TOPIC:
HEALTH CARE REFORM AND COLLEGE AND UNIVERSITY EMPLOYEE HEALTH CARE PLANS: THE INITIAL IMPACT

INTRODUCTION:
The Patient Protection and Affordable Care Act ("PPACA" or "Act"), as amended by the Health Care and Education Reconciliation Act ("Reconciliation Act"), imposes a number of new requirements on self-insured and fully-insured group health plans sponsored by private and public colleges and universities. While the changes under the PPACA go into effect over the next several years, this NACUANOTE focuses on the most immediate actions required by colleges and universities that sponsor or administer group health plans for their employees.

The PPACA delegates significant authority to the Departments of the Health and Human Services ("HHS"), Labor ("DOL"), and Treasury ("Treasury") (collectively "the Departments"), which are tasked with filling in much of the detail as to how group health plans meet their new obligations to employees. Most of the guidance colleges and universities need to plan for the many imminent changes under the PPACA has already been released by these Departments.

This NACUANOTE discusses the following:

- The meaning of "group health plan" under the Act;
- The meaning of "grandfathered plan" under the Act;
- The coverage and reporting reforms applicable to all group health plans, generally effective January 1, 2011;
- The additional coverage reforms applicable to group health plans that are not grandfathered, generally effective January 1, 2011;
- The reforms applicable to health flexible spending accounts ("FSAs"), health reimbursement accounts ("HRAs"), and health savings accounts ("HSAs"), generally effective January 1, 2011; and
- The continued availability of the HIPAA opt out rules for public institutions.

DISCUSSION:
A THRESHOLD ISSUE: WHAT IS A "GROUP HEALTH PLAN"?
The new coverage mandates under the PPACA apply to "group health plans" as defined in the Public Health Service Act ("PHSA") [1]. Generally, a group health plan is any plan, fund or program established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing medical care to employees or their dependents directly or through insurance or reimbursement [2]. Thus,
self-insured and fully-insured major medical group health plans sponsored by both private and public colleges and universities are subject to the PPACA coverage mandates. No exemption is provided for church plans. HRAs, whether unfunded or funded by a voluntary employees' beneficiary association ("VEBA"), are also subject to the PPACA coverage mandates to the extent that they are available for use during active employment, although special rules apply in certain cases.

A group health plan for purposes of the coverage mandates does not include the following plans:

- Health FSAs under Internal Revenue Code Section 125, if other group health plan coverage (other than a HIPAA excepted benefit [3]) is made available to the employee and the maximum benefit under the health FSA for the year does not exceed twice the employee's salary reduction election under the FSA for the year (or, if greater, the amount of the employee's salary reduction election under the health FSA for the year, plus $500).

- Accident-only coverage (including accidental death and dismemberment), disability income insurance, general or automobile liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance (e.g., mortgage insurance), coverage for on-site medical clinics, and other similar coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

- Limited scope dental benefits, limited scope vision benefits, or benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, if provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the group health plan. Benefits (whether provided through the same plan or a separate plan) are not an integral part of a group health plan if participants have the right to elect not to receive coverage for the benefits and to the extent a participant elects to receive coverage for the benefit, the participant is required to pay an additional premium for that coverage.

- Coverage for a specified disease or illness, hospital indemnity, or other fixed indemnity insurance, if provided under a separate policy, certificate, or contract of insurance, there is no coordination between the benefit and any exclusion of benefits under the employer's group health plan, and the benefits are paid without regard to whether benefits are provided with respect to such event under the employer's group health plan.

- Medicare supplemental health insurance, coverage supplemental to TRICARE, or similar supplemental coverage designed to fill gaps in primary coverage, if offered as a separate policy, certificate, or contract of insurance.

- HSAs, although the high deductible health plan ("HDHP") that accompanies an HSA would be a group health plan subject to the mandates.

- Retiree-only group health plans [4].

A THRESHOLD ISSUE: DOES YOUR PLAN HAVE GRANDFATHERED PLAN STATUS?

The applicability of many of the coverage mandates and reporting requirements under the PPACA depends on whether the group health plan qualifies as a "grandfathered plan." Generally, a grandfathered plan is a group health plan that was in existence on March 23, 2010 [5]. As long as a group health plan maintains its grandfathered status, the limited application of the PPACA lasts indefinitely. The Departments published an Interim Final Rule on June 17, 2010, which addresses the types of plan changes that will cause a group health plan to lose grandfathered status [6].

The Act provides that a group health plan will retain its grandfathered status even if the plan permits employees participating in the plan to enroll their family members and/or permits new employees and their families to join the plan. The Interim Final Rule clarifies that new employees include both
new hires and existing employees that are new enrollees. The Interim Final Rule additionally provides specific standards regarding the plan changes that an employer or employee organization may make without losing grandfathered status. These standards apply separately to each benefit package made available under a group health plan (e.g., if an HMO, PPO, and HDHP option are all offered under the plan, each such option is analyzed separately), and noncompliance with even one of the standards will cause the benefit package (not the plan) to completely lose grandfathered status. If a group health plan makes any of the following changes, it (or the benefit package, as applicable) will lose grandfathered status:

- eliminates all or substantially all benefits to diagnose or treat a particular condition that was covered on March 23, 2010, regardless of whether the change affects relatively few individuals covered under the plan;
- increases the percentage cost sharing requirements on participants above the percentage in effect on March 23, 2010, for any benefits under the plan;
- increases the fixed-amount cost-sharing requirements above the amount in effect on March 23, 2010, more than the following maximum thresholds –
  - for fixed-amount cost sharing requirements other than co-payments, medical inflation plus 15 percent, and
  - for fixed-amount co-payments, the greater of medical inflation plus 15 percent or 5 dollars increased by medical inflation;
- decreases the employer or employee organization contribution rate for any tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate in effect on March 23, 2010;
- changes an overall annual limit on plan benefits in the following circumstances –
  - imposes an overall annual limit on the dollar value of benefits, if the plan did not impose an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010;
  - imposes an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010, if the plan imposed an overall lifetime limit but not an overall annual limit on the dollar value of benefits on March 23, 2010;
  - decreases the dollar value of an annual limit, if the plan imposed an overall annual limit on the dollar value of benefits as of March 23, 2010;
- changes insurance carriers (except for collectively bargained insured plans under the special grandfathering rule discussed below) [7].

The Interim Final Rule contains detailed examples of how these rules operate. The Rule also contains anti-abuse provisions to prevent employers from shifting employees to other grandfathered health plans with fewer benefits to circumvent the limits on plan changes. These standards all apply as compared to the plan terms in effect on March 23, 2010. Plan changes that became effective after March 23, 2010, but were legally binding or adopted prior to March 23, 2010, are treated as in effect on March 23, 2010 under transitional relief. Additionally, if an employer made a change to its group health plan after March 23, 2010, but prior to June 17, 2010, the plan is permitted to revoke or modify the change effective with the first day of the first plan year beginning on or after September 23, 2010, in order to bring the plan back into grandfathered status in accordance with the Interim Final Rule.

Subject to further guidance, any other changes will not cause a group health plan to lose grandfathered status. Thus, an institution can make voluntary changes to its group health plan to increase benefits, to conform to required legal changes, to voluntarily adopt other coverage mandates in the PPACA, and to change third party administrators without losing grandfathered status. Moreover, changes in premiums do not impact grandfathered status (although if the college or university share of the premium is a fixed dollar amount, increases in premiums may require the institution to increase its share to avoid the contribution rate with respect to participants increasing more than 5 percent from that in effect on March 23, 2010).
A special rule applies to fully-insured (not self-insured) group health plans that are maintained pursuant to one or more collective bargaining agreements. Fully insured collectively bargained plans maintain their grandfathered status until the date on which the last agreement relating to that coverage that was in effect on March 23, 2010 terminates, even if there is a change in insurance carriers during that period and even if one or more of the PPACA coverage mandates are voluntarily adopted early. When the last agreement terminates, the plan may maintain grandfathered status indefinitely under the general grandfathering rule so long as no changes are made that would cause it to lose grandfathered status [8]. The Interim Final Rule also clarifies that collectively bargained plans are subject to the same coverage reform mandates under the PPACA at the same time that such mandates are effective with respect to other grandfathered plans—e.g., collectively bargained plans must comply with the adult child coverage mandate, the elimination of lifetime and annual dollar limits, and the prohibition on preexisting condition exclusions at the same time that such mandates become effective for all grandfathered health plans.

In order to maintain grandfathered status, the Interim Final Rule requires a group health plan to include a statement in its plan materials provided to participants or beneficiaries that the plan believes that it is grandfathered under the PPACA and that provides contact information for questions and complaints. The Interim Final Rule contains model language that may be used by group health plans to satisfy this disclosure requirement [9]. Colleges and universities are required to include such a statement in plan materials that relate to the first plan year in which the PPACA coverage mandates apply to the plan. The scope of what is meant by "plan materials" is unclear, but institutions should at a minimum include the required statement in their group health plan summary plan descriptions and open enrollment materials. A grandfathered group health plan is also required to maintain records documenting the plan or policy terms in effect on March 23, 2010, and all other documents necessary to explain and verify its status as a grandfathered health plan, and make such documents available to participants and the Departments upon request.

Given the limited ability to make changes to group health plans while still maintaining grandfathered status under the Interim Final Rules, it is critical that colleges and universities understand what coverage and reporting mandates they avoid by maintaining grandfathered status. Many institutions may find that their group health plans already comply or come close to complying with several of these additional mandates, and that the maintenance of grandfathered status is simply not critical given the significant constraints on plan changes. While discussed in detail below, the appendix to this NACUANOTE includes a complete list of the coverage and reporting mandates, the effective date of each mandate, and whether it applies to grandfathered health plans.

**ROUND ONE CHANGES REQUIRED FOR ALL GROUP HEALTH PLANS**

The PPACA amends the PHSA (and requires conforming amendments to the Code and ERISA) to provide two rounds of health coverage reforms applicable to group health plans. The first round of reforms takes effect with the first plan year that begins on or after September 23, 2010, or January 1, 2011 for calendar year plans [10]. The second round of reforms becomes effective for plan years beginning on or after January 1, 2014, and includes restrictions on waiting periods, a complete prohibition on pre-existing condition exclusions, and mandated cost-sharing limits [11]. The second round of reforms coincides with a host of more sweeping changes under the Act, including an individual mandate to maintain health coverage and the establishment of state-run private insurance marketplaces, called "exchanges," through which individuals and small employers can purchase health insurance at guaranteed levels of coverage. This NACUANOTE will focus only on the first round of reforms because the implementation of the later reforms will likely be impacted by future regulations issued prior to 2014.

The following first round of reforms applies to all group health plans sponsored by colleges and universities, including grandfathered plans.
**No Lifetime or Annual Limits on “Essential Health Benefits”** [12]

**Requirement.** Group health plans are generally prohibited from establishing any lifetime limits or annual limits on the dollar value of any "essential health benefits" for any participant or beneficiary.

This general prohibition applies only with respect to covered benefits that are "essential health benefits." Lifetime and annual limits may continue to be placed on covered benefits that are not essential health benefits. Essential health benefits is a term that will be defined by the Secretary of HHS, but include services in ten broad categories and are intended to cover the scope of benefits provided under a typical employer plan [13]. The preamble to the Interim Final Rule that was published on June 28, 2010, addressing lifetime and annual limits [14], provides that plan sponsors may make a good faith effort to comply with a reasonable interpretation of the term essential health benefits until the Secretary issues further regulations.

Additionally, under a transition rule, the PPACA and the Interim Final Rule permit a group health plan to impose "restricted" annual limits on essential health benefits for plan years beginning prior to January 1, 2014. Specifically, the Interim Final Rule provides that the annual limit on the dollar value of essential health benefits cannot be less than:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;
- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and
- $2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014.

Note, however, that if not in place on March 23, 2010, imposition of these limits would result in a plan losing its grandfathered status. In determining whether an individual has met the restricted annual limit in a given plan year, a group health plan may only take into account essential health benefits, and amounts paid by the plan for non-essential health benefits cannot accrue toward these restricted annual limits before 2014.

The Interim Final Rule creates a special enrollment opportunity for individuals whose coverage or benefits ended by reason of reaching a lifetime limit prior to the first plan year beginning on or after September 23, 2010, and who is otherwise eligible for coverage under the plan. The group health plan must provide affected individuals with a notice that the lifetime limit no longer applies and also provide a special enrollment period that lasts at least 30 days to give any such individual an opportunity to reenroll in the plan (so long as otherwise eligible for coverage). Given the difficulty of identifying affected individuals, colleges and universities may want to consider providing the notice to all employees eligible to participate in their group health plan. The notice must be provided, and the enrollment period must begin, no later than the first day of the first plan year beginning on or after September 23, 2010. The Departments have issued a model notice that plan sponsors can use to comply with this rule [15].

As discussed above, HRAs are group health plans subject to the PPACA. HRAs by design place annual dollar limits on the amount of benefits that are covered by the HRA. The Interim Final Rule provides that if HRAs are "integrated" with other coverage as part of a group health plan where the other coverage complies with the rules on annual limits, then any contribution limits applicable to the HRA will not violate the PPACA. Stand-alone HRAs that cover retirees-only (this would generally include the Emeriti program, for example) are also not subject to this rule since retiree-only plans are exempt from the PPACA. However, stand-alone HRAs that are not retiree-only and that are not integrated with a group health plan do not have a special exemption from the annual limit rules. The preamble to the Interim Final Rule requests comments on the proper treatment of stand-alone HRAs
going forward.

There is also no exception to the annual and lifetime maximum rules under the Interim Final Rule for "mini-med" plans or other limited benefit plans. However, a group health plan—including a stand-alone HRA, mini-med plan or limited benefit plan—may apply for an annual waiver from the annual limit restrictions for plan years beginning on or before January 1, 2014, if the plan can demonstrate that compliance with the Interim Final Rule would result in a significant decrease in access to benefits or a significant increase in premiums [16].

**Considerations.** The Interim Final Rule issued with respect to grandfathered plans (discussed above) generally provides that a plan will lose grandfathered status if it implements or reduces an existing annual limit. Thus, if a grandfathered plan does not have an overall annual limit in effect on March 23, 2010, and chooses to impose a restricted annual limit until 2014, the plan will lose grandfathered status. Note also that this mandate applies to lifetime limits and annual limits on the *dollar value* of benefits provided to a participant or beneficiary. A group health plan is still permitted to place other limitations on benefits, such as limits on days of treatment or number of visits.

**Extension of dependent coverage** [17]

**Requirement.** Group health plans that provide dependent coverage of children must continue to make such coverage available to an adult child until the child turns age 26. An Interim Final Rule published on May 13, 2010, with respect to the adult child mandate [18], provides that a group health plan that offers dependent child coverage can define "dependent" for purposes of eligibility for coverage in terms of the relationship between the child and the employee only. While neither the Act nor the Interim Final Rule define "child" for purposes of the coverage mandate, the Departments issued frequently asked questions on September 20, 2010, which provide that the scope of the coverage mandate is limited to an employee's son, daughter, stepchild, adopted child or child placed for adoption, or eligible foster child [19]. The Interim Final Rule makes clear that group health plans that offer dependent child coverage must cover both married and unmarried children until age 26, but are not required to cover the spouse or child of such adult children.

Many group health plans define dependent coverage eligibility in terms of the tax dependency requirements under Internal Revenue Code Section 152, *e.g.*, by imposing financial dependency and residency requirements, income limitations, and full-time student status for older children. These types of restrictions are no longer permitted with respect to children under age 26 who are included within this coverage mandate. However, if a group health plan covers adult children age 26 or older, or children outside the scope of the coverage mandate (*e.g.*, grandchildren or domestic partner children), the plan may continue to restrict the eligibility of these individuals based on residency, support or other factors, if permitted by state law. To the extent that state law mandates coverage for dependents more broadly than the federal law, the state law will continue to apply.

The Interim Final Rule also provides that a group health plan that offers dependent child coverage cannot vary the terms of that coverage – including the cost of that coverage – based on the age of the child who has not attained age 26. For example, a plan cannot charge higher premiums to dependent children who are older than 21, or offer such children more limited coverage. However, a plan could increase premiums for coverage of additional dependents regardless of age without violating the Interim Final Rule (*e.g.*, self-only, self-plus-one, self-plus-two, self-plus-three-or-more).

Group health plans offering dependent child coverage must provide an opportunity for employees to enroll their adult children who are currently ineligible for coverage due to their age, but who will become eligible when the PPACA mandate becomes effective, and who previously lost coverage, were denied coverage, or were never eligible for coverage under the plan due to their age. Just as with the special enrollment opportunity described above with respect to individuals who previously
met a plan’s lifetime limit, the opportunity to enroll must be made available for at least 30 days, and
the institution must both offer and give notice of the enrollment opportunity to employees no later
than the first day of the first plan year beginning on or after September 23, 2010. This will likely
coincide with the open enrollment periods for many plans. Note, however, that if a plan’s open
enrollment period is less than 30 days (as many are), the opportunity for adult children who
previously lost or were denied coverage because of their age must still remain open for at least 30
days. The Departments have issued a model notice that plan sponsors can use to comply with this
rule [20]. The adult child enrolled under this special enrollment opportunity must be offered all benefit
packages available to similarly situated individuals and at the same cost, effective as of the first day
that the Act’s coverage mandate becomes effective for the plan. If an employee has the opportunity
to enroll an adult child during under this opportunity, the plan must also permit the employee to enroll
if not already enrolled, or if already enrolled, to switch to a different benefit package. A plan is not
required to enroll an adult child unless the employee also enrolls in the plan.

Prior to 2014 only, a grandfathered group health plan may limit eligibility to those adult children who
are not eligible to enroll in any other eligible employer sponsored health plan, other than a group
health plan of a parent. Therefore, if an adult child is eligible for coverage through his own employer
or the employer of his spouse, the grandfathered group health plan is not required to extend adult
child coverage to that individual. Note that student health insurance coverage is not employer
coverage. If the adult child is eligible for both parents’ group health plans, neither plan may deny
coverage to the child, regardless of either plan’s grandfathered status. Grandfathered plans wishing
to take advantage of this limited exception may want to set up a certification process in connection
with its enrollment process under which an employee (or the adult child’s employer or adult child’s
spouse’s employer) must certify that the adult child is not eligible for other employer-based
coverage.

Importantly, the Reconciliation Act amended the Internal Revenue Code to eliminate the imputed
income concerns related to offering dependent coverage to children who do not qualify as federal tax
dependents [21]. For this purpose, a “child” has the same meaning as under the coverage mandate,
and, therefore, includes the employee’s son, daughter, stepchild, adopted child or child placed for
adoption, or eligible foster child. On April 27, 2010, the Internal Revenue Service issued Notice
2010-38, which clarifies that employers can stop imputing income, effective March 30, 2010, with
respect to any health plan coverage— including coverage under health FSAs, HRAs, VEBAs, and
401(h) accounts in retirement plans— that is extended to an employee’s child who has not attained
age 27 as of the end of the taxable year. Notice 2010-38 also provides that institutions can
immediately permit employees to make salary reduction contributions for health benefits under a
cafeteria plan, including a health FSA, for children under age 27 as of the end of the taxable year, so
long as the institution retroactively amends the cafeteria plan prior to December 31, 2010.

Considerations. Note that if a group health plan does not cover dependent children, then this new
mandate does not apply. If a group health plan does cover dependent children, the coverage
mandate applies only with respect a covered dependent who is the employee’s son, daughter,
stepchild, adopted child or child placed for adoption, or eligible foster child. The frequently asked
questions issued by the Departments on September 20, 2010, do not directly address whether a
group health plan that covers dependent children could define child for eligibility purposes more
narrowly than the above individuals, e.g., by excluding foster children from coverage. However, it is
clear that if a group health plan defines child more broadly by choosing to cover children who do not
fall within the coverage mandate, additional restrictions may continue to apply with respect to such
individuals. For example, a group health plan may establish two classes of dependent children—one
class that is subject to the PPACA that can only be defined by relation to the employee and age, and
a separate class that is not subject to the PPACA that can be restricted by age, student status,
marital status, residency, or any other dependency factors (for example, grandchildren or disabled
children who are older than 26).

The Secretary of HHS has urged insurance companies to continue coverage for dependents who
graduate from college or age out of their parents' health plans during 2010, prior to the effective date of the adult child coverage mandate, noting both the general good health of adult children and also the money saved by avoiding the administrative costs of disenrolling adult children who will then be reenrolled the next plan year. Many major insurers have announced that they will agree to extend coverage to at least some adult children in 2010 [22]. This change may impact self-insured plans as well because insurers who also act as third party administrators may make changes to their processes to enable all employers to make extended coverage available early.

Colleges and universities that have already extended coverage to children beyond the parameters of a tax dependent as a matter of plan design or due to state law can immediately stop imputing income to employees for such coverage. Note that institutions will still need to continue to impute income with respect to other covered individuals outside the scope of the coverage mandate who are not tax dependents of the employee, such as same-gender spouses, domestic partners, or the children of either.

**Ban on Pre-Existing Condition Exclusions for Children** [23]

**Requirement.** Group health plans are prohibited from imposing any pre-existing condition exclusions on enrollees under age 19. This requirement will be expanded to all enrollees effective for plan years beginning on or after January 1, 2014. The June 28, 2010 Interim Final Rule defines a pre-existing condition exclusion as any limitation or exclusion of benefit (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage under a group health plan, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

**Considerations.** Presumably, a plan that enrolls an adult child age 19 or older who was not previously enrolled could still impose a pre-existing condition exclusion (consistent with existing limitations under HIPAA) until plans are required to eliminate those exclusions for all individuals in 2014. Following the elimination of all pre-existing condition exclusions in 2014, Congress could repeal the creditable coverage and portability provisions under HIPAA, and/or the Departments could suspend the need to provide creditable coverage notices when a participant loses coverage under an employer health plan.

**No Rescission** [24]

**Requirement.** A group health plan cannot rescind coverage under the plan with respect to an individual once the individual is covered under the plan unless the individual performs an act, practice or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact. The June 28, 2010 Interim Final Rule provides that in the case of fraud or intentional misrepresentation of material fact, a group health plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. For purposes of this mandate, rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation of coverage on a prospective basis is not a rescission. In addition, a group health plan is permitted to cancel coverage retroactively if a plan participant fails to timely pay required premiums or contributions toward the cost of coverage.

**Considerations.** Diligent monitoring of employee eligibility for health plan coverage will be critical in light of this new mandate. An institution's or plan administrator's neglect in monitoring the eligibility of its employees for group health plan coverage will no longer justify a retroactive rescission of coverage—e.g., plan sponsors can no longer retroactively discontinue coverage as a result of a dependent audit in the absence of a finding of fraud or intentional misrepresentation of material fact.
Form W-2 Reporting [25]

Requirement. The Act requires colleges and universities, beginning for the tax year of 2011, to report the aggregate cost of employer provided health care coverage (both employee and employer) on each employee's Form W-2. On October 12, 2010, however, the IRS issued guidance [26] making reporting of health care coverage for tax year 2011 voluntary. The guidance stated, however, that beginning for tax year 2012, Form W-2 reporting of health insurance coverage cost will be mandatory. For fully insured plans, aggregate cost is the premium paid. For self-insured plans, aggregate cost is to be determined in accordance with rules similar to those that apply for purposes of determining COBRA premiums for self-insured plans. The aggregate cost total includes employer contributions to HRAs, but does not include contributions to an HSA or salary reduction contributions to health FSAs. The aggregate cost total excludes the cost of fully-insured dental and vision plans, but includes the cost of self-insured dental and vision plans regardless of whether otherwise exempt from the PPACA coverage mandates as limited scope plans.

Considerations. An employee who terminates employment in 2012 has the right to request a Form W-2 early, so institutions will need to consider how to comply with this requirement in preparation for 2012. No policy reason for a distinction between fully-insured and self-insured dental and vision plans appears to exist, particularly given that the fact that they are treated the same for purposes of the PPACA coverage mandates. Since the statutory language seems fairly clear on this point, this may need a legislative fix. Finally, because retired employees do not receive Forms W-2, it is unclear how this requirement will be met with respect to retiree health care. Presumably, at least one function of this informational report is to determine whether the value of employer-provided coverage will exceed certain limits and be subject to penalty taxes for excess coverage that go into effect in 2018. Because the value of retiree coverage would also appear to be subject to the excess coverage penalty tax in 2018, it seems likely that a similar reporting requirement will be imposed on retiree plans in the future, whether through a Form 1099 or through a more direct reporting mechanism to the Internal Revenue Service.

ADDITIONAL ROUND ONE CHANGES FOR PLANS WITHOUT GRANDFATHERED STATUS

The Act also contains a number of additional requirements that apply to those group health plans that do not have grandfathered status, effective the first plan year that begins on or after September 23, 2010. Some group health plans may already satisfy these additional requirements in significant part, which will affect how strenuously an institution might seek to preserve the plan's grandfathered status.

Mandated Coverage for Preventive Health Services [27]

Requirement. Group health plans must cover the following items and services and must do so without any cost-sharing requirements (e.g., deductibles, co-pays, co-insurance, etc.):

- evidence-based items of services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force with respect to the individual involved; [28]
- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources
An Interim Final Rule published on July 19, 2010 [29], provides that recommendations and guidelines issued before September 23, 2009, must be included in group health plans without cost-sharing requirements as of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). Recommendations and guidelines issued on or after September 23, 2009, are not required to be provided on a first dollar basis until the first plan year that begins on or after the date that is one year after the date the recommendation or guideline is issued [30].

The Interim Final Rule provides guidance with respect to when a group health plan may impose cost-sharing requirements for office visits during which required preventive services are provided, which depends on the primary purpose of the office visit and the manner in which the services are billed. The Rule makes clear that if a group health plan satisfies this coverage mandate through its in-network providers, then the plan is not required to provide coverage for preventive services on an out-of-network basis, and if it chooses to do so, it can impose cost-sharing with respect to the out-of-network providers. Moreover, a plan that provides preventive services in addition to those required by this coverage mandate may continue to impose cost-sharing on those services and items.

**Considerations.** While many group health plans have moved to provide some level of preventive care services on a first-dollar basis, plans frequently limit the benefits by either limiting the services that are considered "preventive" or by imposing a dollar limit on preventive or wellness benefits. This provision will require plans to cover, without dollar limits and without any cost-sharing, a defined set of preventive care services. The recommendations and guidelines that outline the preventive services required to be covered by group health plans under this coverage mandate were not written for this purpose, and it is not always clear how a particular recommendation translates to mandated coverage under a group health plan. The Interim Final Rule is helpful in that it provides that, to the extent not specified in a recommendation or guideline, a group health plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive item or service.

This mandate will impose a cost on colleges and universities (at least in the short term), and may be a reason to attempt to maintain grandfathered plan status. On the other hand, institutions may feel that they need to voluntarily meet this mandate from a competitive and/or employee morale standpoint. In addition, if covering these preventive care services meets the goal of catching health conditions in their early stages, plans could see long-term cost savings in reducing the high-cost claims for diseases that are not typically caught until in advanced stages.

**Mandated Patient Protections [31]**

**Requirement.** If a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider or a pediatrician for the participant's child, the plan must permit the participant or beneficiary to designate any participating primary care provider or pediatrician who is available to accept the participant or beneficiary and who is in the plan's network. Moreover, a plan may not require pre-authorization or referral by the plan in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The June 28, 2010 Interim Final Rule also imposes a notice requirement on group health plans that require the designation of a primary care provider. The notice must inform participants that they may choose a primary care provider or pediatrician of their choice and obtain OB/GYN care without prior authorization. This notice must be provided whenever the plan provides a participant with a
summary plan description or similar description of benefits under the plan, and the Interim Final Rule contains model language for this purpose [32].

Additionally, if a group health plan covers emergency services:

- it must do so without requiring prior authorization, regardless of whether the service provider is in-network or out-of-network;
- the plan may not require that the provider furnishing emergency services be a participating network provider;
- if the emergency services are provided out-of-network, the plan may not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; and
- if the emergency services are provided out-of-network, the plan cannot impose costs that are different than those imposed with respect to in-network services.

Considerations. The provisions relating to choosing a primary care provider and pediatrician will only apply to group health plans that require enrollees to formally designate a primary care provider, and are limited to providers who are in the plan's network. Plans that do not require an affirmative designation of a primary care provider are not affected by these provisions. However, all plans will be affected by the provisions prohibiting prior authorization and requiring in-network cost-sharing for emergency services provided in an emergency services department of a hospital. Note that whether an individual has an "emergency medical condition" for purposes of seeking emergency services is determined by whether a "prudent layperson" would have reasonably expected the absence of immediate medical attention to place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, to cause serious impairment to bodily functions, or to cause serious dysfunction of any bodily organ or part.

**Extension of Nondiscrimination Rules to Full-Insured Plans** [33]

**Requirement.** Code Section 105(h) prevents self-insured group health plans from discriminating in favor of highly-compensated individuals in terms of eligibility and benefits in the self-insured plan. The result of violating these prohibitions is the taxation of the highly-compensated individuals on the discriminatory reimbursements they receive under the discriminatory plan. The Act now imposes similar nondiscrimination rules on fully-insured group health plans. If a fully-insured group health plan fails to comply with these nondiscrimination rules, rather than resulting in a loss of a tax benefit for highly compensated individuals, the plan will be subject to an excise tax or civil money penalty of $100 per day per individual discriminated against [34].

**Considerations.** Fully-insured plans have sometimes been used to provide enhanced benefits to highly-compensated individuals such as administrators to avoid the nondiscrimination rules applicable to self-insured group health plans. Those practices will come to an end with the extension of the nondiscrimination rules to insured plans. In addition, the expansion of these requirements to fully-insured plans, as well as the extension of regulatory authority to the Secretary of HHS, will likely result in more scrutiny being placed on self-insured plans already subject to nondiscrimination rules. Note that unlike the discrimination rules that apply to retirement plans, both private and public colleges and universities are subject to the nondiscrimination rules that apply to self-insured, and now fully-insured, group health plans. Institutions may, therefore, want to review their self-insured plans for potential nondiscrimination issues at this time.

**Mandated Claims Appeal Processes** [35]

**Requirement.** Group health plans are required to have both an internal and external appeals
process for appeals of coverage determinations and claims. The internal appeals process must satisfy the existing claims regulations under ERISA, as modified by additional standards set forth in the Interim Final Rule published on July 23, 2010 [36]. These modifications to the ERISA processes include:

i. A rescission of coverage must be treated as an adverse benefit determination, regardless of whether there is an adverse effect on any particular benefit at the time of the rescission.

ii. Claimants must be notified of benefit determinations for urgent care claims within 24—rather than 72—hours after receipt of the claim by the plan.

iii. A group health plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim—or any new or additional rationale on which a final internal adverse benefit determination will be based. This information must be provided to the claimant as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

iv. A group health plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

v. Notice of an adverse benefit determination must be provided in a "culturally and linguistically appropriate manner" that provides specific information in addition to that already required under ERISA.

If a group health plan fails to strictly adhere to the ERISA claims processes, as modified above, the claimant is deemed to have exhausted the internal claims and appeals process regardless of how insignificant the noncompliance. In such case, the claimant may proceed with initiating an external review or pursue any available remedies under ERISA or State law without completing the internal review process. To give plans and issuers more time to implement procedures and make necessary changes to computer systems in order to fully comply with these additional standards, the Departments have instituted an enforcement grace period until July 1, 2011 with respect to the standards listed under paragraph i and ii above, as well as the deemed exhaustion result for failure to strictly adhere to these processes [37].

A group health plan must also satisfy a State or a Federal external appeals process. The Interim Final Rule provides that the State external review process will apply if the group health plan (or the insurer insuring a fully-insured group health plan) is subject to and bound by the State process and the State process satisfies the consumer protections in the NAIC Uniform External Review Model Act [38]. Although self-insured group health plans subject to ERISA are not subject to State external review processes due to ERISA preemption, a non-ERISA self-insured group health plan such as a church or nonfederal governmental plan may be subject to a State external review process. In order to provide States time to modify their statutes in accordance with this mandate, a State's external review processes will be deemed to comply with the NAIC standards for plan years beginning prior to July 1, 2011. If the State's external review process does not satisfy the NAIC standards for plan years beginning on or after July 1, 2011, the Federal external review process will apply.

If the State external review process does not apply, then the Federal external appeals process will apply. The Interim Final Rule provides that the Federal external process applies to any adverse benefit determination except for a determination as to whether a participant or beneficiary is eligible under the terms of the plan. The Departments have provided an interim safe harbor for group health plans that are subject to the Federal external review process, which includes a standard and expedited external review process [39].

The Interim Final Rule for this coverage mandate also provides that all notices must be culturally and linguistically appropriate, and that non-English notices must be provided when a significant portion of
the plan participants are literate only in the same non-English language.

**Considerations.** Group health plans sponsored by private colleges and universities are already required to have an internal appeals process that satisfies the ERISA requirements, and many group health plans sponsored by public institutions likewise follow a claims and appeals process that is similar to ERISA. Moreover, some states already mandate an external review process similar to that in the Act applicable to group health plans sponsored by public institutions and to fully insured plans. Even for those plans that already have internal and external procedures in place, however, the procedures will need to be expanded in accordance with the Final Interim Rule.

For those plans that are not already subject to a state-mandated external appeals process, the effects of this new requirement may be significant. The result of the external appeals process, which is conducted by an independent third-party entity, will be binding on the plan, thus taking final decision-making authority outside of the plan's appeals committee or other decision-making body. Many institutions will need to amend plan documents and change procedures to conform to these new requirements. While the Interim Final Rule permits an employer to delegate responsibility for the internal and external appeals to a third party administrator, it will be important that provider agreements are updated to provide for this delegate and indemnification should a failure occur. *The external review process may be the primary reason why some institutions seek to keep their group health plans grandfathered.*

**CHANGES TO HEALTH FSAS, HRAS, AND HSAS**

Effective January 1, 2011, over-the-counter medications will no longer be reimbursable expenses from health FSAs, HRAs, and HSAs, unless the medication is either prescribed or is insulin [40]. Additionally, penalty taxes on distributions from HSAs for non-medical expenses will increase from 10% to 20% (and from 15% to 20% for Archer MSAs) as of January 1, 2011. Finally, a $2,500 contribution limit will be imposed on health FSAs as of January 1, 2013.

These changes to the FSA, HRA, and HSA requirements are straightforward revenue raisers for the federal government to help pay for the cost of the Act. The effect of all of these changes will be to increase individuals' taxable income with respect to reimbursements that previously would have been excludable from income. The “hard” effective date of January 1, 2011 relating to the elimination of reimbursement for over-the-counter medications under a health FSA means that these medications cannot be reimbursed during the 2½ month grace period, if any, under the FSA. In addition, the use of health FSA and HRA debit cards is generally no longer permitted for the purchase of over-the-counter medications after December 31, 2010 because current debit card systems are unable to recognize and substantiate that an over-the-counter medication was prescribed [41]. Note that the restrictions on reimbursable medications do not impact other medical expense items available for reimbursement from a health FSA, such as contact solution, band-aids, and other first aid supplies that are not medications.

These changes will require amendments to flexible benefit plan documents and summary plan descriptions prior to June 30, 2011. In addition, although not affirmatively required by the Act, employees should be put on notice that reimbursement for over-the-counter drugs will end on December 31, 2010. This is particularly important for plans that have grace periods and as employees are determining their FSA elections for 2011.

**HIPAA OPT OUT FOR PUBLIC INSTITUTIONS**

State and local government self-insured group health plans, such as those sponsored by public colleges and universities, have historically been able to elect to "opt out" of certain HIPAA coverage mandates outlined in the PHSAct, so long as they provided annual written notice to enrollees and to
the Secretary of HHS of this election. Specifically, these plans were able to opt out of compliance with the following requirements:

- limitations on pre-existing condition exclusion periods;
- requirements for special enrollment periods;
- prohibitions against discriminating against individual participants and beneficiaries based on health status (except for provisions added by the Genetic Information Nondiscrimination Act of 2008);
- standards relating to benefits for newborns and mothers;
- parity in the application of certain limits to mental health and substance use disorder benefits (including the requirements imposed by the Mental Health Parity and Addiction Equity Act of 2008);
- required coverage for reconstructive surgery following mastectomies; and
- coverage of dependent students on a medically necessary leave of absence.

The PPACA amended the HIPAA opt-out provisions of the PHSA so that State and local government self-insured health plans will no longer be able to opt-out of the first three requirements listed above. This change is effective for plan years beginning on or after September 23, 2010. Recognizing that the guidance issued with respect to the HIPAA opt-out provisions has arrived somewhat late for plans that could be affected as early as October 1, 2010, the Department of HHS has stated that it will not take any enforcement actions with respect to opt-out elections for plan years beginning prior to April 1, 2011, related to the first three requirements listed above.

**CONCLUSION:**

Colleges and universities now have a sound basis upon which to begin thinking about how the “first round” of changes will affect its group health plans and health FSAs. As colleges and universities prepare to comply with the mandatory changes under the PPACA for the upcoming plan year, they should keep in mind the possibility that making discretionary changes to their plans could compromise any grandfathered status that the plans might now enjoy. Colleges and universities should be preparing now for the open enrollment period for the first plan year in which the PPACA mandates will apply, to ensure that plan materials are updated as required if grandfathering status is maintained, to timely comply with the multiple notice requirements to the extent applicable, and to meet the special enrollment rules for adult children and employees who have previously exhausted the lifetime limits of the plan.

**FOOTNOTES:**

**FN1.** PPACA § 1551.


**FN3.** A "HIPAA excepted benefit" is a specified benefit program that is statutorily exempt from both the HIPAA portability requirements and the coverage mandates under the PPACA. The benefit programs listed in the first five bullet points in this section are all HIPAA excepted benefits.

**FN4.** See Preamble to the Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final
Rule and Proposed Rule, 75 Fed. Reg. 34538 (June 17, 2010) (to be codified at 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Part 147). Colleges and universities that cover their active employees and retirees under the same group health plan should consider whether it makes sense to transfer retirees to a separate group health plan that covers retirees only going forward.

FN5. PPACA § 1251(a), as amended by PPACA § 10103(d), and further amended by Section 2301 of the Reconciliation Act.


FN7. Although the Interim Final Rule generally provides that a change in insurance carriers will cause a group health plan to lose grandfathered status, the Departments issued frequently asked questions on September 20, 2010, in which they indicated that they will shortly address the circumstances under which grandfathered plans may change carriers without losing grandfathered status. The frequently asked questions are available at http://www.dol.gov/ebsa/faqs/faq-aca.html.

FN8. In other words, if on the date that the collective bargaining agreement expires the group health plan has not been amended or changed such that it would have lost grandfathered status under the general grandfathering rule comparing the plan terms to those in effect on March 23, 2010, then the group health plan will continue to be grandfathered until such date that a change is made that takes it out of grandfathered status under the general rule.

FN9. This model language is available at www.dol.gov/ebsa/grandfatherregmodelnotice.doc.

FN10. See generally PPACA § 1001, as amended by PPACA § 10101.

FN11. See generally PPACA § 1201, as amended by PPACA § 10103.

FN12. PPACA § 1001, as amended by PPACA § 10101(a); new PHSA § 2711.

FN13. These categories of benefits are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. PPACA § 1302(b).


FN15. This model language is available at www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc.

FN17. PPACA § 1001, as amended by Reconciliation Act § 2301(b); new PHSA § 2714.


FN20. This model language is available at www.dol.gov/ebsa/dependentsmodelnotice.doc.

FN21. Reconciliation Act § 1004(d).


FN23. PPACA § 1201; new PHSA § 2704.

FN24. PPACA § 1001; new PHSA § 2712.

FN25. PPACA § 9002; amends Internal Revenue Code § 6051(a).


FN27. PPACA § 1001; new PHSA § 2713.

FN28. Note that current recommendations by the U.S. Preventive Services Task Force relating to breast cancer screening, mammography and prevention do not include the controversial standards that were issued in November 2009 which generally delayed the recommendation for women to begin receiving routine preventive mammograms from age 40 to age 50.


FN30. An up-to-date listing of all required recommendations and guidelines is available at http://www.healthcare.gov/center/regulations/prevention/recommendation.html.

FN31. PPACA § 1001, as amended by PPACA § 10101(h); new PHSA § 2719A.

FN32. This model language is available at http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc.

FN33. PPACA § 1001, as amended by PPACA § 10101(d); new PHSA § 2716.

FN34. On September 20, 2010, the Department of the Treasury and the Internal Revenue Service released Notice 2010-63, which invites comments concerning the application of rules prohibiting non-grandfathered insured group health plans from discriminating in favor of highly compensated
individuals.

FN35. PPACA § 1001, as amended by PPACA § 10101(g); new PHSA § 2719.


FN40. PPACA §§ 9003–9005, as amended by PPACA § 10902 and Reconciliation Act § 1403; amends Internal Revenue Code §§ 106, 125, 220, and 223.

FN41. See Internal Revenue Service Notice 2010-59 (certain exceptions apply).

FN42. See Department of HHS, Office of Consumer Information and Insurance Oversight Memorandum: "Amendments to the HIPAA opt-out provision (formerly section 2721(b)(2) of the Public Health Service Act) made by the Affordable Care Act" (Sept. 21, 2010) (a delayed effective date for collectively-bargained plans applies).

AUTHOR:

Tara S. Sciscoe, Partner, Ice Miller LLP, Indianapolis, IN

RESOURCES:

Appendices

- List of Coverage and Reporting Mandates
- Action Item Checklist for the Upcoming Year

NACUA Resources:

- Health Care Reform Resources and Links
Permitted Uses of NACUANOTES Copyright and Disclaimer Notice

Copyright 2010 by Tara S. Sciscoe. NACUA members are authorized to reproduce and distribute copies of NACUANOTES, in whole or in part, with or without attribution, to faculty, staff and students of their respective institutions. Re-distribution may include incorporation into other communications from NACUA members and occur by any convenient means, including transmission by email or posting to a NACUA member’s web page. NACUA members are asked not to affirmatively re-distribute NACUANOTES to persons other than the faculty, staff and students of their institutions, or to other NACUA members.

Disclaimer. NACUANOTES do not constitute legal advice. Counsel and other readers should affirmatively examine issues addressed by NACUANOTES based the facts of each matter and on their own interpretation of applicable federal, state and local law, as well as applicable institutional policies.

"To advance the effective practice of higher education attorneys for the benefit of the colleges and universities they serve."