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Impact of Health Care Reform on Group Health Plans– The First Years

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Over the next several years, group health plans face significant new challenges under the lengthy and complex Health Care Reform Law. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and then was immediately amended by the Health Care and Education Reconciliation Act on March 30th (collectively, the "Health Care Reform Law"). The Health Care Reform Law drastically changes health care as we know it and requires immediate action and ongoing analysis and restructuring of benefits in the years to come.

The Health Care Reform Law has numerous provisions with various effective dates which are applicable depending on group health plan status. Of key importance, the law draws a distinction between "grandfathered" and "non-grandfathered" group health plans. Group health plans which had an individual enrolled in it on March 23, 2010 (and that have not made certain changes to the plan) are deemed "grandfathered" and are exempt from certain provisions. In contrast, non-grandfathered health plans are required to comply with all aspects of the Health Care Reform Law applicable to group health plans.

This article summarizes various provisions of the Health Care Reform Law relevant to group health plans becoming effective over the next few years. Unless otherwise noted below, the following provisions become effective for group health plans on their next plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans). Please note that this article does not detail every provision going into effect in any given year.

Dependent Coverage for Children Up to Age 26

Group health plans, including grandfathered plans, that provide dependent coverage must continue to make such coverage available for an adult child until the child reaches age 26. Coverage must be made available regardless of the child's marital status, financial dependency, residency, or student status. However, for plan years beginning before 2014, a grandfathered group health plan that provides dependent coverage of children must only continue to make such coverage available for an adult child until the child reaches age 26 if such adult child is not eligible to enroll in another eligible employer-sponsored health plan. Coverage for eligible adult children will not be considered taxable income to the employee or the child through the end of the taxable year in which the child attains age 26.

Prohibition on Lifetime Benefit Limits and Restricted Annual Benefit Limits

Grandfathered and new group health plans (1) may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary and (2) may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of essential health benefits. Beginning in 2014, group health plans may not establish annual limits on the dollar value of benefits for any participant or beneficiary. Group health plans may still place annual or lifetime limits on specific covered benefits that are not essential health benefits and may still exclude all benefits for a specific condition.

Limited Grounds for Rescinding Coverage

Group health plans, including grandfathered plans, are prohibited from retroactively rescinding coverage for individuals who are enrolled under the plan, unless the covered individual performs an act, practice, or omission that constitutes fraud or unless the individual makes an intentional misrepresentation of material fact prohibited by the terms of the plan.

Prohibition of Preexisting Condition Exclusions

Group health plans, including grandfathered plans, may not impose any preexisting condition exclusions for plan years beginning on or after January 1, 2014. For plan years beginning on or after September 23, 2010, group health plans may not impose any preexisting condition exclusions for children under the age of 19.

Extension of Nondiscrimination Rules

The nondiscrimination rules of Internal Revenue Code §105(h)(2) are extended to apply to non-grandfathered fully-insured group health plans.

Mandated Claims Appeals Processes

Non-grandfathered group health plans must implement an effective appeals process for appeals of coverage determinations and claims which at a minimum (1) has an internal claims appeal process which incorporates the claims and appeals procedures of ERISA; (2) provides notice to enrollees of the internal and external appeals process in a culturally and linguistically appropriate manner and the availability of any applicable assistance with the appeals process; and (3) allows enrollees to review their file, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeal. Additionally, a non-grandfathered group health plan must comply with the applicable state external review process for such plans, which meets minimum standards set forth by either the National Association of Insurance Commissioners or the Secretary of Health and Human Services (the "Secretary").

Mandated Coverage of Preventive Health Services

Non-grandfathered group health plan must provide and cannot impose any cost sharing requirements on certain recommended preventive care items and services established under the Health Care Reform Law.

Mandated Patient Protections

Non-grandfathered group health plans with a network of providers must contain patient protections relating to the designation of a primary care provider, the designation of a pediatrician as a primary care provider, and patient access to obstetrical and gynecological care. Additionally, if any non-grandfathered group health plan provides or covers benefits with respect to services in an emergency department of a hospital, it must do so (1) without requiring prior authorization determination (even if the emergency services are provided on an out-of-network basis); (2) regardless of whether the service provider is a participating network provider with respect to the services; (3) without imposing requirements or costs different that those imposed on in-network participating providers; and (4) generally without regard to any term or condition of coverage.

Small Employer Tax Credit

For taxable years beginning January 1, 2010, an employer with no more than 25 full-time employees and average wages of less than $50,000 that purchases health insurance for its employees and covers at least 50 percent of the total premium cost is eligible for a tax credit of up to 35 percent of the cost of the employer's premium contribution in the small group market (up to 25 percent credit in the case of tax-exempt employers).

Automatic Enrollment for Large Employers Offering Coverage

In accordance with the regulations promulgated by the Secretary, an employer with more than 200 full-time employees and that offers employees enrollment in one or more health benefits plans must automatically enroll new full-time employees in one if its plans, subject to any waiting period authorized by law, and to continue the enrollment of current employees in a health benefits plan offered through the employer. Additionally, any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in. Currently, the effective date for this requirement is a bit unclear. The provision does not contain a separate effective date, so by default, the effective date is March 23, 2010. However, the provision also states that implementation is in accordance with regulations promulgated by the Secretary. Accordingly, the automatic enrollment requirement may not be effective until such regulations are issued.

Employer Annual Reporting Requirements regarding Quality of Care

Non-grandfathered group health plans must annually submit, to the Secretary and enrollees under the plan, a report during each open enrollment period regarding wellness and prevention programs. The Secretary is required to develop reporting requirements for group health plans and issue regulations by March 23, 2012.

60-Day Prior Notice of Material Modifications

Group health plans, including grandfathered plans, must provide notice to enrollees of a material modification in any of the terms of the plan or coverage1 no later than 60 days prior to the date on which such modification will become effective. Penalties of up to $1000 may apply for each willful failure to meet the 60-day advance notice requirement. The effective date for this provision is a bit of gray area in the law because the specific provision requiring 60-day prior notice of a material modification does not contain an effective date. Some commentators are claiming this provision does not go into effect until 2012 while others claim it went into effect March 23, 2010.

Over-the-Counter Drug Prohibition

For taxable years beginning after December 31, 2010, costs for over-the-counter medicine and drugs may not be reimbursed through an HSA, HRA, health FSA, or Archer MSA unless such medicine and drugs are prescribed by a doctor or are insulin.

Simple Cafeteria Plans for Small Businesses

For plan years beginning on or after January 1, 2011, a simple cafeteria plan may be established by an employer that employed on average 100 or fewer employees in the preceding two years. An employer maintaining a simple cafeteria plan will be treated as meeting any applicable nondiscrimination requirements. To fall within the definition of a simple cafeteria plan, a cafeteria plan that is established and maintained by an eligible employer must comply with certain contribution, eligibility, and participation requirements.

Uniform Explanation of Coverage Document

Issuers of insured health plans and plan administrators of self-insured health plans, including grandfathered plans, are required to provide applicants, enrollees, and policy and certificate holders a summary of benefits and coverage before enrollment or re-enrollment. The summary of benefits and coverage must include certain appearance, language, and content requirements. The Secretary has until March 23, 2011 to provide guidance regarding the uniform explanation of coverage and a group health plan has until March 23, 2012 to provide such explanation to applicants and enrollees. Penalties of up to $1000 may apply for each willful failure to provide a summary.

Flexible Spending Account Limit

For taxable years beginning January 1, 2013, the flexible spending account limit on salary deferral will be $2,500, adjusted in future years for changes in the cost of living. This legislation is overwhelming in nearly every sense of the word. Plans sponsors and group health plans should immediately have their plan design, procedures, and administration thoroughly reviewed.

IRS Circular 230 Disclosure

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1 This requirement is only applicable if the material modification is not already reflected in the most recently provided summary of benefits and coverage.

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