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Federal Healthcare Reform Begins for Health Plans

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The passage of federal healthcare reform in 2010 marks a new era for employer-sponsored health plans. Along with the requirements of other recently passed laws, group health plans must comply with several new provisions of the Patient Protection and Affordable Care Act ("PPACA") summarized below. This article only addresses the impact of PPACA on employer-sponsored group health plans, and not the many issues for hospitals, doctors, and other medical providers. Unless otherwise noted, these changes took effect after September 23, 2010 (January 1, 2011 for calendar year plans).

One of the first health care reform changes to take effect was the change in the taxation of health coverage for children, effective March 30, 2010. Prior to health care reform, the taxation of health coverage of children depended on whether the children qualified as tax dependents for health care purposes under complicated definitions of "qualifying child" or qualifying relative." Now, health care coverage can be provided on a tax-free basis for children (including adopted children, children placed for adoption, stepchildren and foster children) through the calendar year in which the child turns 26. This rule applies regardless of the marital status of the child, the residence of the child, or whether the child is financially dependent upon the employee or the employee's spouse.

PPACA requires group health plans that cover children to extend the children's eligibility until the child's 26th birthday. Eligibility for children under age 26 cannot depend on the child's student, marital, dependency or employment status. The only allowable exception is that certain grandfathered plans may exclude adult children who have access to employer-sponsored coverage, but this exception only applies until 2014. Regulations adopted under PPACA also require that plans treat all children under age 26 the same, including charging the same premium for all children under age 26. PPACA does not require plans to cover the child's spouse or the child's own children.

In a significant change for consumer-driven health care, over-the-counter drugs will not be reimbursable through health savings accounts ("HSAs"), health flexible spending accounts and health reimbursement arrangements ("HRAs"), unless the drugs are prescribed or are insulin.

PPACA requires that employers with more than 200 employees automatically enroll full-time em-

ployees into health plans when they are first eligible to join the plan and automatically continue enrollment of current employees. Employees will have a right to opt out of the coverage. This provision takes effect when the Department of Labor issues regulations clarifying the details of this requirement, such as what benefit option will be subject to the rule for employers offering multiple health plans or health plan options.

PPACA prohibits aggregate lifetime limits and lifetime limits on "essential health benefits." Essential health benefits will be defined by the Secretary of Health and Human Services and must include, at a minimum, benefits in the following categories:

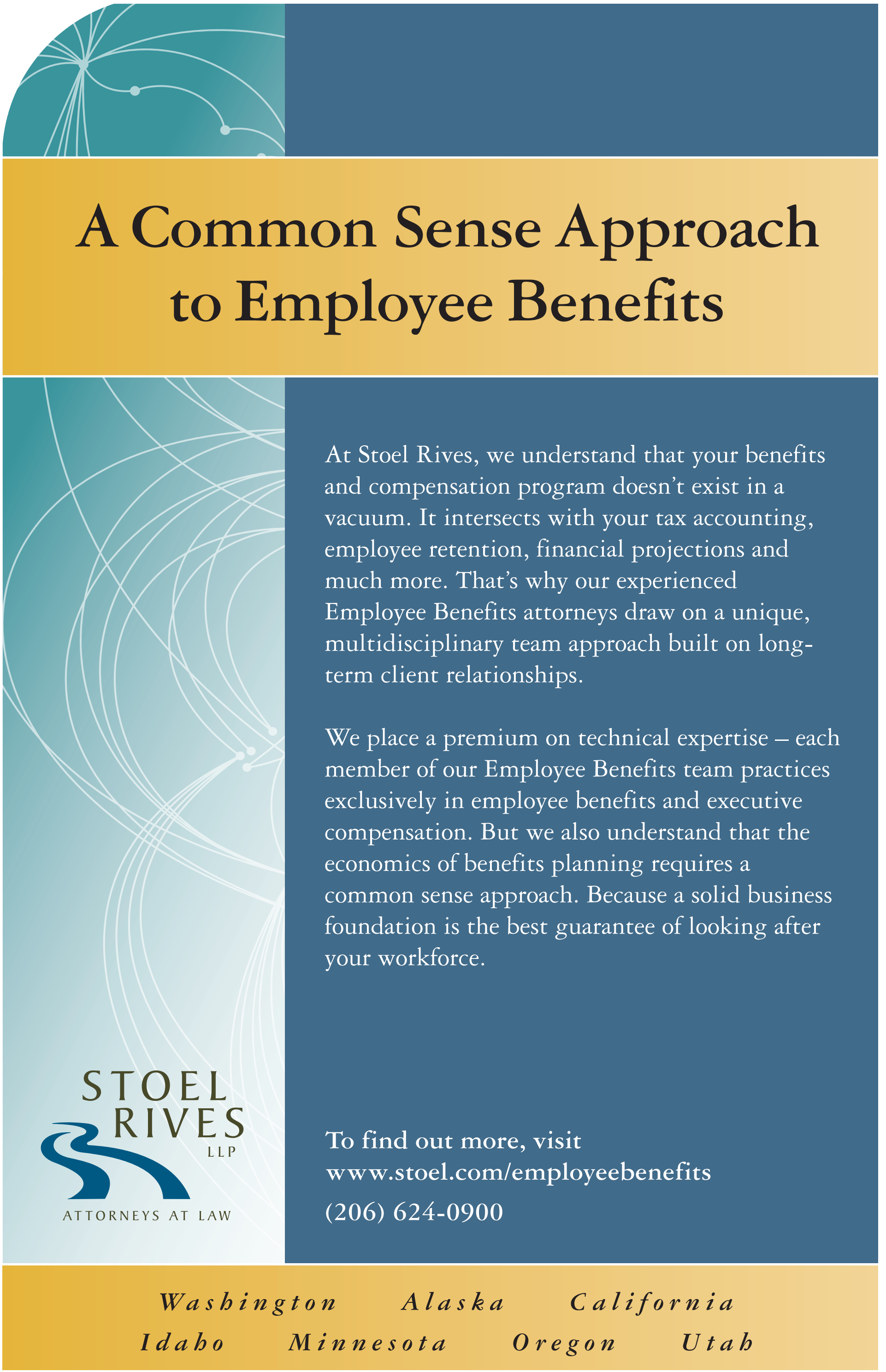
- Ambulatory patient services;
- Emergency services;
- Maternity and newborn care;
- Prescription drugs;
- Hospitalization;
- Laboratory services;
- Mental health and substance use disorder services;
- Rehabilitative and habilitative services and devices;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Regulations interpreting the meaning of these terms have not been released at the time of this writing. The regulatory agencies have indicated that they will take into account good-faith efforts to comply with a reasonable interpretation of the term "essential health benefits" until additional guidance is issued.

Lifetime and annual limits on non-essential health benefits are still allowed, as are exclusions for benefits for specific conditions.

PPACA also prohibits most aggregate annual dollar limits on essential health benefits. However, regulations allow an annual dollar limit on essential health benefits for plan years starting between September 23, 2010 and September 23, 2011, if the annual dollar limit is at least $750,000. This minimum annual limit increases to $1.25 million for 2012 and $2 million for 2013. These limits apply to each individual, not to each family.

Plans can no longer have preexisting condition exclusions for children under age 19. Preexisting condition exclusions are any limi-



tations or exclusions based on the fact that the condition was present before the date of coverage. For example, a plan may not exclude benefits for surgery resulting from an injury that occurred prior to the effective date of coverage. Beginning January 1, 2014, the prohibition on preexisting condition exclusions expands to include participants and beneficiaries age 19 and over.

PPACA imposes a number of new requirements on "new" plans, which are plans that are not "grandfathered." Grandfathered plans are plans that were in existence on March 23, 2010 and have not been amended in a way that causes them to lose their grandfathering status. Changes that will cause a loss of grandfathering status include:

- Eliminating all or substantially all benefits for a particular condition;
- Increasing the percentage of cost-sharing for non-fixed amounts (such as changing co-insurance from 10 percent to 20 percent);
- Certain increases to fixed-amount requirements, such as co-payments or deductibles;
- Decreasing the employer contribution percentage; or
- Adding or reducing annual dollar limits.

New plans are subject to the following requirements:

- New plans must provide preventive services without cost-sharing such as copayments or coinsurance. This includes all preventive care, screenings, immunizations and services recommended by certain governmental agencies; however, plans may refuse to cover or may impose cost-sharing for out-of-network services.
- New plans must meet new internal and external review process standards, including:
  - o both ERISA and non-ERISA plans must comply with ERISA claims procedures;
  - o plans must comply with new internal claims procedures, including issuing determinations on urgent care claims within 24 hours and ensuring the independence and impartiality of decision makers; and
  - o plans must comply with an external review process that meets certain minimum consumer protection standards modeled on standards of the National Association of Insurance Commissioners.
- New plans must pay the same benefits for emergency care, whether provided in-network or out-of-network.
- New plans must allow the designation of any primary care physician or pediatrician as the primary care physician.
- New plans cannot require authorization or referral for obstetrics/gynecology services or emergency care.
- New insured plans must meet nondiscrimination requirements.

Plans will be carefully considering the costs and benefits of losing grandfathered status in light of these requirements.

Complying with health care reform will be the main focus for group health plans this year and for the next several years. In addition to implementing required plan design changes and sending out required notices, plans and employers will be carefully monitoring health coverage costs.

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