Health Care Reform: Summary of Mandates Affecting Traditional Group Health Plans

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Summarized below are some of the main changes to traditional group health plans mandated by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (together, "health care reform").

Employers should review the changes and consider the impact to their plans—for example, any changes in plan design and administration or employee communication materials.

Group health plans that were in effect on March 23, 2010, may qualify as "grandfathered plans" and, therefore, are not required to comply with certain health care reform mandates, as indicated below. An upcoming advisory will discuss the topic of grandfathered plans. Interim final rules on grandfathered plans are available **here**.

Changes Effective for Plan Years Beginning on or After Sept. 23, 2010	Applies to Grandfathered Plans?
Dependent coverage up to age 26 Plans providing dependent coverage must cover adult children up to age 26, regardless of whether the child is married, a student, a dependent, or residing at home. Plans must notify such adult children and provide a 30-day enrollment window. **See the U.S. Department of Labor's (DOL's) model notice.** See our advisory, "**Early Coverage of Adult Children: Compliance Traps for Employers**," for discussion of early compliance with this requirement.	**Yes,** although until 2014 grandfathered plans may deny coverage if adult child is eligible under another employer's plan.
No lifetime limits on "essential benefits" Lifetime limits on the dollar value of essential health benefits are prohibited. Plans must provide a 30-day special enrollment period for otherwise eligible individuals who have met the lifetime limit. **See the DOL model notice**.	**Yes**
Restricted annual limits on "essential benefits" Annual limits for essential benefits are prohibited for plan years beginning on or after Jan. 1, 2014. Prior to plan years beginning before Jan. 1, 2014, a plan may impose restricted annual limits on the dollar value of essential benefits, as determined by regulations.	**Yes**
No rescission of coverage Group health plans may not rescind an enrollee's coverage. Limited exceptions apply for the enrollee's fraud or misrepresentation.	**Yes**
No pre-existing condition exclusions Pre-existing condition exclusions are prohibited for children under age 19. For plan years beginning on or after Jan. 1, 2014, pre-existing condition exclusions are prohibited for all participants. Plans must continue to provide certificates of creditable coverage for participants losing coverage.	**Yes**

Code Section 105(h) nondiscrimination rules apply to insured plans Insured group health plans must pass the Code Section 105(h) eligibility and benefits tests that currently apply to self-insured plans.	**No**
Preventive care first-dollar coverage Employers may not impose cost sharing for certain preventive care, such as immunizations and well-baby care.	**No**
Designation of primary care practitioner/pediatrician Group health plans requiring designation of a primary care provider must permit participants to designate any available provider or, in the case of a child, any pediatrician. **See the DOL model notice**.	**No**
No preauthorization of OB/GYN permitted No preauthorization or referral is permitted for care from an obstetrician or a gynecologist. **See the DOL model notice**.	**No**
No preauthorization requirements for emergency services No preauthorization of emergency services is permitted, and plans must provide coverage for out-of-network providers (including no increased cost sharing).	**No**
Early Retiree Reinsurance Program The Early Retiree Reinsurance Program aims to reimburse health care costs for certain retirees. The U.S. Department of Health and Human Services (HHS) is accepting applications to certify plans: **See HHS's press release** and refer to our advisory, "**New Guidance Clarifies Early Retiree Reinsurance Program**."	**Yes**
Internal and external appeals process required The internal appeals process should incorporate DOL claims procedures. For external review procedures, insured plans must comply with the National Association of Insurance Commissioners' Uniform External Review Model Act or, in its absence, standards set by HHS. Self-insured plans must comply with HHS standards. Plans are also required to provide in a culturally and linguistically appropriate manner notices describing internal and external appeals, and any available assistance for enrollees.	**No**

Changes Effective for Plan Years Beginning on or After Jan. 1, 2014	Applies to Grandfathered Plans?
No waiting periods in excess of 90 days Waiting periods exceeding 90 days for enrollment are prohibited	**Yes**
Limits on annual cost-sharing Annual cost-sharing, including the annual deductible, may not exceed $5,950 for individual coverage and $11,500 for family coverage.	**No**
Limits on annual deductibles Annual deductibles may not exceed $2,000 for single coverage, and $4,000 for family coverage. Limits may be increased by amounts that are reimbursable under a flexible spending account.	**No**

Changes with Various Effective Dates	Applies to Grandfathered Plans?
W-2 reporting The value of an employee's employer sponsored health insurance coverage must be included on the employee's W-2. Reporting must begin with W-2s issued in 2012 for the 2011 tax year.	**Yes**
4-page summary of benefits By March 23, 2012, in addition to ERISA's SPD and SMM requirements, employees must be provided with a 4-page summary of benefits and coverage prior to enrollment or re-enrollment. HHS will issue guidance.	**Yes**
Auto-enrollment required for employers with more than 200 full-time employees Employers with more than 200 full-time employees must automatically enroll new full-time employees in one of the employer's health plans and must continue the enrollment of current employees. Employees may be enrolled in the lowest-cost option, after the plan waiting period, and must be able to opt-out of coverage. This change will be effective in accordance with (yet to be issued) DOL regulations.	**Yes**
Transparency disclosures Plans must make certain transparency disclosures to HHS covering, for example, claims payment policies and practices. The requirement will apply after HHS issues guidance.	**No**
Quality of care reporting Group health plans must submit an annual report to the Secretary of HHS addressing plan or coverage benefits and provider-reimbursement structures affecting quality of care. Regulations are expected to clarify when the report must be submitted.	**No**