PUBLICATION

Health Care Reform's Impact on Employers

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While at present there are no mandates on employers – either in or out of the construction industry – to provide health coverage to independent contractors or even to employees, those businesses that do provide health coverage are finding that an entire new regulatory world awaits them.

The new law affects employer-sponsored group health plans with a host of new rules and requirements, some of which became immediately effective and others of which are delayed for a number of years. Some provisions apply to so-called “grandfathered plans,” while others apply initially only to non-grandfathered plans.

Because so many of the changes – particularly the most costly ones – don't become effective until 2014 or beyond, this article addresses only those changes effective now through 2012.

Some of the key changes and their impact on employer plans are outlined here.

Grandfathered Status

Many employers are already planning revisions to their medical plans for 2011. Under health reform, if “grandfathered plans” (generally plans with at least one participant on March 23, 2010) make changes in their benefit structure, they may lose grandfathered status.

The advantage of being a grandfathered plan is that the plan does not have to comply with a number of otherwise applicable requirements that become effective in 2011 and 2014, such as:

- coverage of certain preventive care services without cost-sharing;
- certain appeals processes, requirements relating to access to primary care physicians, emergency services, pediatric care, and OB/GYN services;
- nondiscrimination based on health status;
- no discrimination against providers;
- restricted annual out-of-pocket limits; and
- coverage of clinical trials.

Under the draft regulations, published June 14, 2010, changes that will result in the loss of grandfathered status include:

- elimination of all or substantially all benefits to diagnose or treat a particular condition;
- any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement);
- any increase in a fixed-amount cost-sharing requirement other than a copayment (e.g., deductible or out-of-pocket limit), if the total percentage increase exceeds the increase in the overall medical inflation;
- any increase in a fixed-amount copayment, determined as of the effective date of the increase, if the total increase in the copayment exceeds the greater of an amount equal to $5 increased by the

overall percentage increase in medical inflation or if the total increase in the copayment is greater than the increase in medical inflation plus 15 percentage points; or
- a decrease in the contribution rate by employers and employee organizations towards the cost of similarly situated individuals by more than five percentage points below the previous contribution rate.

The language relating to grandfathering status and collective bargaining plans is unclear. It appears that self-insured plans maintained pursuant to a collective bargaining agreement will maintain grandfathered status (as long as they meet all other rules under these regulations) even after the agreement expires. The proposed regulations clarify that collectively bargained plans are subject to all other mandates that apply to non-collectively bargained grandfathered plans.

The draft regulations provide guidance around transition rules for plan changes that were planned but not put into effect until after enactment of the reform law. A group health plan or health insurance issuer does not lose its grandfathered status if it:

- adopted changes pursuant to written amendments on or before March 23, 2010, even though they were not effective at that time;
- made changes to the plan after March 23, 2010 that were made pursuant to a legally binding contract entered into on or before March 23, 2010; or
- made changes to the plan after March 23, 2010 that were made pursuant to a filing on or before March 23, 2010 with a state insurance department.

If a group health plan or health insurance issuer makes changes that are adopted prior to publication of the interim final rules, the changes will not cause the plan to cease to be a grandfathered health plan if the changes are revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010.

Expansion of Coverage for Young Adults: Age 26 Rule

A plan (whether insured or self-funded) that provides dependent coverage for children must continue to make that coverage available to an adult child (whether or not married) until the child turns 26. The plan is not required to make coverage available for a spouse or child of a child receiving dependent coverage. Regulations require the cost of the Age 26 coverage be no more than for younger dependent children. While not required, the Obama administration has encouraged early adoption of the Age 26 Rule.

This change is effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). This mandate applies to grandfathered plans as well as nongrandfathered plans. However, until January 1, 2014, a grandfathered plan can limit this Age 26 Rule coverage to children who are not eligible to enroll in other employer-provided coverage.

The law amends the Internal Revenue Code to extend the individual federal income tax exclusion for medical care benefits under an employer-provided plan so that benefits provided to an employee's child who has not turned 27 as of the end of the year are excludible, even if the child does not otherwise meet the Code's definition of dependent. This provision was effective March 30, 2010.

Elimination of Preexisting Condition Exclusions for Children Under Age 19

A plan (whether insured or self-funded) may not impose any preexisting condition exclusion on enrollees who are under 19 years of age. (The law prohibits imposing preexisting condition exclusions altogether after 2013.) This change is effective for plan years beginning on or after September 23, 2010.

This prohibition applies to grandfathered plans as well as nongrandfathered plans.

Elimination of Lifetime and (after 2013) Annual Limits on Essential Benefits

A plan (whether insured or self-funded) may not establish lifetime limits on the dollar value of "essential health benefits" for any participant or beneficiary. Also, a plan's annual limits on the dollar value of essential health benefits will be restricted (in accordance with regulations yet to be issued). (The law prohibits these annual limits altogether after 2013.)

"Essential health benefits" is broadly defined to include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Regulations will further define essential health benefits.

The elimination of Lifetime Limits is effective for plan years beginning on or after September 23, 2010. The elimination of Annual Limits is effective for plan years beginning on or after January 1, 2014.

This prohibition applies to grandfathered plans as well as nongrandfathered plans.

Elimination of Over-the-Counter Drug Reimbursement

Over-the-counter medications (except for insulin) are no longer eligible for reimbursement under health savings accounts, Archer MSAs, or health flexible spending accounts.

This provision is effective for tax years beginning on or after January 1, 2011. This means that flexible spending account plans with grace periods that extend into 2011 will not be allowed to reimburse over-the-counter medications in 2011. Any over-the-counter medicine purchased on or after January 1, 2011 and submitted for reimbursement during the two-and-a-half-month grace period will require a prescription.

There is no grandfathering associated with this provision.

Limit on Health FSA Deferral Contribution

Annual salary reduction contributions to health flexible spending accounts are limited to $2,500 (an amount that may be adjusted for inflation after 2012). The change is effective January 1, 2013. There is no grandfathering associated with this provision.

Anti-Discrimination Rules Applicable to Fully-Insured Health Plans

An insured group health plan must comply with certain requirements in the Internal Revenue Code that prohibit discrimination in favor of certain highly compensated employees. (Under prior law, only self-insured plans were subject to this nondiscrimination requirement.) This change is effective for plan years beginning on or after September 23, 2010.

This prohibition does not apply to a grandfathered plan. Therefore, companies that currently maintain insured benefits that would otherwise be discriminatory should take steps to preserve the plan's grandfathered status.

Penalties

Failure to comply with any of the Health Care Reform mandates could subject an employer to an excise tax of $100 per day per person to whom the failure relates. ERISA's civil enforcement rules also may apply to violations of this provision.

Small Employer Tax Credit

For tax years 2010 through 2013 small employers (those employing fewer than 25 employees with average annual wages of less than $50,000) who purchase health insurance for their employees may receive a sliding scale tax credit. Small employers with 10 or fewer workers with an average wage of $25,000 or less may receive the full value of the credit. To qualify for a tax credit, an employer must contribute at least 50 percent of the total premium cost of a benchmark premium.

Eligible small employers are those with fewer than 25 full-time equivalent (FTE) employees. The credit phases out for employers starting with 10 FTEs and fully phasing out at 25 FTEs. Generally business owners/partners and their relatives are not to be counted as FTEs and nor are seasonal employees counted. However, employees of affiliated entities must be counted using the affiliation rules of IRC §414(b), (c) (m) or (o).

The guidelines for calculating the tax credit are complicated and employers are urged to consult with their advisers for a detailed determination of their eligibility for this credit.

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