Federal Agencies Issue First Wave of Health Care Reform Regulations

June 6, 2010 by Adam Santucci

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The Patient Protection and Affordable Care Act ("PPACA" or the "Act") (pdf), commonly referred to as the "health care reform law," is nearly 900 pages long and imposes a multitude of new requirements on employers and their group health plans. Yet, despite its length, the Act leaves many basic questions regarding its requirements unanswered. For example, employers that seek to comply with the Act's requirement regarding the provision of unpaid breaks for mothers to express breast milk for children up to one year of age do not yet know how many breaks must be provided per day or how long the breaks must be. Similarly, group health plans that are "grandfathered," and therefore exempt from certain of the Act's requirements, do not yet know what types of plan amendments jeopardize grandfathered status. Important questions like these will likely be addressed over the course of the next several months, and years, in federal regulations. In May 2010, federal agencies issued the first wave of "interim" regulations under the Act.

Interim Final Rules Relating to Dependent Coverage of Children to Age 26 The Act requires all group health plans, regardless of grandfathered status, to extend dependent coverage to children until they reach age 26. This requirement goes into effect for plan years beginning on or after September 23, 2010 (i.e. January 1, 2011 for calendar year plans). Grandfathered plans may exclude an employee's child who is over the age of 19 if he has other employer-provided coverage available - other than through one of the child's parents. However, this limited exclusion does not apply to non-grandfathered plans and the exclusion will be eliminated altogether in 2014.

On May 10, 2010, the Internal Revenue Service, Department of Labor and Department of Health and Human Services jointly issued "interim final regulations (pdf)" governing the extension of dependent coverage. The regulations expressly prohibit group health plans from denying or restricting coverage to dependents under the age of 26 on the basis of residency, student status, employment status or financial dependency. The regulations also clarify that the extension of coverage does not apply to the grandchild of an employee.

Although plans may charge an employee more for coverage as the number of his or her covered dependents increase, the regulations prohibits plans from varying the terms of dependent coverage based on age (unless the dependent is 26 or older). In other words, a plan may not charge more to cover a 25-year old dependent than it does a 5-year old. Similarly, older dependents cannot be offered fewer plan options than younger dependents.

Under the regulations, dependents under the age of 26 who previously lost coverage or who were denied coverage due to their age must be given an opportunity to enroll in the plan. The enrollment opportunity must begin no later that the plan's first plan year beginning on or after September 23, 2010 and must last at least thirty days. In addition, a written notice of this opportunity must be provided to the dependent or to the employee-parent. It may be included as part of other enrollment materials; however, the notice must be prominent.

Interim Final Rules Relating to PPACA's Early Retirement Reinsurance Program The Act also created a temporary reinsurance program for employer health plans (insured and self-funded) that provide coverage for eligible early retirees between the ages of 55 and 64.

The program is intended to reimburse plan sponsors for 80% of the cost of an eligible enrollee's benefits between $15,000 and $90,000. This program will cease upon the earlier of 2014 or depletion of the $5 billion reinsurance pool. Payments are on a first come, first served basis and some believe that the reinsurance pool could be depleted in a matter of days or even hours.

Interim final regulations (pdf) issued by the Department of Health and Human Services ("HHS") on May 5, 2010 set forth the eligibility requirements a plan must meet in order to participate in the program and outline the types of information that will be require d on the application for reinsurance benefits. HHS has not yet issued an application form for this purpose, but is expected to do so in the next several weeks. Interested plans should closely monitor the HHS website.

Notably, in order to be eligible, a plan must be "certified with the Secretary [of HHS]" and must "include programs and procedures that have generated or have the potential to generate cost-savings with respect to plan participants with chronic and high-cost conditions." The regulations further require that proceeds under the program be used for purposes such as reducing the sponsor's health benefit premiums, costs, copayments, deductibles, coinsurance or other out-of-pocket costs.

For additional information regarding health care reform, please click here to view the McNees Whitepaper regarding What Employers Need to Know about Health Care Reform. In addition, we will post additional articles on this blog as other regulations are issued.