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HEALTH INSURANCE ALERT

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No Time Like the Present for Health Reform

The Changes that Impact Employers are Starting Now

By Rhonda D. Orin and Bridget Healy

Although many changes that flow from the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively referred to as PPACA), will not take effect until 2014, others become effective within the next few months. Certain PPACA provisions, for example, take effect as of September 23, 2010. A short description of these provisions, as well as regulations issued by the Department of Health and Human Services (HHS) and other federal agencies, is provided below.

Annual and Lifetime Limits

One of the most significant new provisions regards annual and lifetime limits for "essential health benefits" for participants and beneficiaries.

- For plan years beginning on or after September 23, 2010, but before September 23, 2011, group health plans and health insurance issuers may not establish annual limits under $75,000.
- For plan years beginning on or after September 23, 2011, but before September 23, 2012, the annual limit must not be less than $1.25 million.
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, the annual limit must not be less than $2 million.
- From 2014 forward, there can be no annual limit at all.

The annual limitations apply on an individual basis. The annual limitation rules do not apply to flexible spending accounts and health spending accounts.

With regard to lifetime limits, their use is prohibited in all plans or insurance policies issued or renewed after September 23, 2010.

Prohibition on Rescission

Also important is a new prohibition on arbitrary rescissions, as when an insurance company discovers errors in the paperwork regarding an ill participant. As of September 23, 2010, PPACA imposes restrictions on the rights to group health plans and health insurance issuers to rescind coverage and requirements for them to provide advance notice of cancellation. Specifically, a plan may rescind coverage in cases of fraud or inten-

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tional misrepresentation but must provide 30 days notice. Interim regulations provide that a rescission in coverage is to be treated as an "adverse benefit determination" and is subject to the rules regarding denied claims.

Emergency Services

On and after September 23, 2010, group health plans and health insurance issuers that provide emergency service benefits must not require pre-authorization or impose different cost-sharing amounts for out-of-network emergency service providers. Recently issued interim regulations regarding this provision provide a detailed description of the cost-sharing analysis.

Preventive Care

Another new provision regards preventive care. As of September 23, 2010, group health plans and health insurance issuers must provide coverage for preventive care and permit the selection of primary care providers. For all plans and issuers that are not grandfathered, this care must be provided without any cost-sharing to the enrollee, provided that the care is rendered by in-network providers. A current list of preventive care services may be found at http://www.healthcare.gov. It includes coverage for various types of vaccines, including the flu vaccine, and screening for a wide variety of medical issues and conditions, such as various types of cancers and infections, obesity, depression, diabetes, HIV and osteoporosis.

Coverage for Adult Children

Considerable media attention has been paid already to a new provision regarding coverage for adult children. As of September 23, 2010, group health plans and health insurance issuers are required to provide coverage for adult children up to age 26, including married adult children. Both married and unmarried children qualify for this coverage. It applies to existing employer plans unless the child has an offer of coverage through another employer. Although many group health plans and health insurance issuers have been doing so already, as of September 23, 2010, this action becomes mandatory, not voluntary.

Pre-Existing Conditions for Children Under 19

As of September 23, 2010, group health plans and health insurance issuers are prohibited from implementing exclusions for pre-existing conditions for children under age 19. This prohibition extends even to grandfathered plans and issuers, except for issuers of stand-alone retiree-only health plans in the private market.

Claim Appeals Procedures

On or after September 23, 2010, group health plans and health insurance issuers must establish an internal claims appeals procedure that includes an external review process. The external review will be done by an independent entity and the health plan or issuer will pay the costs.

Recently issued interim regulations modify existing Department of Labor regulations regarding claims and appeals procedures for employee benefit plans. Most significantly, if a plan fails to strictly comply with the new requirements regarding the claims appeals procedure, the claimant will be deemed to have exhausted his or her administrative remedies and be permitted to seek judicial review. In addition, if a claimant's internal appeal is denied, the interim regulations provide guidance on the external review process. For self-insured plans, a federal external review process may apply if the applicable state has not adopted an acceptable external review process.

What If Your Plan is "Grandfathered"?

Certain health plans are considered "grandfathered" plans under the PPACA, and may be subject to less than all of the above required changes. Grandfathered plans are those plans that were in existence as of March 23, 2010 (the date of enactment of the PPACA). Recently issued interim regulations provide details regarding when a plan has grandfathered status, a highly nuanced topic beyond the scope of this overview.

Grandfathered plans must comply with certain of the requirements under PPACA, including:

1. prohibition on pre-existing condition exclusions;
2. coverage for adult children under the age of 26 (except for adult children eligible for employer-sponsored coverage);
3. restrictions on annual and lifetime limits for "essential health benefits";
4. prohibition on rescissions of coverage except in cases of fraud or intentional misrepresentation and prohibition on cancellation of coverage without prior notice;
5. for flexible spending accounts, over-the-counter drugs no longer qualify for reimbursement;
6. health insurance companies offering group health insurance must provide an annual report on the percentage of premiums spent on non-claims, and if the amount spent on non-claims exceeds a certain percentage, the insurance company must provide an annual rebate to all enrollees; and
7. advance notice of material plan modifications.

Changes That Take Effect as of January 1, 2011

Finally, as of January 1, 2011, employers that sponsor health care plans will be required to report the aggregate cost of health care coverage on employees W-2 forms. The aggregate cost is to be calculated using the cost of coverage rules in COBRA. Employers should be prepared to provide this information for former employees in cases in which the employee receives continuation health care coverage. While employers should maintain their records throughout 2011 with this requirement in mind, its impact will not be felt until early 2012, when the W-2s for the 2011 tax year are due.