

Impact of Health Care Reform on Group Health Plans

Group health plans will be impacted significantly by health care reform. Employers should work with their consultants to review the changes and consider the impact to their plans, including any changes in plan design and administration, as well as employee communication materials.

Group health plans that were in effect on March 23, 2010, may qualify as “grandfathered” plans and, therefore, are not required to comply with certain health care reform mandates. There are, however, rules that apply to all group health plans, regardless of whether they are “grandfathered” plans.

Key Provisions for All Group Health Plans

(Effective for plan years beginning on or after September 23, 2010)

- Plans providing dependent coverage must cover adult children up to age 26, regardless of whether the child is married, a student, a dependent, or residing at home. Existing grandfathered plans must allow for enrollment to age 26 only if a young adult is not eligible for other employer coverage. This allowance for grandfathered plans ends in 2014.
- A group health plan may not limit or exclude benefits (or deny coverage) based on the fact that a preexisting condition was present before the effective date of coverage. This provision only applies to children under age 19, but will extend to adults for plan years beginning on or after January 1, 2014.
- Group health plans may not rescind an enrollee’s coverage, unless the enrollment involved fraud or misrepresentation.
- Lifetime dollar limits on essential health benefits are prohibited. Individuals who previously reached a lifetime limit under a group health plan and are otherwise still eligible for coverage must be notified that the lifetime limit no longer applies and given a 30-day special enrollment window.
- Annual limits on essential health benefits may not be less than the following amounts for plan years beginning before January 1, 2014 (the date after which all annual dollar limits on essential health benefits will be prohibited).

For Years Beginning On or After			
Effective Date	September 23, 2010	September 23, 2011	September 23, 2012
Limit	\$750,000	\$1.25M	\$2M

Grandfathered Plans

(Effective for Plan Years beginning on or after September 23, 2010)

The health reform regulations define a “grandfathered health plan” as health coverage provided by a group health plan or an insurance issuer in which an individual was enrolled on March 23, 2010. A health plan in effect on March 23, 2010 maintains its grandfather status as long as it continuously covers at least one person since that date and will not be impacted if it is renewed. Grandfather status is generally determined separately for each benefit option, so a plan may have some options that are grandfathered and some that are not.

Key Provisions for Non-Grandfathered Plans

- Non-discrimination rules (code section 105(h)) that currently apply to self-insured plans will now be expanded to cover fully-insured group health plans.
- Employer-sponsored health plans may not impose cost sharing for certain preventive care, such as immunizations and well-baby care.
- Group health plans requiring designation of a primary care provider must permit participants to designate any available primary care provider or, in the case of a child, any pediatrician.
- No preauthorization or referral is permitted for care from an obstetrician or a gynecologist.
- Plans are prohibited from requiring preauthorization or higher cost sharing for out-of-network emergency services.

Implications for Plan Sponsors

Plan sponsors making benefit design decisions for the upcoming plan year should ask their insurers or brokers key questions related to health care reform:

1. What new requirements apply to our plan next year? What amendments should we make to the plan document to stay in compliance with the regulations?
2. Does our plan qualify for grandfathered status? What additional requirements apply if we do not retain grandfathered status?

Other Changes with Various Effective Dates

- **W-2 Reporting** (for 2011 tax year) of the value of an employee's employer-sponsored health insurance coverage.
- **Summary of Benefits** must be provided to employees prior to enrollment by March 23, 2012.
- **Auto-enrollment of full-time employees into employer-sponsored health plans will be required** for businesses with more than 200 full-time employees beginning January 1, 2011.
- **Over the Counter drugs** will not be allowed for reimbursement under FSA/HSA/HRA without a prescription beginning in 2011.
- **Plans will be required to make transparency disclosures (e.g., claims payment policies)** and report on various **quality of care metrics** to Health and Human Services (still awaiting regulations with specifics).

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