Health Care Reform Analysis: Impact on Dependent Eligibility Audits

Health Care Reform Provisions Regarding Coverage of Adult Children and New Limitations on Rescission of Coverage Will Impact How Dependent Eligibility Verification Audits (“DEVAs”) Are Conducted

Overview

Many group health plan sponsors in the U.S. have operated on the “honor system” in managing dependent eligibility. Generally, employees have not been required at the time of enrollment to provide evidence that any particular individual they wish to cover under the plan satisfies the plan’s eligibility requirements. As employers begin more closely to examine their covered health plan populations, they typically are finding that 4% to 8% of covered individuals are ineligible for group health plan benefits, regardless of the industry, geography, or size of the particular employer.

The recently enacted Patient Protection and Affordable Care Act and related Health Care and Education Reconciliation Act of 2010 (together, the “Health Care Reform Law”) will affect coverage of an employee’s children under an insured or self-insured group health plan and the ability of a group health plan or insurer to rescind, or otherwise cancel, such plan or coverage for any individual. For calendar year plans, these changes generally are effective January 1, 2011, although a delayed effective date may apply for health insurance coverage maintained pursuant to one or more collective bargaining agreements ("CBAs") ratified before March 23, 2010. In view of these new developments, employers should carefully consider now how to administer their plans and how DEVAs should be conducted under the Health Care Reform Law.

Ineligible Dependents

There are many reasons why an enrolled dependent may be ineligible for group health plan coverage. For example, plan sponsors often do not have sufficient resources continuously to track and verify dependent eligibility. In addition, while some employees may purposefully arrange for coverage of ineligible individuals, many do not fully understand the plan’s eligibility criteria or forget to update eligibility information when there is a change in family circumstances. Some categories of ineligible dependents that Aon typically has found when performing DEVAs include:

- Children who exceed the maximum age limits permitted under the plan;
- Married children;
- Former spouses following divorce;
- Children who are no longer the employee’s eligible dependents (e.g., due to divorce), where coverage is not mandated by a qualified medical child support order;
- Grandchildren;
- Uncles/aunts;
• Live-in girlfriend/boyfriend/domestic partner and their children; and
• Children who obtain their own employer-based coverage after graduation from college.


Coverage of Adult Children: The primary focus of the Health Care Reform Law is to provide affordable health coverage for Americans who are uninsured (or underinsured) and to institute certain insurance market reforms. One of the key reforms is to allow adult children to enroll in, or remain on, their parent’s group health plan or health insurance coverage until their 26th birthday. Adult children (under age 26) are eligible for this extended coverage regardless of their marital or student status, or whether they are claimed as a dependent on the employee’s federal income tax return. Although the Health Care Reform Law applies to the adult child, it does not require coverage of a child of the adult child, and does not appear to require coverage of the spouse of the adult child.

• Effective Date: The Health Care Reform Law’s requirement to cover adult children generally applies to grandfathered plans (health insurance coverage and group health plans in existence on March 23, 2010) and nongrandfathered plans effective for plan years that begin on or after September 23, 2010 or, if later (for health insurance coverage maintained pursuant to one or more CBAs ratified before March 23, 2010), the date on which the last of the CBAs relating to the coverage terminates.

• Special Rule for Grandfathered Plans: For plan years beginning before January 1, 2014, the adult children coverage requirement applies to grandfathered group health plans only if the adult child is not eligible to enroll in another eligible employer-sponsored health plan (a group health plan or group health insurance coverage offered by an employer to employees which is a governmental plan, or is any other plan or coverage offered in the small or large group insurance market within the state). Therefore, the Health Care Reform Law does not require grandfathered plans to cover an adult child who is eligible for another eligible employer-sponsored health plan until the first plan year beginning on or after January 1, 2014.

• Aon Comment: From a practical standpoint, not all adult children who are eligible to enroll in their parent’s plan will enroll when this Health Care Reform Law provision becomes effective. They may not enroll due to inertia, insufficient knowledge about the plan, a belief that they do not need health coverage, or their unwillingness to pay any additional premium. However, adult children who lack other affordable group health coverage and who have existing medical conditions are likely to enroll. Once enrolled, they are more likely than not to remain covered until no longer eligible due to a maximum age or other eligibility condition.

Unanswered Questions: There are several questions as to how the adult children coverage provision of the Health Care Reform Law applies to plan sponsors, which may not be fully answered until future official guidance is issued. For example:

• It is not entirely clear whether an employer may require adult children to complete a formal enrollment application (a separate election) to obtain coverage on their parent’s plan.
• How much employers will be permitted to charge employees for the extended coverage of an adult child is not presently known.

• It is not entirely clear whether the age 26 adult children coverage provision of the Health Care Reform Law will apply to any otherwise eligible dependent who has reached a lower plan-imposed maximum age limitation (e.g., not only the employee’s natural born, step, adopted, or foster child, but also a child of a live-in partner, a niece or nephew, a grandchild, etc.).

• Employers will need to determine how to coordinate this adult children coverage requirement with the various state insurance laws that currently permit individuals to cover adult children under certain circumstances (e.g., subject to certain restrictions regarding age, marital status, student status, financial dependence, etc.).

Prohibition on Rescissions: The Health Care Reform Law also provides that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not rescind the plan or coverage with respect to any covered individual, unless the individual has committed fraud or made an intentional misrepresentation of a material fact as prohibited by the plan or coverage. In addition, coverage cannot be cancelled unless there is prior notice to the covered individual and certain other requirements as set forth in the Public Health Service Act (“PHSA”) are satisfied.

• Effective Date: This provision of the Health Care Reform Law applies to grandfathered and nongrandfathered health plans effective for plan years that begin on or after September 23, 2010 (however, a later effective date similarly may apply in the case of health insurance coverage maintained pursuant to one or more CBAs ratified before March 23, 2010).

Unanswered Questions: The application of this rescission provision to group health plan coverage is not entirely clear (the restriction on rescissions was largely a legislative response to instances where insurers have canceled individual health coverage of insured individuals with major medical problems). Moreover, what Congress intended by the use of the term “rescind” is subject to interpretation until regulatory guidance is issued. For example:

• Meaning of “Rescind”. The term “rescind” is not defined by the Health Care Reform Law. The Congressional Research Service (“CRS”), which supports congressional committees and Members of Congress and assists throughout the legislative process, has stated, “A rescission generally refers to the practice of cancelling a health insurance policy after a plan member or policyholder has submitted medical claims.” (See CRS, Private Health Insurance: Changes Made by H.R. 4872, the Health Care and Education Reconciliation Act of 2010, March 23, 2010.) This implies that coverage could be rescinded before any claims have been submitted. Generally, rescinding a contract has meant undoing it from its inception due to a default by one of the parties, as a result of which all parties are placed in the same position they would have been in if the contract had never existed. Rescissions have been permitted in a variety of situations, including instances involving unintentional misrepresentations that are relied on by the insurer.
Future guidance under the Health Care Reform Law on this issue is expected. It may be that this rescission provision is not intended to prohibit the retroactive or prospective removal from coverage of any ineligible dependent, regardless of fraud or intentional misrepresentation. Alternatively, this provision might be interpreted to permit a retroactive voiding of coverage only where the individual has committed fraud or made an intentional misrepresentation of a material fact as prohibited by the plan or coverage, but would permit prospective cancellation of an individual’s coverage if the individual does not satisfy plan eligibility conditions. (Merely being an ineligible dependent does not necessarily mean that any fraud or intentional misrepresentation was committed. For example, an employee may have incorrectly assumed that the dependent is eligible, and the employer neglected to verify eligibility when the dependent was first enrolled.)

- **ERISA and PHSA Applicability.** It is unclear how this rescission provision applies to self-insured plans governed by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), since it permits cancellation of coverage only in accordance with certain provisions of the PHSA that relate to cancellation by an insurer of coverage in the individual or group markets.

- **ERISA Fiduciary Concerns.** From an ERISA fiduciary perspective, plan fiduciaries must administer their health plans in accordance with plan terms. It is unclear how this rescission provision affects the general right of plan sponsors under ERISA plans to establish the plan’s eligibility terms, or the obligation of plan fiduciaries to follow those terms (including ceasing coverage for ineligible dependents).

- **Rescission under ERISA.** The effect of this rescission provision on the existing right of rescission under ERISA is unclear. For example, several courts have held that federal common law allows for the equitable rescission of an ERISA-governed insurance policy that is obtained through the material misstatements or omissions of the insured.

**DEVAs after Health Care Reform**

Conducting a DEVA remains an appropriate, viable, effective, and (in many cases) necessary tool to reduce costs for self-insured and fully insured group health plans, even after enactment of the Health Care Reform Law.

- **DEVAs can significantly reduce costs attributable to coverage of any ineligible dependents, not just ineligible children** (we have found that employers potentially may achieve a cost-savings of 2% to 10% in health plan costs by removing ineligible dependents).

- **DEVAs are particularly important,** for example, where plan terms have changed, there are known eligibility issues, or there have been corporate transactions resulting in newly eligible groups.

- **A DEVA is an effective method of complying with ERISA** by ensuring that plan eligibility terms are being followed. Employers generally have a fiduciary obligation to ensure that an ERISA-governed self-insured or fully insured group health plan is operated in accordance with its terms. This includes confirming that only eligible individuals receive plan benefits and, upon learning that an ineligible person is participating, notifying that individual of his or her ineligibility. A DEVA can help ensure that the plan operates only as intended by the sponsor.
• DEVAs may help avoid the need to provide continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”), for ineligible dependents if they are removed from coverage before a qualifying event occurs (it is unsettled whether a group health plan must provide COBRA continuation coverage for ineligible individuals who are covered when a qualifying event occurs).

Clearly, official guidance on the myriad Health Care Reform Law issues is needed. Until such guidance is issued, Aon Consulting believes that the Health Care Reform Law’s restriction on rescissions should not be intended to restrict the right of a group health plan to remove from coverage any individual who is ineligible because he or she does not satisfy the plan’s eligibility provisions (as modified in accordance with the Health Care Reform Law). Rather, we believe that the purpose and intent of the Health Care Reform Law’s rescission provision is more likely focused on preventing employers and insurers from eliminating plan coverage (unless there is fraud or a material misrepresentation) under circumstances where an otherwise eligible individual has submitted a claim for benefits.

Next Steps

In light of the Health Care Reform Law changes discussed above and the present level of resulting uncertainty regarding health plan coverages, and to mitigate risks in connection with dependent eligibility under a group health plan, employers should consider:

• **2010 DEVAs.** Conducting and completing a DEVA before the Health Care Reform Law provisions regarding coverage of adult children and rescission of coverage are effective (e.g., before January 1, 2011, in the case of a noncollectively bargained calendar year plan). This may maximize the number of ineligible dependents who can be removed from coverage. (Certain adult children may be eligible to reenroll after those provisions become effective. However, this is not likely to result in as many covered adult children as there would have been if a DEVA were not conducted, since those children may obtain other coverage in the interim, may be ineligible for other reasons, or just may not wish to reenroll.)

• **DEVAs after 2010 and before 2014.** Conducting a DEVA before 2014 (if not in 2010), since coverage of adult children in accordance with the Health Care Reform Law may result in larger numbers of ineligible dependents during the phase-in period for plan years beginning before January 1, 2014 (during that period, adult children must be afforded coverage under grandfathered group health plans only if the adult child is not eligible to enroll in another eligible employer-sponsored health plan) than in later years.
• **DEVA Certifications.** Requiring employees to sign a certification of dependent eligibility at the inception of a DEVA, which would (i) describe the plan’s eligibility terms, (ii) require the employee to certify that each currently enrolled dependent satisfies those terms, (iii) indicate that the employer will rely on the certification, (iv) confirm that coverage of any ineligible individual may have adverse tax consequences to the employee (e.g., the employee may have imputed income for the full value of the employer-provided coverage), and (v) note that any intentional misrepresentations regarding eligibility of any covered individual may result in retroactive rescission of coverage of the employee and any covered dependents, as well as disciplinary action (up to and including termination of employment) and other possible legal action, as and to the extent permitted under applicable law.

  - Aon Consulting has modified our DEVA procedures to include utilizing such a certification. We will discuss possible approaches to the certification process with employers before it begins.

  - Use of a proper certification process may lay the groundwork for an employer to rescind coverage for ineligible individuals based on a material misrepresentation under the Health Care Reform Law.

• **Pre-DEVA Certifications.** If a DEVA is not conducted in 2010, requiring all covered employees to sign a similar eligibility certification sometime before the Health Care Reform Law provisions regarding coverage of adult children and rescission of coverage are effective (e.g., before January 1, 2011, in the case of a noncollectively bargained calendar year group health plan). This may reduce costs by removing ineligible employees in 2010, enable employers to act on any misrepresentations before those Health Care Reform Law provisions become effective, and facilitate the removal of an ineligible dependent for fraud or intentional misrepresentation after those provisions becomes effective. The certification may also facilitate the removal of any dependents under age 26 who are ineligible for coverage under a grandfathered group health plan because they have other available eligible employer-sponsored health coverage (for plan years beginning before January 1, 2014).

• **Enrollment Materials.** Including as part of the new hire and annual enrollment procedures a requirement that employees certify eligibility of all covered dependents, and consider obtaining proof of eligibility from employees. Future DEVA audits would verify such documentation and update relevant information.

• **Eligibility Provisions.** Clearly defining all eligibility provisions of a group health plan in the plan document and related summary plan description (“SPD”).

  - Aon Consulting has developed model language for inclusion in a plan document and SPD that clearly and unambiguously defines dependent eligibility.
Right to Require Certifications. Amending any group health plan document and related SPD (if necessary) to provide that the plan sponsor has a right to require certifications by participants from time to time, and that any failure by a participant to complete such a certification when requested is grounds for immediate cancellation of coverage.

- Employers should discuss with their counsel whether such an amendment would have any affect on “grandfathered plan” status under the Health Care Reform Law. We anticipate that this issue will be addressed in future regulatory guidance.

Employment Policies and Procedures. Review employment policies and procedures to ensure they clearly indicate that any fraud or intentional misrepresentations made by an employee to the employer in connection with the employee’s employment, including any information related to any employee benefit plan sponsored or maintained by the employer, may result in disciplinary action (up to and including termination of employment) and other legal action, as and to the extent permitted under applicable law.

- Consideration should be given to including a provision to the effect that termination of employment in such cases also may be considered gross misconduct, as a result of which COBRA coverage may not be available. If an individual is receiving COBRA continuation coverage, fraud or intentional misrepresentations related to the plan may also terminate a qualified beneficiary’s right to COBRA coverage. (Unintentional coverage of an ineligible individual might not constitute gross misconduct for COBRA purposes.)

- It is Aon Consulting’s understanding that group health plan enrollment information in the possession of the employer (rather than the health plan itself) is not protected health information under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and may be used in connection with employment actions if otherwise permitted under applicable law. Employers should confirm this with their counsel.

- Applicable federal and state law, and any contractual obligations, should be considered before an employer takes any adverse employment action.

Early Implementation of Adult Children Coverage. Amending their health plans to permit coverage of adult children in 2010, as if the Health Care Reform Law provisions regarding such coverage requirements were currently effective. In that case, adult children would not be considered ineligible in 2010, unless their coverage is under a grandfathered group health plan and they are eligible to enroll in another eligible employer-sponsored health plan.

- Note: Employers should carefully consider the impact of any amendments that are not required by the Health Care Reform Law so that favorable grandfathered plan treatment of their health plans is not inadvertently lost.
Any change in employment practices (e.g., the institution of a certification process) or benefits involving employees covered by a CBA should be discussed in advance with labor counsel to ensure that it does not violate any applicable labor laws or existing CBAs. It also is strongly recommended that employers discuss the Health Care Reform Law requirements with their counsel before making any plan amendments or taking any adverse action against a plan participant or covered dependent, particularly until further official guidance is issued.

This Analysis summarizes Aon Consulting’s current understanding of how certain provisions of the Health Care Reform Law may affect employers (many provisions still are not entirely clear), and is intended only for informational purposes. It should not be relied upon as to any legal rights, obligations, or liability that any particular employer may have under the Health Care Reform Law. In addition, and consistent with Treasury Department Circular 230, this Alert Update was not prepared with the intent of being used, and cannot be used, by any employer for the purpose of (i) avoiding any tax penalties, or (ii) promoting, marketing, or recommending to another party any matter it addresses.

Q & A

Q. Since group health plans and insurers providing dependent coverage of children generally will need to make coverage available for adult children up to their 26th birthday as a result of the Health Care Reform Law, is there any value in conducting dependent eligibility verification audits (“DEVAs”) now or in the future?

A. Yes – DEVAs are still an appropriate, viable, effective, and (in many cases) necessary tool to reduce costs for self-insured and fully insured group health plans, even after enactment of the Health Care Reform Law. Aon’s experience is that 4% to 8% of individuals covered as dependents are ineligible for group health coverage, regardless of industry, geography, or employer size. Although the number of covered ineligible individuals may decrease after the Health Care Reform Law becomes effective (because more covered children may satisfy the new, higher age limits), there likely will still be many covered individuals who are ineligible.

Q. Does the Health Care Reform Law prohibit employers from conducting DEVAs and removing ineligible dependents?

A. No, DEVAs are not prohibited by the Health Care Reform Law. Nor do we believe that the Health Care Reform Law’s restriction on rescinding coverage of an enrollee (absent fraud or intentional misrepresentation) is intended to require continued health coverage of ineligible dependents under employer-sponsored plans, where those individuals never satisfied the plan’s eligibility requirements in the first place (future official guidance on this issue is anticipated). We believe that employers with ERISA-governed plans have a fiduciary obligation to ensure that plan resources are used only for the benefit of eligible employees and dependents. A DEVA can help assess whether an individual is entitled to any coverage under the plan, based on plan terms as in effect for the audited period.
Q. **What is the value of conducting a DEVA before January 1, 2011, when most employers need to comply with the Health Care Reform Law’s requirement regarding coverage of adult children up to age 26 and restriction on rescissions?**

A. Employers may conduct a DEVA and remove ineligible dependents, including those who may be under age 26, before those Health Care Reform Law provisions become effective (generally, January 1, 2011, in the case of calendar year plans; collectively bargained plans may have a later effective date). As a result, employers conducting a DEVA in 2010 can maximize their savings by identifying and dropping ineligible dependents.

Q. **What is the value of conducting a DEVA before January 1, 2014?**

A. For plan years beginning on or after September 23, 2010 (collectively bargained plans may have a later effective date) and before January 1, 2014, adult children (up to age 26) must be provided coverage under a grandfathered group health plan (a plan in existence on March 23, 2010) only if the adult child is not eligible to enroll in another eligible employer-sponsored health plan. Therefore, a DEVA during this phase-in period of the Health Care Reform Law for grandfathered group health plans is likely to uncover more ineligible dependents than after the period ends (when grandfathered group health plans must offer coverage for adult children up to age 26, even if they are eligible to enroll in another eligible employer-sponsored health plan).