Healthcare Reform: What Employers Have to Do Now

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After a year of hearings and ever-changing proposals, Congress finally passed the Patient Protection and Affordable Care Act (H.R. 3590), signed into law March 23, 2010, along with the Health Care and Education Tax Credit Reconciliation Act of 2010, signed into law March 30, 2010, which made agreed-upon modifications to the Patient Protection Act. Together, these bills will be referred to in this article as the "Healthcare Reform Act."

While the Healthcare Reform Act affects employers, patients, taxpayers, providers, and the states over the course of several years (some portions of the Healthcare Reform Act, such as the Cadillac plan tax, do not take effect until 2018), the focus on this article will be on those portions of the Healthcare Reform Act that affect employer sponsors of group health plans, and in particular the portions of the Healthcare Reform Act that take effect in the next few months or years.

Before starting the discussion of the provisions of the Healthcare Reform Act that take effect fairly quickly, it is important to understand the difference between a new plan and a grandfathered plan since certain provisions have a delayed effective date or never take effect at all for a grandfathered plan. If a group health plan or individual health plan was in effect on March 23, 2010, it is considered "grandfathered" and is exempt from some of the rules listed below—some permanently, some temporarily. The legislation indicates grandfathered status is retained even if new employees are added to the plan or if a current participant enrolls new dependents. Interim final regulations on what constitutes a grandfathered plan were pubished in the *Federal Register* on June 17, 2010.[1] Any plan that does not meet the rules for being grandfathered is considered new and is subject to all the provisions listed below.

HEALTHCARE REFORM ACT PROVISIONS TAKING EFFECT IN 2010/2011

- **Advance Notice.** Effective September 22, 2010, participants under health insurance plans must be given at least 60 days advance notice of material changes in coverage. This is considerably more notice than had previously been required under the Employee Retirement Income Security Act of 1974 (ERISA), which required notice of changes within 60 days after the changes were adopted.

The effective date for all the provisions listed below is the first plan year beginning six months or more after the enactment date (January 1, 2011, in the case of calendar year plans). Unless otherwise stated, these rules apply to both new and grandfathered plans.

- **Lifetime and Annual Limits.** Health insurance plans (both insured and self-insured) must cease having lifetime limits on "essential health benefits." This term is to be defined by the Department of Health and Human Services. It is believed the term "essential health benefits" does not include dental and vision benefits, so such benefits can continue to have lifetime limits. With regard to annual limits, a cap (to be defined by regulation) will apply with regard to essential health benefits. In 2014 and thereafter, no annual limit at all may be applicable.
- **Preexisting Conditions.** No preexisting condition exclusion can apply against a child under age 19. In 2014 and thereafter, no preexisting condition exclusion can apply against any participant.
- **Rescissions.** Coverage cannot be rescinded once a person has been accepted as a participant unless there is fraud or an intentional misrepresentation of a material fact. Although there has been much political discussion about coverage being rescinded when a participant becomes too expensive, in reality many states under insurance law already restricted rescission to cases of fraud and misrepresentation, although misrepresentation under state law could also include an unintentional omission of fact. The Healthcare Reform Act requires an intentional misrepresentation, which will make it more difficult, but not impossible, for coverage to be rescinded.
- **Cost Sharing.** With regard to new plans only, there can be no cost sharing on certain preventative services. What services are included is to be defined by regulation.
- **Extension of Nondiscrimination Rules.** This rule applies to new plans only. In the past, self-insured plans were subject to nondiscrimination rules that required that a plan not favor highly compensated employees.

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Traditionally insured plans were not subject to these rules, the thinking being underwriting would remove most discrimination. The Healthcare Reform Act now extends these nondiscrimination rules to new insured plans as of September 19, 2010. For example, it will no longer be possible to purchase an insured group health policy that covers only key employees.

- **Nondependent Children.** This rule applies differently to new plans and grandfathered plans. For new plans, nondependent children will be able to stay on a parent's policy until age 26 (but only if the employer plan provides dependent coverage). There is no requirement of being a student, even married children are eligible for coverage, and a child eligible for coverage under another employer-sponsored health plan must be offered coverage. For grandfathered plans until 2014, older nondependent children as described above have to be added only if the child is not eligible for other employer-sponsored health plan coverage.
- **Appeals.** For new plans only, a new claims denial procedure must be implemented. While the procedure includes the protections already found under ERISA, additional rights such as being able to review the entire file, present new evidence, and continue coverage pending the outcome are added.
- **New Tax Credit.** Starting in 2010, small employers (25 or fewer employees) are eligible for a tax credit for a portion of their cost of providing health insurance. The full credit is available if average wages are $25,000 or less, and a partial credit is available up to average wages of $50,000. To be eligible for the credit, the employer must pay at least 50% of the cost of employee-only coverage.
- **New Safe Harbor Cafeteria Plan.** Employers with 100 or fewer employees can establish a new kind of cafeteria plan with simplified nondiscrimination rules. Under a simple cafeteria plan, the eligibility requirements would be met if all employees with at least 1000 hours of service can participate and each employee who is eligible can elect any benefit available. Regarding contributions, the plan would be considered nondiscriminatory if the employer made certain contributions for all participants separate and apart from any salary reduction contributions. This new cafeteria plan would not benefit employers whose cafeteria plans are funded solely through salary reduction contributions.
- **Flexible Spending Accounts.** Flexible spending accounts and health savings accounts still have no cap but over-the-counter drugs cannot be reimbursed unless there is a physician prescription. The penalty for making a health savings account withdrawal for nonmedical purposes increases from 10% to 20%. A cap of $2500 (indexed) on flexible spending accounts will apply starting in taxable years on and after January 1, 2013.

The foregoing summarizes only those provisions taking effect within a year of enactment of the Healthcare Reform Act. Many other provisions take effect in 2014, but it is widely expected that some of those other provisions may be modified or even possibly eliminated during the intervening years if they are found to be unworkable or unrealistic in their present form. Some readers may remember health legislation passed in 1986 adding a new complicated Section 89 to the Internal Revenue Code. The legislation was so unwieldy that it was repealed before it ever took effect. Because the provisions of the Healthcare Reform Act with the earliest effective dates are for the most part straightforward and fairly uncontroversial, employers should assume these provisions will indeed take effect and take appropriate action. ■

The above discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.

REFERENCE

1. 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. *Federal Register.* June 17, 2010;75(116): 34537-34570.