



## Health Insurance Compliance after Health Care Reform

### Overview

We have just spent the past year implementing Health Care Reform under the Patient Protection and Affordable Care Act of 2010 (PPACA), and it is now clear that most insurance companies are significantly increasing their compliance standards, even if a compliance requirement is not directly related to PPACA. Their philosophy may be that since they are paying attention to the PPACA rules they might as well pay attention to all of them. Or maybe they feel that sloppy compliance monitoring may cost them money and with additional PPACA rules scheduled for implementation in 2012 and 2013, they will need to run as financially efficient an operation as possible. In either case, plan sponsors of group health insurance should be aware of both specific regulations that apply, as well as company policies that the plan sponsor must now begin to administer accurately and consistently. Both are discussed below.

### Compliance Regulations

There are a number of Federal and State regulations that impact group insurance contracts. Generally the following comments refer to fully insured (as opposed to self-funded plans) medical plans but prescription, dental and vision may also be included. There are also other regulations that the primary insurers in this area handle for fully insured plan sponsors and we will not mention them here. A self-funded plan however should review additional compliance responsibilities that are likely to apply.

The chart below reflects seven regulations of which every employer should be aware. The intent of this article is to show the differences in counting methods and time periods that are used to determine who must comply. Some laws count part time employees on a pro-rata basis and others give equal weight to part-time and full-time status. For example, two employees working 20 hours each may count as only one employee for purposes of COBRA, but count as two under FMLA or the Federal Mental Health Parity Act. Some regs include union or leased employees and others exclude them in their counting formula. In addition, while COBRA is based upon prior year only, many of the other regulations look at the current year or the prior year.

LAW	COUNTING METHOD	TIME PERIOD
Federal COBRA	20 or more common law employees on more than 50% of the typical business days including part-time, seasonal, union or leased employees. Part-time and seasonal workers are counted on a pro-rata basis.	Prior Calendar Year
PA Mini COBRA	2 to 19 common law employees including part-time, seasonal, union or leased employees. Part-time and seasonal workers are counted on a pro-rata basis.	Prior Calendar Year
PA Autism Insurance Act	PA insured group health plans with 51 or more employees including full and part time	None disclosed in the Act. Generally look at the count as of the plan's renewal date.
Federal Mental Health Parity Act	51 or more employees including full and part time	Prior Calendar Year
Family & Medical Leave Act	Private sector employers with 50 or more full or part time employees for at least 20 workweeks	Current or Prior Calendar Year
Medicare Secondary Payer Status	20 or more employees each working day for at least 20 weeks, including full or part time (regardless of hours worked).	Current or Prior Calendar Year
Form 5500 Filings	100 or more participants including current and former employees	Beginning of Plan Year

Near renewal, most of the carriers send some sort of questionnaire to each plan sponsor to complete. Our experience is that the questionnaires do not do a thorough job of explaining how to conduct the counting, who to include/exclude, or the time periods to use. At the beginning of each calendar year, we send our clients an Employee Count Worksheet to help us know their situation and to help provide guidance on the correct products to obtain to remain in compliance.

## Compliance Policies

In addition to governmental regulations, some insurers are also starting to enforce the policies the plan sponsor has stated in their application regarding how they will administer the plan. These items include hours worked requirements, service waiting periods, and other similar topics. Most are decisions the plan sponsor makes, but the insurers will administer the plan according to these policies and expect that the policies be applied in a non-discriminatory manner. Carriers who are not monitoring these policies are instead transferring the liability to the plan sponsor. One in particular makes a point to say they will rely solely on the employer to make all eligibility determinations. Below is a list of typical policy issues we encourage employers to establish and consistently administer among their employee population. These comments are not intended to apply to qualified plans such as a 401(k) plan.

POLICY	EXPLANATION
Employee Classes	While a portion of PPACA may ultimately restrict an employer's ability to deny health insurance to certain employee classes, a temporary postponement has delayed that piece of the legislation. Until it is implemented, classes in fully insured plans should be based upon employment related issues in a non-discriminatory way. Examples of sample classes for whom available benefits can differ would be exempt, non-exempt, hourly, salaried, officers, owners, clerical, administrative, etc.
Probationary Period	Some employers require new hires to work for some period of time before they can begin accruing any service hours toward eligibility.
Service Waiting Period	While some employers will make new hires eligible for benefits immediately, others require a service waiting period such as 30, 60 or 90 days. Under PPACA, a maximum 90 day service waiting period is allowed.
Hours Worked Requirement	To be considered benefits eligible, plan sponsors must select a weekly hours worked requirement. 40 hours is considered normal but many employers use 37.5, 30 or even 25.
Benefit Start Date	Coverage will begin as of the chosen benefit start date following satisfaction of the Service Waiting Period. Benefits can start as early as the date of hire, first of the month following date of hire, after X days of employment, or first of the month following X days of employment.
End of Coverage Date	Employers must know when coverage ends following loss of eligibility, such as termination of employment. It can be as quickly as date of termination, or it can be end of month following date of termination. Some carriers will mandate end of billing month as the loss of coverage date. Under PPACA's new rescission rules, it is critical to report loss of eligibility promptly since retroactive changes may not be allowed.
Leave Policy	When someone is on leave or disability, FMLA requires coverage for 12 weeks. Most insurers do not allow coverage for more than 90 days unless actively at work. A company policy regarding whether employment is terminated at the end of the FMLA period or 90 days for those not subject to FMLA should be enforced uniformly with all employees. While termination of employment may have a negative connotation, it may be the best course of action to allow a disabled employee access to all of the benefit plans available to a disabled person.
Domestic Partner Benefits	It has been estimated that as much as 20% of the workforce is made up of couples who are not formally married. In PA, Common Law marriages are no longer recognized, so someone who is not married could be ruled ineligible for medical benefits. A Domestic Partner Benefit can make benefits available to both opposite sex and same sex couples.

As part of our renewal process, The Conestoga Group will help employers establish and document uniform policies that are consistent with the plan sponsor objectives. In addition, a Human Resource Information System (HRIS) can be used to apply these policies uniformly to all employees. Additional details on HRIS are available by contacting Brad Palmer at [brad.palmer@conestoga.biz](mailto:brad.palmer@conestoga.biz). Health Care Reform is bringing many changes to the workplace. We believe regulatory compliance and employer policy compliance should be the first areas to review and confirm you are in fact compliant.

*The Conestoga Group is an insurance, investment and employee benefits broker and consulting firm based in Frazer, PA. Conestoga specializes in providing financial products and services to small businesses and their owner/executives and other employees. Founder and President Brad Palmer is an Investment Advisory Representative of Commonwealth Financial Network-a Registered Investment Adviser and member firm of the FINRA/SIPC. Brad can be reached at 610-889-9500 extension 101 or at [brad.palmer@conestoga.biz](mailto:brad.palmer@conestoga.biz).*

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