

## Healthcare Reform: Core Concepts for Employer Group Health Plans

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While it is still too early to tell whether the healthcare reform bills on Capitol Hill will ultimately become law—or collapse into bitter recriminations—it is already possible to pick out the core employer group health plan concepts that are likely to appear in any successful legislation.

These core concepts appear in roughly similar form in both the House and Senate bill language and, while they may differ somewhat in content, timing, or application, already provide useful guideposts that employers should consider as they wrap up open enrollment for 2010 and begin to consider group health plan design parameters for 2011.

Most of these core concepts exist independently from the contentious healthcare reform issues such as employer and individual mandates, public plan options, purchasing exchanges, income tax increases, taxation of health benefits, Medicare changes, and abortion, and could represent key provisions in a narrower legislative package if Washington pulls back from a broader healthcare reform bill.

While these core concepts reflect current objectives on Capitol Hill, they are not necessarily bipartisan in nature, and could certainly lose some of their current momentum as mid-term elections near, or if those elections bring about a change in the governing majorities in either the House or Senate.

However, on the basis of the current House and Senate bills, we anticipate that any near-term healthcare reform legislation will include, with regard to employer group health plans, the following core concepts. These will narrow the flexibility currently enjoyed in the design and operation of employer group health plans, particularly for self-insured plans:

- **Guaranteed Issue and Renewal**

The ability to obtain new insured coverage (or continue insured healthcare coverage with the same carrier) will expand availability and enhance continuity of care for employers and participants. Such expansion could, however, result in increased costs as insurers find it harder to manage risks across their portfolio of business.

- **Insurance Rating Ratios**

Narrowing the gap between the most and least expensive healthcare coverage offered by an insurer (and further limiting the reasons for variation in items such as age, family size, geography, and potentially tobacco use) will primarily impact the individual insurance market. However, it could

also significantly increase costs for employers with insured benefits whose demographics slant toward younger employees.

- **Medical Loss Ratios**

Forcing insurers to spend a set percentage of their revenues on medical costs (thereby possibly decreasing profitability) may place increased profit pressure on other business lines (such as third-party administration services) or encourage marginally profitable insurers to exit the market in certain geographic areas.

- **Rescission Restrictions**

Restricting the ability of insurers to rescind coverage (except in the case of fraud or material misrepresentation) should allow employers with insured coverage to enjoy greater stability of coverage across their workforce.

- **Explanation of Coverage**

Establishing specific guidelines and requirements governing health plan descriptive information will require extensive changes to open enrollment material and possibly to Summary Plan Descriptions. These changes may lead to less creativity surrounding the explanation and communication of health benefits and make integration with other employee benefits communication materials challenging.

- **Discrimination Rules**

Healthcare reform will likely impose stronger nondiscrimination rules on health plans. These rules may be tied to wage-based discrimination, insurer-imposed restrictions, the new Treasury guidance project created to address discrimination in self-insured retiree medical benefits, or the final cafeteria plan nondiscrimination rules. The new rules will place employers under increasing pressure to prove that the design, availability, pricing, and operation of their medical plans do not discriminate. Employers that gravitate towards uniform plans, pricing, and availability should find it easier to demonstrate nondiscrimination in their group health plans.

- **Automatic Enrollment**

Borrowing a page from recent successful 401(k) plan rules—and hoping to gain a similar advantage based on employee inertia—many employers will be required to automatically enroll new employees in health plan coverage. This will drive up administrative costs, even if the individuals subsequently opt out of coverage.

- **Preexisting Condition Exclusions**

Employers that still impose preexisting condition exclusions on new participants will have to eventually abandon these exclusions and cover all new participants for all health issues. This may, however, allow employers to end the practice of distributing Health Insurance Portability and Accountability Act (HIPAA) Certificates of Creditable Coverage, which have been uniformly required of all employers, even those that do not impose preexisting condition exclusions.

- **Extended Dependent Coverage Requirements**

Following the lead of many state insurance laws, employers will have to allow employees to keep their dependents on employer group health coverage until the dependent reaches age 26 or 27. This will increase costs for employers and could result in COBRA continuation rights that run almost up until age 30.

- **Waiting Periods**

Waiting periods before individuals can receive health coverage will not be able to exceed 90 days, and employers that impose waiting periods will be penalized for periods that extend between 30 and 90 days. Employers with high turnover will experience not only increased healthcare costs but also additional recordkeeping, COBRA, and third-party administration costs.

- **Preventive Care**

Preventive care benefits will have to be covered at 100%, which will require many plans to enhance their benefits packages. While this may ultimately result in future cost savings due to a healthier workforce, many employers will see a short-term increase in costs.

- **Out-of-Pocket Limits**

Plan participants' maximum exposure to medical expense cost sharing will be limited in a fashion similar to current high-deductible healthcare plans.

- **Annual Limits**

Annual limits on benefits cannot be "unreasonable". This provision has been the subject of recent attention and unless modified, could undercut lifetime maximum-limit restrictions.

- **Lifetime Maximums**

Lifetime maximums on benefits will be impermissible, though possibly only "unreasonable" lifetime limits will be prohibited. Either approach will result in additional employer costs for catastrophic medical benefits. However, they could also result in greater retention of employees who currently run into these limits and must move elsewhere to receive medical coverage for themselves or family members.

- **Wellness Incentives**

Employers may be able to increase the amount of incentives associated with meeting wellness goals or criteria. Assuming that such changes do not run afoul of ADA or GINA Title II limits, employers may be able to provide additional rewards for healthy behavior and goals and this should help make medical coverage more affordable in future years.

- **Medical FSA Limits**

Medical flexible-spending arrangements (FSAs) will be subject to a first-ever statutory maximum of \$2,500 per year. Unless indexed, this limit will quickly erode the usefulness of medical FSAs and make it harder to pay for big-ticket items (like orthodontia) on a pre-tax basis.

- **OTC Drugs**

In an effort to finally put the over-the-counter drug genie back in the bottle, medical FSAs and health reimbursement arrangements (HRAs) will not be able to reimburse for over-the-counter drugs. Health savings accounts (HSAs) and medical savings accounts (MSAs) will not be able to reimburse such drugs on a tax-free basis. While prescribed over-the-counter drugs and insulin may still be permissible, participants will find it much harder to avoid year-end use-it-or-lose-it rules in medical FSAs—which will drive up forfeitures in medical FSAs.

- **HSA Withdrawals**

The tax for withdrawals from HSAs for impermissible tax-free medical benefits will be doubled to 20%, which may limit the interest of employers and employees in funding HSAs.

- **Medicare Retiree Drug Subsidy Taxation**

Employers that decided to retain retiree drug programs and receive the associated Medicare Part D employer subsidy will be taxed on the subsidy. This will not only cause employers to revisit whether they should continue the underlying retiree drug program but can also cause immediate adverse accounting consequences.

- **Medicare Part D Donut Hole**

The dollar amount of retiree drugs that are currently not covered due to the “donut hole” will either shrink or the cost of such drugs will be discounted. Either result will make participation in a Medicare Part D program more palatable, and could lead to a reduction in employer-provided retiree drug plans.

- **Employer Reporting**

Employer reporting will be significantly increased—and the underlying reporting tasks will depend upon whether employers are subject to a mandate, if the value of health benefits is taxed, and whether individuals are subject to an individual mandate. In any event, there will be new annual forms for employers to fill out, and the reporting will require new levels of interaction between human resources departments, payroll departments, third-party administrators, and insurers—plus new penalties for failure to properly report. Employers may also come under increasing pressure to validate their COBRA pricing methodology (and we expect new IRS rules regarding establishing COBRA prices regardless of the outcome of healthcare reform).

Morgan Lewis will continue to monitor these likely healthcare reform core developments along with the broader and more contentious concepts of the proposed bills. If you have any questions about how healthcare reform may impact your employer group health plans, please contact any of the following Morgan Lewis attorneys:

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