

## Health Care Reform: The Changing Landscape for Group Health Plans

By Alton L. Knighton, Jr. and Neil V. Birkhoff

The recent health care reform legislation will affect virtually every segment of the medical industry. Group health plans are no exception. Employers will need to examine their health plans to determine whether those plans must be revised and will need to take the legislation into account in structuring any new plans.

On March 23, 2010, the President signed the Patient Protection and Affordable Care Act. On March 30, 2010, he signed the Health Care and Education Reconciliation Act of 2010. The two Acts will affect employers, employees and group plans in ways both favorable and unfavorable.

The legislation is long, complex and, in numerous regards, not well drafted. We will need further guidance from governmental authorities in order to fully comprehend the effect of the Acts on group plans. This article is intended only to provide an overview of the new structural requirements for group health plans; a comprehensive discussion of the new requirements must necessarily wait until a later date. With limited exceptions, this article does not cover the new tax rules applicable to group plans, the employers who maintain them and the employees who participate in them or the new reporting and disclosure rules for group plans.

Except as noted, the requirements discussed below apply to group health plans regardless of whether they are

insured or self-insured.

**Effective Dates.** The new structural requirements are not all effective at the same time. Instead, they will take effect over a period of years. The effective dates for the new rules are noted below.

**Grandfathered Plans.** In order to gauge the effect of the Acts upon a group plan, one must first determine whether the plan is a grandfathered plan. A grandfathered plan is a plan that was in existence on March 23, 2010. Such a plan will continue to be grandfathered even though additional employees are permitted to enroll in the plan and employees can elect to cover additional family members. What is not clear is whether the plan will be grandfathered if it is materially amended after March 23 (this being one of the areas in which further guidance is needed).

A grandfathered plan is required to comply with some, but not all, of the new rules set forth in the Acts. The rules that are applicable to grandfathered plans are identified below.

**The Early Requirements.** A group health plan must comply with some of the new requirements for its first plan year that begins after September 23, 2010 and for subsequent plan years. Thus, for a plan that operates on the calendar year, the appropriate plan provisions would need to be in effect for the plan year that begins January 1,

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2011. The first round of requirements are the following:

**Prohibition on Lifetime Limits.** A plan will not be permitted to impose a dollar limit on the “essential health benefits” that will be provided to an individual over his lifetime. Grandfathered plans are subject to this requirement.

**Restriction on Annual Limits.** A plan will be permitted to impose a dollar limit on the essential health benefits that will be provided to an individual during a particular year only to the extent determined by the Department of Health and Human Services. For plan years beginning after 2013, no annual limit may be imposed with respect to essential health benefits. Grandfathered plans are subject to the restriction, and subsequent prohibition, on annual limits.

**Prohibition on Rescission.** An individual’s coverage under a group plan cannot be rescinded except for fraud or an intentional misrepresentation of a material fact. This presumably would not preclude termination of the individual’s coverage for failure to pay premiums or comparable charges or prohibit the employer from terminating the plan. Grandfathered plans are subject to this rule.

**Preventive Health Services.** A plan is required to cover certain preventive services, such as immunizations and infant screenings. The plan may not require a copayment for these services or apply the charges for the services against a deductible.

**Coverage of Older Dependents.** If a plan provides coverage for dependents, it must cover dependents until age 26, regardless of student status. Grandfathered plans are subject to this rule, but, for any plan year beginning before 2014, a grandfathered plan is not required to cover an adult child of an employee if the child is eligible to enroll in a non-grandfathered group health plan.

**Limit on Exclusions for Preexisting Conditions.** A plan may not exclude an individual from coverage based upon a preexisting

condition if the individual has not attained age 19. Grandfathered plans are subject to this rule.

**Choice of Provider.** If a group plan requires that a primary care provider be designated for an individual covered by the plan, the individual must be permitted to select any primary care provider who participates in the plan’s network. The Acts specifically provide that this provider may be a pediatrician if the individual is a child. If the plan requires a referral from the designated primary care provider in order to obtain treatment by another provider, such a referral may not be required for obstetrical or gynecological care, and an obstetrician or gynecologist who participates in the plan’s network must be permitted to make referrals in the same manner as a primary care provider.

**Emergency Services.** If a plan covers emergency room services, it must provide coverage for those services without prior authorization and regardless of whether those services are rendered by a participating provider.

**Appeals Process.** A plan must establish a process for internal appeals of coverage and claims decisions that meets prescribed requirements. In some situations, external appeals must be permitted.

**Limits on Nonprescription Drugs.** If health benefits are provided under a flexible spending arrangement (a type of cafeteria plan), no amounts may be reimbursed to an employee from such arrangement for the cost of any medicine unless such medicine is a prescribed drug or insulin. This limit will not apply to any nonprescription medicine if the employee incurred the expense of acquiring the medicine prior to 2011. Grandfathered plans may be subject to this restriction, but this is not clear.

**Prohibition on Discrimination.** An insured group health plan may not discriminate in favor of “highly compensated individuals” (a term that includes, among others, the top 25% of an employer’s employees, when ranked by compensation) with respect to eligibility to participate or with respect to benefits.

**Later Requirements.** A number of new requirements will take effect after 2011.

**Prohibition on Exclusions for Preexisting Conditions.** For plan years beginning after 2013, a group plan may not exclude an individual from coverage based upon a preexisting condition, regardless of the individual's age. Grandfathered plans are subject to this rule.

**Prohibition on Annual Limits.** As noted above, for any plan year beginning after 2013, no group plan (whether it is grandfathered or not) may impose a dollar limit on the essential health benefits that will be provided to an individual during a particular year.

**Limitation on Waiting Periods.** For any plan year beginning after 2013, a plan may not have a waiting period for participation that is longer than 90 days. Grandfathered plans are subject to this rule.

**Limits on Deductibles and Copayments.** For plan years beginning after 2013, the amount which a group plan may require for deductibles and copayments will be limited.

**Limit on FSA Contributions.** For taxable years beginning after 2012, if health benefits are provided under a flexible spending arrangement, an employee may not elect to have salary reduction contributions of more than \$2,500 made to the arrangement for a taxable year. The \$2,500 limit may be increased to reflect changes in the cost of living. Grandfathered plans may be subject to this limit, but this is not clear.

**Automatic Enrollment.** If an employer with more than 200 full-time employees maintains a group health plan, any new full-time employee who has satisfied the applicable waiting period must automatically be enrolled in the plan, although the employee must be given the opportunity to opt out of coverage under the plan. It is not clear when this requirement becomes effective.

Employers and practitioners will need further guidance in order to fully understand the new legislation. Unfortunately, a number of the new requirements will affect group health plans – both grandfathered plans and non-grandfathered plans – on January 1, 2011. In order to comply with these requirements, plan documents may have to be amended in 2010 and before we have adequate guidance. Presumably the Feds will not be calling foot faults as we muddle through this transition period.



**Alton L. Knighton, Jr.**, a principal in the firm, focuses his practice in the areas of tax-exempt bonds, taxable financings, employee benefits and estate planning.

*Al can be reached at knighton@woodsrogers.com or at 540-983-7632.*



**Neil V. Birkhoff**, a principal in the firm, focuses his practice in the areas of tax planning, employee benefits and estate planning and administration.

*Neil can be reached at birkhoff@woodsrogers.com or at 540-983-7699*

## Woods Rogers Tax Group:

**NEIL V. BIRKHOFF, Chair**  
540.983.7699  
birkhoff@woodsrogers.com

**BRIAN MICHAEL BROWN**  
804.343.5023  
bbrown@woodsrogers.com

**CLAUDE D. CARTER**  
540.983.7588  
ccarter@woodsrogers.com

**NICHOLAS C. CONTE**  
540.983.7630  
conte@woodsrogers.com

**R. NEAL KEESEE, JR.**  
540.983.7627  
keese@woodsrogers.com

**TALFORD H. KEMPER**  
540.983.7622  
kemper@woodsrogers.com

**TALFORD H. KEMPER, JR.**  
540.983.7552  
fkemper@woodsrogers.com

**ALTON L. KNIGHTON, JR.**  
540.983.7632  
knighton@woodsrogers.com

**J. LEE E. OSBORNE**  
540.983.7516  
losborne@woodsrogers.com

**ALEXANDER I. SAUNDERS**  
540.983.7607  
saunders@woodsrogers.com

**CHRISTINE FRENZ UNDERWOOD**  
540.983.7512  
cunderwood@woodsrogers.com

**JOSHUA C. WYKLE**  
540.983.7562  
jwykle@woodsrogers.com