

Legislative Update

Health Care Reform: Upcoming Plan Design Issues

KEY PLAN DESIGN ISSUES

Grandfathered Plans

Whether certain provisions of the health care reform law will apply to a group health plan depends on whether the plan is considered a “grandfathered plan.” A grandfathered plan is one that was in existence on March 23, 2010, the day the main legislation was passed. Certain health care reform provisions do not apply to grandfathered plans, even if they renew the coverage or allow new employees or current participants’ family members to enroll. It is unclear what could cause an existing plan to lose its grandfathered status, but additional guidance is expected. Special rules apply to collectively-bargained plans.



Retiree Reinsurance Program Available

The health care reform law established a reinsurance program to assist employers with the cost of providing coverage to early retirees. The program is set to begin by **June 23, 2010**, and will run through December 31, 2013, or until its \$5 billion in funding is exhausted. The Department of Health and Human Services is currently working to establish the application process, which is scheduled to be available in June 2010.

Extended Dependent Coverage

Effective for **plan years beginning on or after September 23, 2010**, group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage of children must make coverage available for adult children up to age 26, regardless of the child’s marital or student status. There is no requirement, however, to cover the child of a dependent child. **This requirement applies to both grandfathered plans and new plans.** However, until January 1, 2014, it only applies to grandfathered plans with respect to dependent children who are not eligible for coverage under another employer’s health plan. On and after January 1, 2014, the provision applies to all plans regardless of a dependent child’s eligibility for coverage under another employer health plan.

The health care reform legislation amended federal tax law, **effective March 30, 2010**, to allow employers to offer tax-free health insurance coverage to adult children of employees during those taxable years in which the children are age 26 or under for the entire taxable year. The Internal Revenue Service has issued [Notice 2010-38](#), which provides guidance on the tax benefits of this coverage. It also indicates that cafeteria plans may be amended retroactively to provide for this coverage as long as they are amended by **December 31, 2010**.

Prohibitions on Lifetime and Annual Limits

Effective for **plan years beginning on or after September 23, 2010**, group health plans and health insurance issuers offering group or individual health coverage may not establish lifetime limits on the dollar value of essential benefits. Group health plans may also not establish unreasonable annual limits. In 2014, all annual limits are eliminated. These prohibitions apply to new and grandfathered plans.

Elimination of Rescissions

Under the health care reform rules, plans will no longer be able to rescind coverage once an individual is covered under the plan. This change is effective for **plan years beginning on or after September 23, 2010** and applies to all plans (grandfathered and new). There are exceptions to this rule for situations involving fraud or intentional material misrepresentation. In the event that coverage will be cancelled, individuals must be given prior notice.

Pre-existing Condition Exclusions for Children Eliminated

Plans may not apply pre-existing condition exclusions to children under the age of 19, effective for plan years **beginning on or after September 23, 2010**. This rule applies to both grandfathered and new plans. Note that for plan years beginning on or after January 1, 2014, all pre-existing

condition exclusions will be prohibited.

Nondiscrimination Rules Apply to Fully-Insured Plans

Effective for **plan years beginning on or after September 23, 2010**, new fully insured plans must satisfy the requirements of Internal Revenue Code section 105(h)(2). That section provides that a plan may not discriminate in favor of highly compensated individuals as to eligibility to participate and that the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.

New Appeals Process Required

Effective for **plan years beginning on or after September 23, 2010**, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims, including internal and external review. This requirement applies to new plans only. The process must provide for notice of the process to enrollees and permit enrollees to review their file, to present evidence and testimony as part of the appeals process and to receive continued coverage pending the outcome of the appeals process.

Coverage Changes

Effective for **plan years beginning on or after September 23, 2010**, the health care reform law puts the following rules in place for new plans:

- Certain preventive care, such as immunizations and well-baby care, must be covered without cost-sharing requirements.
- If a primary care provider must be designated, each participant, beneficiary and enrollee must be able to designate any available participating primary care provider (including a pediatrician for children).
- Preauthorization or increased cost-sharing may not be imposed on emergency services (in or out of network).
- Preauthorization or referral may not be required for obstetrical/gynecological care.

Limits on Reimbursements for Over-the-Counter Medication

The health care reform law has revised the definition of "qualified medical expenses" for purposes of reimbursement from health FSAs and health reimbursement arrangements (HRAs), and distributions from Archer medical savings accounts (Archer MSAs) and HSAs. Under the new definition, qualified medical expenses include amounts paid for medicines or drugs **only if the medicine or drug is a prescribed drug** (determined without regard to whether the drug is available without a prescription) or is insulin. This means that money from these accounts cannot be used to pay for over-the-counter medications that do not have a prescription. The definition is effective **January 1, 2011**.

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