply to employers with 50 or more workers who choose to offer mental health or substance use disorder benefits in a group health plan. Below is an overview of the parity requirements:

The Laws

The MHPAEA and the Mental Health Parity Act of 1996 (MHPA) together require parity between medical/surgical benefits and mental health or substance use disorder (MH/SUD) benefits with respect to aggregate lifetime and annual dollar limits, financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits). The MHPAEA and MHPA do not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the laws' parity provisions.

The laws apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully-insured arrangements. The laws also apply to health insurance issuers who sell coverage to employers with more than 50 employees.

What Are Some of the New Rules Plans Need to Consider?

Financial Requirements – The general parity requirements are extended to financial requirements, such as co-pays and co-insurance.

Deductibles - Combined deductibles are required for MH/SUD benefits and medical/surgical benefits. Separate deductibles are now prohibited. That is, a plan may not apply one deductible to MH/SUD benefits and another deductible to medical/surgical benefits.

MH/SUD Benefits - So that benefits are not misclassified, plans must use generally recognized independent standards of current medical practice in defining whether benefits are MH/SUD benefits.

Treatment Limitations - Both quantitative (e.g., visit limits) and nonquantitative (e.g., medical management standards) treatment limitations are subject to the parity requirements.

Coverage Units - Plans must apply parity requirements for financial requirements and treatment limitations based on each "coverage unit" (e.g., self-only, family, and employee plus spouse).

Prescription Drugs - Plans are permitted to divide prescription drug coverage into tiers and apply the parity requirements separately to each tier of drug coverage based upon reasonable factors such as cost, generic versus brand name, and mail order versus pharmacy pick up.

Disclosures – Disclosures from ERISA plans can follow existing requirements. Plans not subject to ERISA must provide disclosures within a reasonable time and in a reasonable manner.

Exemptions - If applicable, the increased cost exemption can only be claimed for alternating years.

Steps to Take Now

Plan sponsors should become familiar with the interim final regulations and review their health plans. It is likely that additional plans may now be subject to the parity requirements. Plans will need to evaluate whether any substantive changes must be made to their plan designs, such as providing for a combined deductible. Plans will also need to review their administration of benefits in order to ensure that administrative procedures are in compliance by the regulatory deadline.

Please contact your [B_Abbrname] representative for more information.

The information contained in this newsletter is not intended as legal or medical advice. Please consult a professional for more information.
Content © 2010 Zywave, Inc. All rights reserved.