

legislative brief

NEW LAW PASSED FOR NURSING MOTHERS

Among its many components, the recently passed health care reform bill included a provision that modifies the Fair Labor Standards Act (FLSA) to require employers to provide reasonable break time and a private place for female employees to express milk after giving birth. There are five requirements that employers must abide by:

1. Employers must provide reasonable break time for nursing mothers.
2. A private place other than a bathroom must be provided for the breaks.
3. Compensation during the breaks is not required.
4. Small employers need not comply if doing so would present an "undue hardship."
5. State laws that provide greater protection to nursing mothers still apply.

The section of the law with this provision took effect **on March 23, 2010**, so employers must immediately take action to comply with this law (except those in a state that already mandates breaks for nursing mothers). Employers should identify one or more private locations for nursing mothers, and modify relevant policies and procedures, including break policies, breast-feeding policies and employee handbooks.

CONGRESS PASSES HIRE ACT

On March 18, President Obama signed the Hiring Incentives to Restore Employment (HIRE) Act into law. Highlights of the legislation include:

- Employers are exempt from paying the employer share of Social Security employment taxes on wages paid in 2010 to newly hired, qualified unemployed workers.
- Employers are provided with a tax credit for retaining qualified unemployed workers for at least 52 consecutive weeks with some wage restrictions.
- For tax years beginning in 2010, the HIRE Act boosts the maximum amount that can be expensed under Code Sec. 179 for certain depreciable business assets and boosts the beginning of the investment-based phase-out amount.
- Allows insurers of certain tax credit bonds to elect to receive a direct payment instead of a tax credit to the bondholder.



LaMair-Mulock-Condon's Health Care Reform

LMC hosted the Health Care Reform Seminar on May 20th, which received overwhelming positive feedback. The seminar consisted of a summary and review of the key points of the reform, an insurance carrier review panel, positive and negative outcomes of reform provisions, small employer taxes and more.

Susan Freed of the Davis Brown Law Firm kicked off the seminar by discussing legislative timelines, terminology, and additional aspects of the reform that are still up for debate.

Insurance carrier representatives including Denise McWilliams (Wellmark), Dave Daniel (Principal), and Dan Keuter (United Healthcare) followed Susan Freed to discuss the insurance carrier's point of view on the health care reform. Each member of the panel discussed how their insurance company was planning to accommodate the new legislative regulations.

Following the carrier panel, LMC's own Rick Debartolo and Fred Bounds analyzed key components of the health care reform bill. The discussion allowed attendees to view both the positive and negative impacts on employee benefits that are to come.

Sean Yolish from Merit Resources closed the seminar by discussing the small business tax credit that will also go into effect.

LMC strives to empower our clients with up-to-date benefit information and give them the ability to make confident decisions for their company and its employees. Thank you to those who attended the Health Care Reform Seminar and we invite you to LaMair-Mulock-Condon's next educational seminar on August 26th: **Share to Compare**.

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5th Annual Share To Compare Seminar

Presented by
LaMair-Mulock-Condon Co.



LMC invites mid-market companies to participate in the 5th annual benefits benchmarking survey, 2010 Share to Compare. This survey is free of charge and will be highly beneficial to benchmark with other companies & help you with your 2011 planning.

At the Share to Compare Survey Seminar, analysts will provide an overview and interpretation of the 2009 Iowa-Area Mid-Market survey results. Survey participants will compare their organization's benefits package against both local and national benchmarks. Additional speakers on benefits and wellness topics critical to your industry will also present.

Please contact your LMC account manager for additional information and RSVP details. We hope to see you there!

When: August 26th, 2010
Time: 10:00 a.m. – 2:00 p.m.
Where: Connixions Conference Room
3901 121st Street
Urbandale, IA 50323

Lunch Provided

Interim Final Rules on Patients' Bill of Rights

FULL ARTICLE AND DETAILS CAN BE FOUND AT www.LMCins.com



EXECUTIVE SUMMARY

The Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) have issued interim final rules related to the provisions of the Patient Protection and Affordable Care Act (PPACA) regarding pre-existing condition exclusions, lifetime and annual limits, rescissions and other patient protections. Most of these provisions are effective for plan years beginning on or after September 23, 2010.

EXPLANATION OF THE INTERIM FINAL RULE

Pre-existing Condition Exclusions: PPACA prohibits any pre-existing condition exclusions from being imposed by group health plans or group health insurance coverage, including grandfathered group health plans. PPACA also extends this prohibition to individual health insurance coverage, although it does not apply to grandfathered individual policies. This prohibition generally is effective with respect to plan years beginning on or after January 1, 2014. However, for enrollees who are under 19 years of age, this prohibition takes effect for plan years beginning on or after September 23, 2010.

Lifetime and Annual Limits: PPACA generally prohibits group health plans, and group and individual health insurance issuers, from imposing lifetime or annual limits on the dollar value of health benefits, effective for plan years beginning on or after **September 23, 2010**. Although annual limits are generally prohibited, "restricted annual limits" are permitted for essential health benefits for plan years beginning before January 1, 2014.

- ❖ **Restricted Annual Limits:** The interim final rules establish a three-year phased approach for restricted annual limits. Annual limits may not be less than the following amounts for plan years beginning before January 1, 2014:
 - \$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.
- ❖ **Covered Plans:** The prohibition on lifetime and annual limits applies to both new and grandfathered group health plans. However, it does not apply to grandfathered individual policies.
- ❖ **Essential Health Benefits:** PPACA specifically provides that plans may impose annual or lifetime per-individual limits on specific covered benefits that are not "essential health benefits." Regulations still need to be issued on the definition of essential health benefits, but it will include at least the following general categories of items and services (full list can be found on www.LMCins.com):
 - Hospitalization
 - Maternity and newborn care
 - Mental health & substance use disorder, including behavioral health treatment
 - Rehabilitative/Habilitative services & devices
 - Preventive and wellness services, including chronic disease management
 - Laboratory services
 - Prescription drugs
 - Emergency services
 - Ambulatory patient services
- ❖ **Enrollment Opportunities:** Under the interim final rules, individuals who reached a lifetime limit prior to the date the regulations are effective and are otherwise eligible for plan coverage must be given a notice that the lifetime limit no longer applies. They must also be permitted to re-enroll in the plan if they are no longer enrolled. The notices and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

Patient Protections: PPACA imposes three new requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and benefits for emergency services and are effective for plan years beginning on or after **September 23, 2010**. They do not apply to grandfathered plans. The rules regarding choice of health care professional apply only to plans that have a network of providers.

- ❖ **Choice of Primary Care Provider:** If a group health plan, or group or individual health insurer, requires a participant to designate a primary care provider, the participant must be able to choose any participating primary care provider who is able to accept the participant as a patient. This rule includes a pediatrician as the primary care provider for a child.
- ❖ **OB/GYN Care:** Plans that provide coverage for obstetrical and/or gynecological care (OB/GYN care) and require the patient to designate an in-network primary care provider may not require preauthorization or referral for a female participant seeking such care.

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- ❖ **Emergency Services:** PPACA places additional requirements on plans and health insurance issuers that provide hospital emergency room benefits. Plans and issuers must provide those benefits without requiring prior authorization and without regard to whether the provider is an in-network provider. Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost sharing requirements, such as copayments or coinsurance rates, imposed for out-of-network emergency services cannot exceed the cost-sharing requirements for in-network emergency services.

Grandfathered Plans: New Regulations

The recent health care reform law provides that certain “grandfathered” plans are exempt from some of the new requirements under the law. Recently, the Departments of Health and Human Services, Labor and Treasury issued regulations to clarify which plans could retain grandfathered status.

Making significant changes to reduce benefits or increase costs will cause a plan to lose its grandfathered status, including the following changes:

- **Significantly cutting or reducing benefits** - such as no longer covering care for certain diseases
- **Significantly raising co-payment charges** - cannot raise more than \$5, adjusted annually for medical inflation
- **Raising co-insurance percentages**
- **Significantly raising deductibles** - can only increase by a percentage equal to medical inflation plus 15 percentage points – based on recent inflation rates, about 19-20% annual increases would be allowed
- **Significantly reducing employer contributions** - cannot decrease these contributions by more than 5 percentage points
- **Adding or tightening an annual limit on what the insurer pays** - plans without an annual limit cannot add one, and plans with a limit cannot decrease it
- **Changing insurance companies** switching insurers removes grandfathered status

Grandfathered Health Plan Coverage FAQ:

Q1: What is a Grandfathered Plan?

Grandfathered health plan coverage is coverage provided by a health insurance issuer or a group health plan in which an individual was enrolled on the date of Health Care Reform enactment, March 23, 2010. A group health insurance coverage or a group health plan does not lose grandfathered status as long as the plan has continuously covered someone since March 23, 2010. Grandfathered health plan coverage includes covered family members of a covered individual member enrolled in the health insurance coverage or group health plan by March 23, 2010.

Q2: What Regulations do Grandfathered Plans Avoid?

- **2010 – 2011**
 1. No cost sharing for preventive care or immunization
 2. Plans that covers employees by class (designed to be discriminatory)
 3. Allow individuals to choose pediatrician or primary care provider
 4. Allow females to choose OB/GYN without referral
 5. Internal appeals and external review process
 6. Allow emergency services without preauthorization and treat as in-network
- **2014**
 1. Cost sharing/deductible limits for certain plans
 2. No discrimination against individuals in clinical trial
 3. No discrimination on health care providers acting within scope of license
 4. Wellness reward to 30%

Q3: What types of changes can be made without losing grandfathered health plan coverage status?

- Changes to premiums amounts.
- Changes to a self-insured plan's third party administrator.
- Coverage changes effective on or after
- March 23, 2010 made pursuant to:
 1. Filing with a State insurance department,
 2. Entering a legally binding contract, or
 3. Adopting written amendments to a plan

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Please contact your LMC representative for additional information regarding any of the articles included in this quarter's newsletter

Prohibition on Canceling Coverage

The recently passed Patient Protection and Affordable Care Act (PPACA) prohibits group health plans and health insurance issuers who offer group or individual coverage from canceling, or rescinding, coverage of an enrolled individual once the enrollee is covered except in cases of intentional misrepresentation or fraud.

Details of the Provision

To make health insurance coverage available for more individuals across the United States, PPACA prohibits rescinding health insurance coverage once an enrollee is covered under a group or individual health plan. This provision applies to new and grandfathered plans. In other words, once an individual is covered under a group or individual plan, their coverage may not be revoked, excluding the exceptions listed below.

Exceptions

Group health plans and health insurance issuers may only rescind coverage in the event that the covered individual performed an act or practice of fraud, or has made an intentional misrepresentation of any facts as prohibited under the terms of the coverage or plan.

For example, loaning your insurance card to someone who is not entitled to use it constitutes fraud.

An example of misrepresentation would be when an individual with an incurable disease indicates that he or she has no major chronic illnesses in order to obtain a lower premium.

In the event of such cases of misrepresentation or fraud, the plan or coverage may not be cancelled without prior notice to the enrolled individual.

Also, coverage may only be cancelled as permitted under the general exceptions to guaranteed renewability of individual coverage and under the rules for network plans.

Effective Date

The Provision prohibiting the rescission of coverage is effective for plan years beginning on or after Sept. 23, 2010, six months after the date of enactment of the health care reform law.