ALLEGIANCE

Health Care Reform: Guidance for Employer-Sponsored Health Plans

The newly enacted health care reform laws have various effective dates for plans, a few of which are effective immediately, with the majority effective in 2011 and 2014.

These two laws, entitled the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Tax Credit Reconciliation Act of 2010 (HCETCRA), will be the subject of regulations to be promulgated by the U.S. Internal Revenue Service, the U.S. Department of Health and Human Services and the U.S. Department of Labor.

Certain plans are **excused from immediate compliance** with many requirements **("grandfathered")**. These plans include both **self-insured plans and fully insured plans**, which are **in existence as of March 23, 2010** (the "date of enactment").

The new law allows grandfathered group health plans to add family members and new employees to the existing plan. It is an open issue as to whether the new law allows grandfathered health plans to make changes to benefits or eligibility going forward without losing grandfathered status. Regulations will be required to clarify this issue.

The new law keeps **ERISA and the federal law regime,** rather than state by state remedies, **intact**. There are **immediate issues** for employer-sponsored plans, including grandfathered plans, that must be addressed to be effective starting the first plan year after September 23, 2010. These issues will require plan amendments and benefit changes.

Except as noted below, the reforms are effective for plan years beginning six months after the date of enactment, meaning January 1, 2011 for calendar year plans and as soon as October 1, 2010 for plans that have a plan year beginning October 1 or later this year.

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A. EFFECTIVE FOR EXISTING PLANS on the first plan year following September 23, 2010:

(1) No annual or lifetime dollar limits on "essential benefits". (Grandfather exception does not apply). To the extent a plan offers these essential benefits, it cannot limit them, but to the extent it offers benefits beyond the "essential benefits", the plan can place limits on those other benefits.

"Essential benefits" consist of at least the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; and pediatric services, including oral and vision care.

(2) Adult dependent children to age 26. (Grandfather exception does not apply). Extension of coverage to adult children through age 25 up to 26th birthday, including married adult children. Children who have coverage available through their own employment do not have to be covered. However, there is **no mandate** that a plan must cover dependent children.**(3) No pre-existing condition exclusions can apply for enrollees under the age of 19. (Grandfather exception does not apply).**

(4) No rescission of coverage except in cases of fraud or intentional misrepresentation. This applies more readily to fully insured individual and group health insurance policies.

(5) Employers with **more than 200 employees** must **automatically enroll** employees for coverage each year, unless the employee affirmatively waives. **(Grandfather exception does not apply).**

(6) A **"summary of benefits"** no longer than 4 pages is required in addition to the SPD. **(Grandfather exception does not apply). B. EFFECTIVE FIRST PLAN YEAR AFTER September 23, 2010, for NEW plans coming into existence after that date (Grandfathered exception applies to all)**

(1) All of the above.

(2) First dollar coverage for preventive care and certain immunizations.

(3) Nondiscrimination rules on highly compensated individuals will apply to fully insured coverage. **(4)** New **external review requirements** for external appeals of coverage and claims and, for self-insured plans, compliance with minimum standards to be established by the Secretary of the U.S. Department of Labor.

(5) New requirements on **choice of provider (insured and self-funded)**. Participants can choose their OB/GYN and primary care physician; dependents can choose their pediatricians and emergency services can be accessed **without prior authorization**.

(6) Self-funded plans will be subject to the law's requirements to issue a **summary of benefits and explanations of coverage** to participants and beneficiaries, just as they are now, except the new law sets forth criteria on format, simplified language, uniform definitions of standard insurance and medical terms, explanation of cost-sharing exceptions, reductions, and limits on coverage, and a requirement to provide common benefits scenarios.

C. EFFECTIVE January 1, 2011:(1) No reimbursement for OTC medicines and drugs (except insulin) by health HSA, FSA, or HRA without prescription.

(2) Employers must report **aggregate value** of employer-sponsored health coverage on annual **Form W-2**.

D. EFFECTIVE January 1, 2012:

Employers in both insured and self-funded plans will have to distribute a **summary of benefits and explanations of coverage**, to be based on forthcoming regulatory standards and format. The summary will be limited to 4 pages and must state whether the plan provides minimum essential coverage and whether the plan meets 60% actuarial value. This is the date for **compliance with the distribution deadline**.

E. EFFECTIVE January 1, 2013:

(1) Health reimbursement **FSA salary reductions** limited to $2,500 each year.

(2) Deduction previously permitted for amounts allocable to **Medicare Part D subsidy** for prescription drugs is eliminated.

(3) New **employer notification** responsibilities on the health insurance exchange, subsidy, etc.

F. EFFECTIVE on first plan year following January 1, 2014. Applies to all Plans, including Grandfathered Plans:

(1) Plans will not be able to require **waiting periods** of over 90 days.

(2) All plans are required to cover "essential benefits". **(3)** For all plans, **cost-sharing provisions** are limited. The amount of deductible and out-of-pocket expenses cannot be capped. The deductible cannot exceed $2000 per person or $4000 per family. Out-of-pocket expenses cannot exceed the cap for HSA compatible high deductible health plans, as that limit exists in 2014.

(4) **No pre-existing conditions** exclusions for any age group on any plan.

(5) Plans must cover the "**routine cost" of treatment in clinical trials**. "Routine costs" and type and scope of clinical trials are not yet clearly defined. **(Grandfather exception does apply).**

Last Caveat: If no separate effective date is given, then the effective date will be the date of enactment. But language which says "in accordance with regulations" gives time to conform to the regulations, whenever they are in effect.

NOTE: This guidance is limited to employer responsibilities, particularly those germane to plan design.

We expect to send further communications as soon as regulations and other guidance exist. Please contact your Allegiance account representative if you have questions pertaining this guidance.