The Interaction of Health Care Reform and Older Benefit Laws

The Affordable Care Act makes several regulations concerning health care coverage obsolete. In light of the availability of coverage through exchanges and prohibitions on coverage denials because of preexisting conditions, plan sponsors may consider changing some of their offerings.
For decades, Congress and the states passed laws and promulgated regulations designed to increase access to health insurance. Now that health care reform is about to provide universal access to all legal residents, there will be some interesting interactions with all those old laws. Some of these interactions may prompt plan sponsors to change their communications and others may prompt changes in benefit offerings.

The Health Insurance Portability and Accountability Act (HIPAA) requires insurers and plan sponsors to provide certificates of creditable coverage when someone loses coverage under an employer-sponsored plan. These certificates allow people to have reduced periods of preexisting condition exclusions under new coverage they obtain. Preexisting condition exclusions are prohibited for plan years beginning on or after January 1, 2014. That will render these certificates unnecessary. The Internal Revenue Service (IRS), the Employee Benefits Security Administration (EBSA) and the Centers for Medicare and Medicaid Services (CMS) have proposed technical amendments to certain health coverage requirements under the Affordable Care Act (ACA) that will ease the burden on plan sponsors.

The good news is that these proposed regulations would amend HIPAA regulations to remove provisions superseded by the prohibition on preexisting conditions. This includes eliminating the need to provide HIPAA certificates of creditable coverage. The proposed amendment to eliminate the requirement to issue a certificate of creditable coverage is proposed to apply December 31, 2014. This delayed effective date is so that individuals needing to offset a preexisting condition exclusion under a plan that operates with a plan year beginning later than January 1 would still have access to the certificate for proof of coverage.

Consolidated Omnibus Budget Reconciliation Act (COBRA) group health plan continuation rules will be obsolete in 2014 since anyone will be able to purchase health insurance without evidence of good health if he or she loses group coverage. Unfortunately for plan sponsors, the COBRA requirements remain in place, and plans will need to continue to offer COBRA coverage.

Department of Labor (DOL) Technical Release 2013-02 provides an updated model election notice for group health plans for purposes of the continuation coverage provisions under Title X of COBRA to include additional information regarding health coverage alternatives offered through the marketplace, also known as an exchange. While no effective date was given for the new notice, it will make sense to start using the new model language once people can begin enrolling in the exchanges, which will be October 1, 2013 for a January 1, 2014 effective date.

The DOL Technical Release recognizes that qualified beneficiaries may want to consider and compare health coverage alternatives to COBRA continuation coverage that are available through the marketplace. Qualified beneficiaries may also be eligible for a premium tax credit (a subsidy to help pay for some or all of the cost of coverage in plans offered through the marketplace). These subsidies are available to people with incomes less than 400% of the federal poverty level. The subsidies are on a sliding scale, so, for example, someone with an income under 250% of the federal poverty level will receive a much larger subsidy than someone with an income just under 400% of the federal poverty level.

Not only will the subsidies make coverage through an exchange more attractive than COBRA continuation coverage, COBRA is typically a richer plan than a bronze plan available through an exchange. People who qualify for COBRA have often lost income due to the qualifying event, and a less expensive plan that still offers catastrophic coverage will be very attractive to many of them.

On the other hand, people are very familiar with COBRA, and the COBRA election process is much simpler than the application process for coverage through an exchange. Therefore, plan sponsors will want to do more than just use the new model election notice that informs people about the marketplace. Plan sponsors should provide examples of the relative cost of COBRA coverage and plans available through the exchange. Such an educational effort should encourage people to make the effort to apply for coverage through the exchange.

Similarly, many early retirees might be better off with coverage through an exchange if significant contributions are re-
quired. Plan sponsors would certainly be better off. The main motivation for many plan sponsors to offer coverage to early retirees has been the fact that many early retirees could not otherwise obtain coverage. Now that coverage will be available, some plan sponsors may want to rethink their strategy and drop coverage for retirees.

While plan sponsors still must provide all covered employees and covered spouses with a general notice about COBRA and notify all qualified beneficiaries of election rights at the time of a qualifying event, if they can steer people to exchanges, they may avoid other burdens. Employers, or the administrators they hire, have to collect and remit premiums. Employers and multiemployer plans must communicate with COBRA participants about open enrollment, monitor the length of time remaining, provide notices of termination and ideally have a complete COBRA procedure manual that they keep updated that reflects all of these notices and activities, as well as others. More importantly, people who elect COBRA continuation coverage typically have higher claim costs than the average employee. The higher claims from COBRA participants drive up premiums or self-funded costs. If people stop electing COBRA continuation coverage, these burdens can be avoided.

If people stop electing COBRA, perhaps a future Congress will recognize an opportunity to streamline government regulation and reduce burdens on plan sponsors by repealing COBRA’s continuation requirements. Unfortunately, repealing COBRA’s continuation requirements would not do away with all of the administrative burdens because most states have similar continuation requirements that apply to smaller groups or situations not covered by COBRA. States may lead the way by repealing some of these laws. Or Congress may make COBRA repeal part of the Employee Retirement Income Security Act (ERISA) and make it clear that ERISA preempts state continuation laws. To complete the task, Congress would also have to repeal the group health plan continuation rules under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If COBRA were repealed, then a number of regulatory changes would be appropriate, including modifying the statement of ERISA rights, changing the contents of a summary plan description and describing the situations in which money in a health savings account (HSA) can be used to pay premiums.

Doing away with the HIPAA certificates of creditable coverage at the end of 2014 is a very good step, and there is more that could be done under HIPAA. ACA made technical amendments to both ERISA and the Internal Revenue Code stating that the provision of the Public Health Service Act that prohibits preexisting condition exclusions applies to group health plans and health insurance coverage. The technical amendments also state that to the extent any provision of ERISA or the Code conflicts with the Public Health Service Act, that provision shall not apply. That leaves plan sponsors with a lot of laws and regulations on the books that are superseded by the new law. Congress and the regulators could clean up the laws and regulations and do away with the parts that no longer apply.

This would be a major undertaking for a benefits wonk since repealing the obsolete portions of HIPAA would not be as easy as repealing COBRA continuation coverage, which could be repealed in its entirety. While the sections relating to limitations on preexisting condition exclusions, rules relating to crediting previous coverage and certificates and disclosures and most of the definitions could all be repealed, there is merit in retaining certain provisions and some of the related definitions. For example, the special enrollment period requirements still make sense so people who experience certain life events do not have to wait until open enrollment.

**takeaways >>**

- A prohibition on preexisting condition exclusions will render HIPAA certificates of creditable coverage unnecessary. Proposed regulations would amend HIPAA regulations.
- Although COBRA requirements also will be obsolete in 2014, the requirement to offer COBRA coverage remains. Plan sponsors will want to let participants know of their more affordable alternatives on health care insurance exchanges.
- Because of the availability of coverage through the exchanges, plan sponsors may want to consider dropping early retiree health insurance.
- Michelle’s Law, requiring continued coverage of dependent students on medically necessary leaves of absence, could be repealed without harming anyone.
- It would give plan sponsors comfort if IRS made it clear that all preventive services, as defined under ACA, are considered medical expenses by IRS.
to participate in an employer-sponsored plan. Also, all the administrative simplification provisions relating to electronic data interchange, privacy and security are still needed to protect health information.

HIPAA also requires insurance companies to offer coverage on a guaranteed-issue basis to people who have exhausted COBRA or who have lost coverage and are not eligible for COBRA. These HIPAA guaranteed-issue policies are quite expensive and will not be needed once coverage is available through an exchange where subsidies could be available.

ERISA Section 609(c)(2) prohibits restrictions based on preexisting conditions at the time of placement for adoption. That could go, too.

Similar to COBRA continuation coverage, qualified medical child support orders will be obsolete because an individual policy will be readily available. Courts could still issue orders requiring noncustodial parents to pay for health insurance for children. When health insurance was not always available to individuals, it made sense to open employment-based coverage to these children. Congress could relieve group health plans of this burden.

Michelle's Law, which requires continued coverage of dependent students on medically necessary leaves of absence, also made sense when sick children could not get any other coverage. Now they can, and this is another law that could be repealed without harming anyone.

ACA requires nongrandfathered plans to cover preventive services with no cost sharing. The rules about HSA-compatible high-deductible health plans (HDHPs) allow plans to cover certain preventive services without a deductible without jeopardizing the HDHP's status as HSA-compatible. Unfortunately, the definitions of what is preventive do not align. The definition of preventive care under ACA is much broader than the definition for HDHPs. A strict reading of the rules should lead to the elimination of all HDHPs and, therefore, all HSAs. Regulators have stated informally that they recognize this problem; however, no action has yet been taken to correct it. Because the preventive services allowed without a deductible were defined by regulations, regulators do not need an act of Congress to fix this problem.

Furthermore, it is not entirely clear that all the preventive services that must be covered at 100% under ACA by nongrandfathered plans qualify as medical expenses under Section 213 of the Internal Revenue Code, as interpreted by IRS. The Code itself includes prevention in the definition; however, IRS interprets the Code and has certain rules in place that may or may not be consistent with the ACA definitions. Since health plans should be reimbursing only medical expenses, as defined under Section 213, there are important tax consequences if a plan covers expenses that do not qualify as medical expenses. Again, since IRS interpretations are the issue here, it would not take an act of Congress to resolve this problem. It would give plan sponsors comfort if IRS updated its Publication 502 to make it clear that all preventive services, as defined under ACA, are considered medical expenses by IRS.

There are complex and interesting interactions between health care reform and older laws governing employee benefits. Regulators have taken some steps to ease old burdens. Plan sponsors can educate former participants about the advantages of the new exchanges over COBRA continuation coverage. Regulators can be urged to clarify some possible inconsistencies between ACA and older interpretations. Ultimately, it would benefit plan sponsors if Congress repealed certain old laws that are now obsolete. Stay tuned: We live in interesting times.

Editor's note: Benefits Magazine goes to press about four weeks before distribution. Please be aware that federal agencies are continually releasing regulatory guidance regarding ACA. The latest guidance and updates are available at www.ifebp.org/acacentral.