New Health Care Reform Requires Changes to Employer Sponsored Health Plans

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The following details immediate action items for health plans to comply with the health reform acts.

Although much of the new health reform law (which is contained in two separate acts: the Patient Protection and Affordable Care Act, or PPACA, and the reconciliation act called the Health Care and Education Reconciliation Act, or HCERA), is not effective until 2011-2014, some of the changes will become effective sooner, and employers, insurers, and health plans should prepare for these earlier changes.

The earliest effective date for some of the new laws is plan years beginning after March 22, 2010. The other early effective date is plan years beginning after September 22, 2010. Thus, it is important to determine what your plan uses as its plan year, which may be the calendar year or the annual anniversary of your contract date, but can be any 12-month period. Check your plan document or your Form 5500 filings to determine this important item.

The effective dates for some of the changes differ for "grandfathered" and "non-grandfathered" plans. A health plan that is already in existence on March 23, 2010 is grandfathered, and that grandfathered status applies to current and future participants. A non-grandfathered plan is one that is newly adopted after March 23, 2010. A plan that simply changes its provider, such as switching from one insurer to another, does not automatically become a new plan, and employers should be sure to retain a plan's original plan number for ERISA reporting purposes (e.g. 501 or 502, etc.) to preserve grandfathered status.

Effective for Plan Years beginning after March 22, 2010 to grandfathered and non-grandfathered health plans:

Advance Notice of Changes. Participants must be notified at least 60 days in advance of the effective date of any material change to the plan.

Effective for Plan Years beginning after September 22, 2010 for grandfathered plans:

Adult Children. Plans that cover dependent children must provide for coverage of children until they reach age twenty-six, regardless of whether the children are the employees' tax dependents and regardless of whether

they are married. This applies only to employees' children, and not to grandchildren. For grandfathered plans, this coverage does NOT have to be provided if the children are eligible to be covered by other employer health coverage, which appears to refer only to the child's own employer and not to an employer plan of a relative, such as a spouse.

Lifetime and Annual Dollar Limits. Plans may not impose lifetime dollar limits on benefits, and no annual dollar limits on essential health benefits. The determination of what is "essential" will be made by the Department of Health and Human Services.

Preexisting Condition Restrictions for Children. Plans cannot impose preexisting coverage restrictions on children under age nineteen.

Emergency Room Services. Plans that cover emergency room services cannot require preauthorization, cannot bar coverage if the provider is not in-network, and must provide coverage on parity with in-network providers (i.e. the same cost-sharing requirements and the same coverage restrictions) for emergency room services.

Coverage Rescission. Plans cannot rescind (meaning retroactively cancel) an individual participant's coverage except for fraud or intentional misrepresentation, and cannot prospectively cancel an individual's coverage without observing certain formalities that normally apply to individual health insurance.

Effective for Plan Years beginning after September 22, 2010 for non-grandfathered plans:

Same as Above. Items 2-5 above apply to non-grandfathered plans.

Adult Children Regardless of Other Coverage. Plans that cover dependent children must provide for coverage of children until they reach age 26, regardless of whether the children are the employees' tax dependents, regardless of whether they are married, and regardless of whether they are eligible for coverage under another employer's health plan. This applies only to employees' children, and not to grandchildren.

Non-Discrimination for Insured Plans. The rules of Internal Revenue Code Section 105(h), which impose adverse tax consequences for plans that discriminate in eligibility or benefits in favor of highly compensated individuals, will apply to fully insured plans in addition to the self-insured plans which are already subjected to these non-discrimination rules. Offering lower premium costs to executives than to rank and file employees is one form of discrimination that violates section 105(h). Additionally, limiting coverage under an insured plan to a group that largely includes the high-paid employees and excluding the lower-paid employees will also likely violate section 105(h).

Preventative Care. Plans must offer first-dollar coverage (i.e. no cost-sharing) for certain items of preventative care and certain immunizations.

Out-of-Pocket Limits. The maximum annual participant cost (which includes deductibles, co-pays, and other out-of-pocket expenses) other than premiums and balance billing amounts for non-network providers and non-covered services cannot exceed $5,000 for single coverage and $10,000 for family coverage.

Claims Appeals. Plans must establish an internal claims appeals process that offers more rights to claimants than are currently available, including notice of availability of state health insurance ombudsmen, rights to review files and present evidence and external review.

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Kathy Conklin