Health Care Reform: New Guidance Released, Lawsuits Move Forward

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A number of governmental agencies have released new guidance for the Patient Protection and Affordable Care Act (PPACA). The various lawsuits brought against the federal government continue to move forward.

IRS Makes W-2 Reporting Optional for 2011

Recognizing the immense obstacles faced by employers trying to meet the new 2011 W-2 reporting requirement, the Internal Revenue Service (IRS) is providing interim relief under Notice 2010-69. Employers will not be required to report the aggregate cost of employer-sponsored coverage on 2011 Form W-2's. The IRS anticipates issuing guidance on the reporting requirement before the end of 2010.

FAQs Released for Market Reforms

The Departments of Health and Human Services, Labor and the Treasury have released a series of Frequently Asked Questions (FAQs) to provide additional guidance on implementing the market reforms of the Affordable Care Act.

FAQs Part I

Part I was released September 20, 2010 and contains sixteen separate Q&A clarifications. Q&A 2 addresses loss of grandfathering due to a greater than 5% reduction in employer contributions. It states that the Departments will not consider an insured grandfathered group health plan to lose grandfathering immediately based on a change in the employer contribution rate if the employer plan sponsor and issuer take the following steps:

- Upon renewal, an issuer requires a plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it); and

- The issuer's policies, certificates, or contracts of insurance disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year.

For policies renewed prior to January 1, 2011, issuers should take these steps no later than January 1, 2011.

Q&A 7 explains that grandfathered plans do not need to comply with the new external review provisions of PHS Act section 2719(b). Fully insured health plans can use existing state external processes in one of the States in which they operate to comply with the new federal external review requirements. Self-funded plans can use the safe harbor in Department of Labor Technical Release 2010-01 to comply with the external review requirement.

Q&A 12 deals with the new standards for claims and internal appeals. It states that on September 20, 2010 the Department of Labor issued Technical Release 2010-02 at http://www.dol.gov/ebsa/newsroom/tr10-02.html that allows an enforcement grace period until July 1, 2011 to give plans and issuers necessary time to make certain procedural and computer system changes to comply with the new requirements.

Q&A 14 clarifies that employers can enforce conditions for dependents under the age of 26 who are NOT covered by the description in Internal Revenue Code Section 52(f) (1). That section of the Code defines children to include only sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children. For an individual not described in Code section 152(f) (1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

FAQs Part II

On October 8, 2010 the Departments released nine FAQs in Part II. Q&A 1 deals with loss of grandfathering and confirms that if you avoid the six listed changes is paragraph (g) (1) of the interim regulations, you do not need to be concerned about loss of grandfathering. These changes deal with eliminating benefits to treat/diagnose or increasing/decreasing various plan design or contribution percentages.

Q&A 2 confirms that benefit packages in plans are independent of one another in losing grandfathering. PPO, POS, and HMO options within a plan are separate benefit packages, any of which can lose or retain grandfathering independently of the others.

Q&A 3 deals with restructuring or adding contribution tiers. If you restructure or change existing tiers you must compare the changes to the prior tiers. If you only add new tiers and leave the existing tiers undisturbed, no comparison is needed.

Q&A 4 clarifies that changing copayments for just one category of services affects the whole plan. This also means that employers can't use averaging in making multiple changes - all changes have to be within the paragraph (g) (1) limits.

Q&A 5 reaffirms that new wellness plans need to follow the paragraph (g) (1) limits when setting up incentives/penalties. Related Footnote 2 hints at HHS increasing the allowable wellness incentive to 50%.

Q&A 6 gives examples of what a separate vision or dental plan looks like, but doesn't address grandfathering implications of separating a combined plan.

Q&A 7 restates the official position on rescission. In the case of plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) coverage may be cancelled prospectively once identified, but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee. Retroactive cancellation is not permitted unless premiums have not been paid in a timely fashion. The Q&A specifically deals with cases of terminated employees who are not on COBRA where the Human Resources area only checks eligibility on a monthly basis. Retroactively removing these former employees who have not paid for COBRA continuation is not a rescission.

Q&A 8 allows the use of "reasonable medical management techniques" to establish frequency, method, treatment or setting for preventive services where it is not specified in the USPTF guidelines.

FAQs Part III

FAQ Part III was released on October 13, 2010. Q&A 1 confirms that health care reform does not apply to group health plans with less than two participants who are current employees.

Links to the FAQs:

FAQs Part I

FAQS about the Affordable Care Act Implementation Part II

FAQS about the Affordable Care Act Implementation Part III

Health Care Reform Lawsuits Proceed

A federal judge in the U.S. District Court for the Northern District of Florida ruled on October 14th that a lawsuit brought by 20 states challenging the health care overhaul law can move forward. This ruling is limited to the plaintiffs' standing to mount the case, as opposed to its merits, which will be discussed at a summary judgment hearing scheduled for December 16. Another health care reform lawsuit filed by private individuals in Michigan was recently dismissed, but the dismissal is expected to be appealed.