

# Health Care Reform: Much Has Come, More to Come

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U.S. trademark resources say the phrase “the gift that keeps on giving” was coined almost 100 years ago to describe something entirely new: the “talking machine” (aka, phonograph). That phrase appropriately describes something entirely new and much talked about in 2010: health care reform.

March 2010 saw the enactment of two laws — the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Tax Credit Reconciliation Act of 2010 (HCERA) — that comprise the health care reform law known as the Affordable Care Act (ACA). Since then, several federal agencies have given us a slew

of regulations, rules and additional guidance to help insurance, benefits and payroll professionals understand the new law.

Regarding flexible benefits, the current forecast is “fair to partly cloudy.” Several issues have become clearer (that is, fair), but as of this writing, several issues require additional explanation (that is, cloudy).

## Areas of Recent Clarification

In June 2010, the DOL, Department of Treasury and Department of Health and Human Services (HHS) issued two sets of interim final rules. The first rule (published in the June 17, 2010, *Federal Register* at 75 Fed. Reg. 3438) relates to grandfathered plans, which existed on March 23, 2010. These plans do not have to comply with many of the group plan and insurance mandates that take effect for plan years starting on or after Sept. 23, 2010. The rule spells out how plans can retain and lose grandfather status. The second rule (published in the June 28, 2010 *Federal Register* at 75 Fed. Reg. 37188) describes these mandates and is commonly referred to as the “Patient’s Bill of Rights.”

In the grandfather rules, the agencies confirmed that the ACA group plan and insurance mandates do not apply to HIPAA-excepted benefits, including most health FSAs, dental-only and vision-only policies, and retiree-only plans. In the rules on the Patient’s Bill of Rights, the agencies further confirmed that the restrictions on annual and lifetime limits do not apply to health FSAs, retiree-only health reimbursement arrangements (HRAs, see ¶291 and ¶311 of the *Handbook*) and HRAs that are integrated with a group plan that is subject to these restrictions.

Notice 2010-38, which the IRS issued on April 27, shed light on the interplay of two new rules related to adult children. The first rule requires that health plans cover adult children up to age 26, starting with plan years on or after Sept. 23, 2010. The second rule allows the value of that coverage to be tax-free up until the year in which that adult child turns age 27. Both provisions drop previous age, residency, college status, and support requirements found in the rules contained in Code Section 152 (see App. A) regarding dependents. What Notice 2010-38 means for health FSAs, HRAs and health savings accounts (HSAs, see ¶292) is that if the plan allows it, expenses for qualified care rendered these adult children are reimbursable on a tax-free basis.

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Two ACA provisions that take effect in 2011 are pretty straightforward.

First, reimbursable drugs and medicines must be prescribed if they are purchased on or after Jan. 1, 2011. This requirement affects health FSAs, HRAs and HSAs and applies regardless of when the plan year starts. Therefore, non-calendar plans must closely scrutinize the purchase date to determine whether an over-the-counter (OTC) expense is reimbursable. Recently, the Special Interest Group for IAS Standards (SIGIS) issued a news release that indicated SIGIS will change the Inventory Information Approval System (IIAS) to comply with the OTC prohibition, resulting in a reduction of 35 percent of auto-substantiated expenses on the IIAS.

Second, the excise taxes imposed on distributions from HSAs and Archer MSAs to cover non-qualified — that is, non-medical — expenses increase to 20 percent, effective Jan. 1, 2011. As a result, any non-medical distributions from those accounts made after Jan. 1 will be subject to the increased excise tax.

### Areas Requiring More Explanation

Some of the areas that received recent clarification require additional enlightenment. For example, the Patient's Bill of Rights rules left open the question as to whether the restrictions on annual and lifetime limits would apply to "stand-alone HRAs that are not retiree-only plans." A stand-alone HRA is typically considered an HRA that does not require participation in the employer's medical plan, but the IRS did not specifically define the term in the rules.

The OTC prohibition is not entirely clear, either. In early July, Rep. Earl Pomeroy (D-N.D.) sent a letter to Treasury Secretary Timothy Geithner. The letter made two key points:

- 1) The prohibition will occur during the busiest time of year and will give many benefits administrators the unenviable choice of commencing the prohibition early to ensure compliance or waiting until year-end and risking noncompliance; and
- 2) What will constitute a prescription needs to be defined.

Geithner received another OTC letter recently. In late June, SIGIS

(in collaboration with the law firm of Alston & Bird) requested that Treasury do three things in advance of Jan. 1, 2011:

- 1) Apply a one-month "good faith" transition period in January where plans could rely on plan participants to provide the required prescription information.
- 2) Clarify what constitutes a "prescribed" drug, specifically whether a doctor's letter of recommendation is sufficient.
- 3) Address how the OTC prohibition will affect drug stores and pharmacies that do not use the IIAS because they qualify under the so-called 90-percent rule (when 90 percent of the prior year's receipts are reimbursable).

Simply put, the rationale for a delay or grace period for the OTC prohibition is that more is required than the proverbial "flipping of the switch."

Another benefit change that goes into effect next year is a hybrid of the traditional cafeteria plan: the SIMPLE cafeteria plan. Such plans do not have to conduct Code Section 125 nondiscrimination testing (see ¶700), and none of the qualified benefits offered under SIMPLE plans need to conduct the applicable tests. This would apply to component benefits like group term life insurance, health and dependent care FSAs.

The SIMPLE plan is not exactly simple. The plan must meet requirements for employer eligibility, employee eligibility and minimum contributions. Employers must employ 100 or fewer individuals during either of the two prior years. All non-excludable employees must be eligible to participate, including those who work as few as 1,000 hours. The employer must make

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## Key Terms (continued from p. 5)

to provide mandated notices communicating extended dependent coverage entitlement.

### Benefits Caps

Employers sponsoring self-funded group health plans lose a cost-control feature under the reform law. Use of annual and lifetime benefits limits are all but prohibited.

For plan years starting six months after the reform act's enactment date (which means Sept. 23, 2010) self-funded group health plans generally may not impose lifetime dollar limits on benefits. They also may not impose annual benefits limits except on a limited basis.

Annual benefits caps are allowed in some situations until 2014. However, the "restricted annual limits" that plans may impose will depend on the scope of "essential health benefits." Interim final rules issued on June 28, 2010 (75 Fed. Reg. 37188) set a progressive phase-out of annual limits on essential health benefits over three years, among other things.

Group plans, however, may set annual or lifetime limits on specific covered benefits that are not essential health benefits (see box). The provision allowing limits on specific covered benefits appears to extend beyond 2013.


It is not clear whether the prohibition on restricting "dollar" limits leaves open annual and lifetime restrictions on numbers of procedures or other terms, for

## Reform (continued from p. 3)

a minimum level of contribution, using either of two methods (uniform percentage or matching). Questions remain about the details of setting up a SIMPLE plan, and it remains to be seen if the additional effort (and expansion to part-time employees) is worth it for employers to avoid nondiscrimination testing.

Other gifts have yet to be opened when it comes health care reform. Examples include the Explanation of Coverage document (2012) and the \$2,500 health FSA limit (which goes into effect in 2013). About the only thing certain right now is that the river of information related to health care reform will continue to flow.

### Finding out More

The grandfather rules are available at: <http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf>. The Patient's Bill of Rights rules are available at: <http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf>. 

example, so many blood transfusions or transplants, or procedures or office visits.

Also, it is not clear how the essential health benefits will be further defined in regulations. For example, what does "hospitalization" mean? Does that refer only to treatment related to stays in hospitals, or does it also mean the myriad emergency room care that occurs on weekends because family physicians are not available? Will hospitalization include services provided through the medical homes that hospitals are adopting to coordinate primary care both in and, apparently, out of the hospital (for patients released but still under the care of the medical home team)?

The permitted use of benefits limits would appear to allow, for example, caps for specific benefits such as bariatric surgery or chemotherapy. What is allowed regarding benefits caps likely will be heavily litigated, particularly in defining essential health benefits. This will depend in part on how regulations define the terms "essential benefits" and "restricted annual limits."

### Rescissions

A common practice before the passage of health care reform was to drop people from the employer's health plan if they engaged in activities detrimental to the plan or the employer. Health care reform attempts to rein in this practice. Under the law, beginning Sept. 23, 2010, group health plans are barred from rescinding a group plan or coverage for an enrollee once he or she is covered, unless he or she has engaged in fraud or made an intentional misrepresentation of material fact as prohibited under the terms of the plan or coverage.

If coverage is rescinded in such a case, the affected individual must be given 30 days advance notice in order to provide him or her and the plan sponsor an opportunity to explore their rights to contest the rescission, or look for alternative coverage, as appropriate.

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## What Are Essential Health Benefits?

"Essential health benefits" include the following: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management services, and pediatric services, including oral and vision care.

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