

Health Care Brief

Health Care Reform Overview



HealthCare Benefits
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Explaining Health Care Reform

Since the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010, it has been the number one topic on the minds of many Americans. This legislation, coupled with the Health Care and Education Reconciliation Act of 2010, will have a landmark effect on how health care benefits are purchased and delivered in the U.S.

Over the past few years, business owners and their employees have grappled with trying to understand all facets of this legislation to determine how it will affect both their organizations and their households. While this legislation continues to face challenges that may impact the timing and implementation of certain provisions, it is necessary to review, understand and address the provisions that must be implemented now and over the next several years. Additional current information and updates on the Affordable Care Act Regulations, including frequently asked questions, are available at <http://www.dol.gov/ebsa/healthreform/>.

In an effort to provide some clarity around this complex legislation, this *Health Care Brief* is designed to provide an overview of the key reform provisions and their associated timeline for implementation.

Disclaimer: This summary is provided as general guidance of the provisions affecting group employer health plans as a result of Health Care Reform. It is a general overview of the regulations as we understand them today. It does not address all of the provisions applicable to employers and is not intended to be legal or tax advice. Additional guidance and regulations are expected in the coming months.

Changes: Effective Dates (as originally passed in PPACA)

Effective September 23, 2010 (six months after the legislation's enactment)

- Coverage for Adult Dependents
 - A group health plan must provide coverage for an adult child until the child's 26th birthday. This provision applies even if the child is married, but coverage is not extended to the adult child's spouse or child(ren).
 - The provision also applies to the stepchildren and foster children of your employees.
 - The only condition which makes an adult child ineligible for coverage to age 26 is if they are eligible for other employer sponsored coverage (and the group plan is grandfathered). The exception for grandfathered plans expires January 1, 2014.
 - Children who qualify must be given an opportunity to enroll continuing for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided no later than the first day of the first plan or policy year beginning on or after September 23, 2010.
 - The benefits provided under this provision must be the same as those available to similarly situated individuals who did not lose coverage because of loss of dependent status and the adult child cannot be required to pay more for coverage than those similarly situated individuals.
 - For a fact sheet on this provision, see the DOL web site:
<http://www.dol.gov/ebsa/newsroom/fsdependentcoverage.html>.
 - Frequently asked questions are available at:
<http://www.dol.gov/ebsa/faqs/faq-dependentcoverage.html>.
- Change in definition of Adult Dependent for purposes of tax free health coverage
 - Effective March 30, 2010, the definition of "dependent" for purposes of tax free health coverage has been expanded to include a child who will not turn age 27 during the year, regardless of whether they would otherwise qualify as a tax dependent.
 - For this purpose, the definition of "child" includes children, stepchildren, adopted children and eligible foster children.
 - This may impact health flexible spending accounts (FSAs) or health reimbursement accounts (HRAs).
- Lifetime coverage limits on the dollar value of coverage may not be established.
- Pre-existing condition limitations may not be imposed for children under age 19.
- Coverage rescissions are not permitted, except in cases of fraud or intentional misrepresentation.
- "Unreasonable" annual limits on the dollar value of "essential health benefits" may not be established ("Unreasonable" to be defined by HHS).
 - Annual and lifetime limits on certain "specific", or non-essential, benefits may be permissible, such as physical therapy.
 - The interim rules clarify that restriction on annual limits does not apply to health flexible spending arrangements (FSAs), medical savings accounts (MSAs), or health savings accounts (HSAs).

- The interim rules will phase out the use of annual dollar limits over the next three years until 2014 when the Affordable Care Act bans them for most plans. Plans issued or renewed beginning September 23, 2010 will be allowed to set annual limits no lower than \$750,000. This minimum limit will be raised to \$1.25 million beginning September 23, 2011, and to \$2 million beginning on September 23, 2012. These limits apply to all employer plans as well as all new individual market plans. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.
- Tax Credits to Small Group if you meet the following criteria:
 - < 25 Employees
 - < \$50,000 yearly wage
 - Employees contribute >50% of premium
 If the above conditions are met, a sliding scale credit of up to 35% is given (25% if tax exempt).
- Employers with more than 200 employees must automatically enroll new full-time employees and provide a notice to employees regarding their right to opt-out. The law is silent as to the effective date of this requirement. It will be effective once regulations have been issued, which may be anytime from 2011 to 2014.

Effective January 1, 2011

- A national voluntary insurance program for purchasing long term care coverage was to be established. Employers could permit employees who wish to participate in the program to make contributions by means of a payroll deduction. They would create automatic enrollment procedures that would either allow workers to opt out or to choose to enroll and pay premiums. The CLASS Program technically became effective on January 1, 2011 and program details were to be established in October 2012. However, implementation of the CLASS Act was suspended on October 14, 2011, due to concerns about fiscal sustainability and affordability.
- Health Savings Account (HSA) distributions for non-qualified medical expenses will be taxed at 20%.
- Over the counter (OTC) drugs not prescribed by a doctor may not be reimbursed through a medical flexible spending account.
 - Merchants will be required to remove OTC drugs from their eligibility lists to ensure they cannot be purchased with a health FSA debit card.
- Health plans and health insurance issuers must begin providing a summary of benefits and coverage (SBC) originally no later than March 23, 2012. Both non-grandfathered and grandfathered plans will need to provide an SBC. An SBC is a concise document providing simple and consistent information about health plan benefits and coverage in plain language. Its purpose is to help health plan consumers better understand the coverage they have and, when selecting new coverage, to help them make apples-to-apples comparisons of different coverage options. On February 9, 2012, the Departments of Health and Human Services, Labor and Treasury released much-anticipated final guidance on the requirement for health plans and health insurance issuers to provide a summary of benefits and coverage to applicants and enrollees. The final regulations modify the proposed SBC guidance that was issued in August 2011.

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- Beginning on the first day of the first open enrollment period that begins on or after September 23, 2012, plans must provide the SBC to participants and beneficiaries who enroll or re-enroll for coverage during the open enrollment period.
- Beginning on the first day of the first plan year that begins on or after September 23, 2012, plans must provide the SBC to participants and beneficiaries who enroll for coverage other than through an open enrollment period, such as newly eligible individuals and special enrollees.
- Issuers must begin providing the SBC to plans on September 23, 2012.

Thus, calendar year plans with an annual open enrollment period that takes place before the start of the plan year will generally need to start providing the SBC on the first day of the open enrollment period for the 2013 plan year.

- Employers with 50 or more employees must report specific information regarding their health plan, waiting periods, lowest cost options, employer’s share of each option and names of full-time employees receiving coverage.

Effective January 1, 2012

- Health Plan W-2 Reporting Requirement
 - This provision will require employers to report the aggregate value of applicable employer-sponsored health insurance coverage on W-2’s.
 - Plans for which coverage costs must be reported under the new requirement include:
 - Medical plans.
 - Rx Drug plans.
 - Executive physicals.
 - On-site clinics if they provide more than de minimus care.
 - Medicare supplemental policies.
 - Employee assistance programs.

Coverage under dental and vision plans is included unless they are “stand-alone” plans.

Effective January 1, 2013

- The maximum annual contribution into a health FSA will be \$2,500.
 - This limit will be adjusted annually in accordance with the U.S. Consumer Price Index.
- Elimination of the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments

Effective January 1, 2014

- U.S. citizens & legal residents are required to have qualifying health coverage.
 - An individual without insurance will be required to pay an annual penalty of whichever amount is greater: \$95 for each uninsured adult in the household or 1% of household income over the filing threshold.
- Waiting periods for enrollment in coverage of no more than 90 days

- Employers with greater than 50 employees may face the following penalties:
 - \$2,000 per employee who has to obtain coverage from the health insurance exchange because the employer does not provide coverage
 - \$3,000 per employee if that employee obtains coverage through the health insurance exchange because the employer-provided coverage is not affordable
 - Not affordable is defined as: the plan's share of the cost is less than 60% of the actuarial value OR the employee's share of the premium is greater than 9.5% of income.

Effective January 1, 2015

- Any individuals without insurance will begin to face increased annual penalties. These penalties will be the greater of \$325 or 2% of household income over filing threshold.

Effective January 1, 2016

- Any individuals without insurance will face increased annual penalties. These penalties will be the greater of \$695, or 2.5% of household income.
 - Families will pay half the penalty for children, with a cap set at \$2,085 per family.

Effective January 1, 2018

- An excise tax will go into effect for high-value health plans (also being referred to as “Cadillac” plans). It will be a 40% tax for annual premiums exceeding \$10,200 for individuals and \$27,500 for family plans.

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Action Plan for Employers

Before the first plan year beginning on or after September 23, 2010

- If you offer health coverage for retirees who are not eligible for Medicare:
 - Determine any issues related to retiree plans as a result of Health Care Reform.
 - Apply for federal reinsurance program by the end of June 2010.
See the White House Fact Sheet on the Early Retiree Reinsurance Program (ERRP) at: <http://www.whitehouse.gov/the-press-office/fact-sheet-early-retiree-reinsurance-program>.
See interim final rule for additional guidance at: <http://edocket.access.gpo.gov/2010/pdf/2010-10658.pdf>.
Additional information on the subsidy program is available on the HHS website at: <http://www.healthreform.gov/>.
The ERRP will no longer accept applications after May 5, 2011, due to availability of funds, according to the Centers for Medicare & Medicaid Services (CMS).
- Review your medical benefit plans:
 - Determine which provisions require your plan to be amended, including adding coverage for adult dependents to age 26, removing lifetime coverage limits, eliminating rescissions, and eliminating preexisting condition exclusions for under age 19.
 - Consider whether your organization will change eligibility for other benefit plans (such as dental, vision, etc.) as a result of changes to medical plan.
 - Ensure there are no “unreasonable” annual limits on essential health benefits.
 - Evaluate whether it makes sense to stay grandfathered. Determine applicable effective dates for provisions that apply to grandfathered and nongrandfathered plans (both collectively bargained and noncollectively bargained plans).
- If (or when) you lose grandfathered plan status, review the following to ensure they are incorporated into your plan and procedures, if not already included:
 - Eliminate cost-sharing for certain preventive services as recommended by governmental agencies.
 - Prohibit discrimination based on salary for coverage or premiums as Internal Revenue Code (IRS) Section 105(h) will now apply to fully insured plans. The IRS issued a notice delaying the compliance date for these new nondiscrimination requirements until further guidance is provided. (Self-insured plans continue to be subject to prior non-discrimination rules).
 - Provide choice/direct access requirements allowing members to designate any participating primary care physician or pediatrician they choose.
 - Eliminate the requirement that female members must obtain a prior authorization to visit a participating obstetrician or gynecologist.
 - Eliminate the requirement for prior authorization for coverage or additional cost-sharing for emergency hospital services, regardless of whether the provider is in the plan’s network.
 - Put a new internal appeals/external reviews process in place for coverage determinations and claims decisions. To comply with the appeal and review mandate, group health plans will need to amend their plans, summary plan descriptions and other communications as well as work with their claims administrators to update any relevant procedures and claims response notices.

PPACA expands the appeals process and external review by changing the current Department of Labor claims procedures in several ways:

- Urgent care claims deadline is shortened to no more than 24 hours (previously was 72 hours).
 - Right to review file and present “testimony” automatically as part of appeal
 - Detailed new content requirements for denial notices:
 - Including diagnosis, treatment, and denial codes
 - Requirement to inform claimants of new evidence or rationales
 - Right to continue receiving coverage during appeal process
 - Regulations interpret this narrowly.
 - Conflict of interest criteria for decision makers
 - Rejection of substantial compliance rules A plan must strictly comply with rules.
 - Requires external review procedures that are binding on the plan New guidance is available at www.dol.gov/ebsa: Notice regarding federal external review procedures; three new model notices; Tech. Rel. 2010-01 regarding federal external review procedures.
 - Requirements for translated denial notices (if there is a minimum number of participants who are literate in only that language).
 - In Technical Release No. 2010-2, the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) provided an enforcement grace period until July 1, 2011, for some of the new standards required under the Patient Protection and Affordable Act (ACA) for health care internal claims and appeals and external review. In Technical Release 2011-01, the EBSA further extended the enforcement grace period until plans years beginning on or after January 1, 2012. The enforcement grace period is in response to some group health plans' and insurers' requests for more time to change plan or policy procedures and to modify computer systems in order to comply with the new interim final claims. Specifically, regarding the timeframe for making urgent care claims decisions, regarding providing notices in a culturally and linguistically appropriate manner, requiring broader content and specificity in notices and regarding substantial compliance, the Department of Labor and the Internal Revenue Service (IRS) will not take any enforcement action against a group health plan, and HHS will not take any enforcement action, during the grace period, against a self-funded nonfederal governmental health plan that is working in good faith to implement such additional standards but does not yet have them in place.
- If you offer a flexible spending account (FSA) or health reimbursement account (HRA):
 - You may immediately permit pre-tax salary reductions for coverage of the child of an employee if the child is under age 27 during the entire taxable year.
 - Your cafeteria plan must be amended on or before December 31, 2010. The amendment can be retroactive, but not earlier than March 30, 2010.
 - Amendments will depend on how the plan is currently drafted.
 - The new tax rule does not apply for Health Savings Account (HSA).
 - Perform cost analysis of employer health program options compliant with Health Care Reform.

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- Develop employee communications, as appropriate, for any changes to plans or processes. Revise/prepare applicable benefit materials including Plan documents, Summary Plan Descriptions, enrollment materials, statement of grandfathered status and so forth.
- For employers with 200 or more employees, continue to watch for guidance and regulations regarding automatic enrollment provisions. Evaluate and determine a procedure to meet this requirement. Develop employee communications and opt out procedures, when needed.

For Small Groups

- Take advantage of the Small Business Health Care Tax Credit. More information about the credit is available on the IRS web site at:
<http://www.irs.gov/newsroom/article/0,,id=220809,00.html>.
 A step by step guide can be found at:
http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf.
 For frequently asked questions:
<http://www.irs.gov/newsroom/article/0,,id=220839,00.html>.

Before January 1, 2011

- If your company currently takes an income tax deduction for the Medicare Part D retiree drug subsidy received from the federal government, address accounting issues relating to the elimination of these tax deductions beginning in 2013.
- If you offer an HSA, advise employees that distributions for non-qualified medical expenses from the plan will be taxed at 20%. Amend plan accordingly.
- If you offer an FSA or HRA, discontinue reimbursement of over the counter (OTC) drugs (with the exception of insulin) through HRAs and FSAs. Communicate this change to employees.
- Revise applicable benefit materials, including Plan documents, Summary Plan Descriptions, enrollment materials and so forth for plans beginning on or after 1/1/2011.
- Establish a procedure for reporting required health plan-related information to applicable governmental agencies.

For Small Groups

- Apply for federal grants to establish wellness programs.

Before January 1, 2012 and during 2012

- Though PPACA established a publicly administered, voluntary long-term care insurance program for purchasing community living services and support, effective January 1, 2011, the Secretary of Health and Human Services (HHS) originally had until October 1, 2012 to designate a benefit plan and publish the details of the Community Living Assistance Services and Supports (“CLASS”) program. In September, 2011, the government announced that it has shelved this program plan. In October 2011, the plans to implement this program were halted due to funding concerns.

- Health care reform law added a requirement that the aggregate cost of employer-sponsored health coverage be reported on an employee's Form W-2 beginning with the 2011 tax year. The aggregate cost of coverage under the plans (including both the employee and employer portions of cost) is determined under rules similar to COBRA minus the 2 percent administrative charge permitted under COBRA. The new reporting provision appears to require a monthly calculation of coverage.

However, the IRS has announced that reporting of this coverage will not be required on any Form W-2 issued for 2011 (i.e., for coverage received in 2011), in order to give employers additional time to make the changes to their payroll systems and procedures that are needed to comply with the new requirement. Instead, such reporting will be optional for 2011 and required for 2012 Form W-2s. A draft version of the 2011 Form W-2 has been released with new Code DD that employers may use to report the cost of employer-sponsored health coverage in Box 12. In March 2011, the IRS issued interim guidance on how employers will be required to inform employees of the cost of their “applicable” employer-sponsored group health plan coverage. On January 3, 2012, the IRS issued [Notice 2012-9](#), which replaced Notice 2011-28, and updated the interim technical guidance on the Form W-2 reporting requirement. The Notice also provides additional transition relief for certain employers, including smaller employers required to file fewer than two hundred and fifty 2011 W-2 forms. These small employers will not be required to report the cost of health coverage on any forms required to be furnished to employees prior to January 2014. The IRS also stressed that health coverage amounts reported on Form W-2 are not taxable, and that the purpose of the reporting is informational and will show employees the value of their health benefits so that they can be more informed consumers. More details can be found at <http://www.irs.gov/pub/irs-drop/n-11-28.pdf>.

- If your plan is non-grandfathered, the Department of Health and Human Services (HHS) issued additional preventive care guidelines for women in August 2011 and you will want to ensure these are included in your plan. These additional guidelines, which are generally effective for plan years beginning on or after August 1, 2012, require non-grandfathered health plans to cover women’s preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, a deductible or coinsurance. Ensure these provisions are included in your plan.
- Discuss with your health insurance provider how the summary of benefits and coverage (SBC) will be prepared and distributed in accordance with the revised effective dates beginning on September 23, 2012. In addition to the final regulations that were released on February 9, 2012, the Departments also provided a final template for the SBC (along with instructions, samples and a guide for the coverage example calculations to be included in the SBC) and the uniform glossary explaining terms commonly used in health coverage. The final regulations, template and uniform glossary are available through the Department of Health and Human Services at: <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.

Before January 1, 2013 and during 2013

- If you offer a Health FSA, amend the plan to limit contributions to a maximum of \$2,500 per year (subject to increase in CPI).
- Distribute summary of benefits and coverage (SBC) documents in accordance with final regulations (as previously noted).

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- Ensure you have an appropriate process in place to manage and administer the Form W-2 reporting requirement for W-2's issued for 2012.
- Revise applicable benefit materials including Plan documents, Summary Plan Descriptions, enrollment materials and so forth for plans beginning on or after 1/1/2013.
- By March 1, 2013, notify current employees about the availability of the exchange. (Notifications for new employees must be provided upon hire). This notification must include whether the employer's plan meets minimum coverage requirements and how to access information regarding premium subsidies that may be available through the Exchange.
- For employers with 200 or more employees, follow up on the status of the automatic enrollment provision, if not previously implemented.

Before January 1, 2014

- Communicate insurance reform changes to all employees, including individual coverage mandates, tax penalties and the phase-in of excise taxes for individuals without coverage.
- Review health plans to determine if they offer an essential benefits package.
- Consider whether your organization will change eligibility for other benefit plans as a result of changes to medical plan.
- For nongrandfathered plans, confirm required provisions will apply effective 1/1/2014. These include limits on out-of-pocket costs, deductibles of \$2,000 for individuals and \$4,000 for families, and eligibility waiting period of 90 days.
- For grandfathered plans, review provisions that must be included in plans as of 1/1/2014, including not allowing waiting periods in excess of 90 days and prohibiting a plan from including pre-existing condition exclusions for any participant. Ensure these provisions are incorporated into the plan.
- Evaluate applicability of federal tax assessment and voucher requirements, if any.
- Review Wellness Provisions. Determine whether to offer employee rewards of up to 30% (increasing to 50%) for participating in wellness programs and meeting certain health-related standards.
- Revise applicable benefit materials including Plan documents, Summary Plan Descriptions, enrollment materials and so forth for plans beginning on or after 1/1/2014.
- For employers with 200 or more employees, follow up on the status of the automatic enrollment provision, if not previously implemented.

Before January 1, 2018

- Determine whether your health plan is subject to the new excise tax (i.e. considered a high-cost plan).

Grandfathered Plans

WHAT ARE “GRANDFATHERED” PLANS?

A “grandfathered health plan” is any group health plan or individual coverage that was in effect on the date of the new law’s enactment on March 23, 2010. The grandfathering relief allows certain plans to avoid many, but not all, of the new rules. Collectively bargained multi-employer and single-employer plans in effect on March 23, 2010 are not subject to the reform rules until the date on which the last of the collective bargaining agreements relating to the coverage terminates.

WHICH PROVISIONS STILL APPLY TO GRANDFATHERED PLANS?

Several provisions that generally will apply to grandfathered plans effective for plan years beginning on or after September 23, 2010 include:

- Adding dependent coverage up to age 26 (until 2014, grandfathered plans may exclude children eligible for other employer coverage).
- Eliminating lifetime maximum limits on essential health benefits.
- Eliminating pre-existing conditions for children under age 19.
- Eliminating coverage rescissions.
- Eliminating annual dollar limits on essential health benefits except as permitted by the HHS.

WHAT ARE THE BENEFITS OF BEING “GRANDFATHERED”?

Some of the *benefits* of having your plan classified as a “grandfathered plan” include:

- Delayed effective date (2014) of the requirement to enroll adult children to age 26 who are eligible for other employer-provided medical coverage.
- Eliminating the requirement to provide coverage for specified preventive care with no cost sharing (i.e. co-pays or co-insurance).
- Plan does not have to eliminate the requirement that female members must obtain a prior authorization to visit a participating obstetrician or gynecologist.
- Plan does not have to eliminate the requirement for prior authorization for coverage or additional cost-sharing for emergency hospital services, regardless of whether the provider is in the plan’s network.
- Avoiding application of Internal Revenue Code Section 105(h) nondiscrimination rules to fully insured plans.

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Some of the *key requirements* that are effective for new plans and nongrandfathered plans renewed on or after 9/23/10 (these do not apply to grandfathered plans):

- Application of Internal Revenue Code Section 105(h). Employers with fully-insured group health plans were able to maintain different coverage with respect to certain highly-compensated employees because those group health plans were not subject to nondiscrimination rules. Those differences in coverage must now be revisited and revised to avoid nondiscrimination issues. Plans cannot base an employee's eligibility or continued eligibility on hourly or annual salary. (Self-insured plans continue to be subject to prior non-discrimination rules). The Internal Revenue Service (IRS) issued a notice delaying the compliance date for these new nondiscrimination requirements. This requirement was supposed to be effective for plan years beginning on or after September 23, 2010. However, the IRS notice delays the effective date of this requirement until after they issue guidance on how plans should apply the new nondiscrimination rules. Until that time, insured plans will not be sanctioned for failing to comply with the nondiscrimination rules.
- New and non-grandfathered policies must cover the full cost of preventive care as recommended by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children and adolescents and additional preventive care for women. A complete list of recommendations and guidelines related to preventive services can be found at <http://www.healthcare.gov/center/regulations/prevention.html>. Among the health care services covered by the new regulations are:

Preventive services. The U.S. Preventive Services Task Force rates preventive services, and those receiving a grade of A or B are covered under these rules, including (with some limitations) breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling. A list of covered preventive services for adults can be found at the government's [healthcare.gov](http://www.healthcare.gov) website.

Vaccines. Health plans will also be required to cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.

Pediatric care. Health plans must cover preventive care for children recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children up to age 21, including regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.

Prevention for women. Health plans must cover preventive care provided to women under the U.S. Preventive Services Task Force listed services in the new regulations, which includes anemia and infection screening for pregnant women, and breast cancer mammography screenings every 1 to 2 years for women over 40. In August 2011, the Department of Health and Human Services (HHS) issued additional preventive care guidelines for women. These additional guidelines, which are generally effective for plan years beginning on or after Aug. 1, 2012, require non-grandfathered health plans to cover women's preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, a deductible or coinsurance.

- The requirement that women be permitted to select an OB-GYN of their choice.
- The new rules for processing claim payment and coverage refusals through an independent appeals process. The new processes must include, at a minimum:
 - An internal appeals procedure.
 - Notices to plan participants (in appropriate languages for employees who do not speak English).
 - A process that allows an enrollee to review his or her file, present evidence and testimony as part of the process and continue to receive coverage pending the appeals process outcome.
 - An external review process that includes consumer protections under the Uniform External Review Model Act.

Some other provisions effective in 2014 for new plans and nongrandfathered plans:

- Coverage of routine patient care costs for participation in approved clinical trials
- Quality of care reporting to the HHS by covered employers

HOW WILL MY PLAN LOSE GRANDFATHERED STATUS?

The U.S. Department of Health & Human Services has recently released a Fact Sheet with information about “Grandfathered” Health Plans. See the full fact sheet at:

http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html

The following excerpt from this fact sheet deals specifically with the loss of grandfathered status:

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with State or other Federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits including:

- Coverage of recommended prevention services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

Under the Affordable Care Act, these requirements are applicable to all new plans, and existing plans that choose to make the following changes that would cause them to lose their grandfathered status.

Compared to their policies in effect on March 23, 2010, grandfathered plans:

- **Cannot Significantly Cut or Reduce Benefits.** *For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.*

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- **Cannot Raise Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20% of a hospital bill). Grandfathered plans cannot increase this percentage.
- **Cannot Significantly Raise Co-Payment Charges.** Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status.
- **Cannot Significantly Raise Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-to-5% so this formula would allow deductibles to go up, for example, by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- **Cannot Significantly Lower Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- **Cannot Add or Tighten an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- **Changing Insurance Companies.** The initial regulations stipulated that if an employer decided to buy insurance for its workers from a different insurance company, this new insurer would not be considered a grandfathered plan. This did not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements. Based on comments received, this provision was amended in November 2010 and is effective prospectively. Under the amended rules, a group health plan is allowed to change health insurance policies or carriers without losing grandfathered status, provided the plan continues to comply fully with the standards set forth in the original rule. The term "group health plan" applies the grandfather provision uniformly to both self-insured and insured group health plans.

REPORTING REQUIREMENTS FOR GRANDFATHERED PLANS

To maintain grandfathered status, a plan must include a statement in any plan materials provided to participants and beneficiaries describing the benefits provided under the plan. The statement must indicate that the plan believes it is a grandfathered plan within the meaning of the Patient Protection and Affordable Care Act (PPACA) and must provide contact information for plan beneficiaries to ask questions or make comments. Model language is available at www.dol.gov/ebsa. The plan must also maintain records documenting the terms of the plan that were in effect on March 23, 2010 and any other documentation needed to verify, explain or clarify its status as a grandfathered plan. These records must be made available for as long as the plan takes the position that it is a grandfathered plan.

For further assistance on this or other Human Resources and benefits issues, please contact HealthCare Benefits at (412) 697-7866 or visit our website at www.hcb-inc.com.

You may also contact Marisa Warford, Director, HR Consulting, directly at (412) 697-0923 or mwarford@hcb-inc.com.



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Disclaimer: This summary is provided as general guidance of the provisions affecting group employer health plans as a result of Health Care Reform. It is a general overview of the regulations as we understand them today. It does not address all of the provisions applicable to employers and is not intended to be legal or tax advice. Additional guidance and regulations are expected in the coming months.