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Health Care Reform: Current Status and Summary of Mandates Affecting Employer Sponsored Traditional Group Health Plans

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As most everyone knows, the U.S. Supreme court recently ruled (June 28, 2012) that the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (together, "Health Care Reform") is constitutional, but for some aspects that do not directly affect employer-sponsored group health plans. As a result Health Care Reform's changes remain relevant. Summarized below are some of the main changes to traditional group health plans.

Employers should review the changes and consider the impact to their plans, particularly any changes that may be required to plan design and administration, and 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.

This is one in a series of advisories on different aspects of health care reform. For other related advisories, please **see our health care reform news and publications page**.

The following are some of the main changes that are effective in 2012 or later.

Changes Effective in 2012	Applies to Grandfathered Plans?
W-2 reporting The value of the employee's health insurance coverage sponsored by the employer must be included on an employee's W-2. Reporting must begin with W-2s issued in 2013 for the 2012 tax year. Employers who issued fewer than 250 W-2s for the previous year are exempt.	**Yes**
4-page summary of benefits and coverage An initial 4-page summary of benefits and coverage (SBC) must be distributed to participants who enroll or re-enroll during open enrollment periods that begin on or after Sept. 23, 2012. Special rules apply for newly hired employees and special enrollees who enroll in coverage other than during an open enrollment period. Updated SBCs must also be distributed prior to plan changes.	**Yes**

Additional requirements for benefit denial notices Notices of benefit denials must be provided in a culturally and linguistically appropriate manner and include additional disclosures, including descriptions of internal and external appeals, and any available assistance for enrollees.	**No**
Tax on group health plans Group health plans must pay tax of $1 ($2 after September 30, 2013, and adjusted thereafter for inflation) multiplied by the number of "covered lives" under the plan. The employer pays the tax for self insured plans; the insurance company pays the tax for insured plans. Effective for plan years ending after September 30, 2012. The tax expires with plan years ending after September 30, 2019.	**Yes**

Changes Effective in 2014	Applies to Grandfathered Plans?
Employer shared responsibility (play or pay) A tax will be imposed on employers with 50 or more FTEs if they do not provide health coverage, or provide inadequate or unaffordable health coverage to their FTEs.	**Yes**
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**

No pre-existing condition exclusions Pre-existing condition exclusions are prohibited for everyone, not just children under age 19.	**Yes**

Change Effective in 2018	Applies to Grandfathered Plans?
Cadillac plan tax An excise tax of 40% will apply to the value of employer sponsored health coverage in excess of $10,200 ($27,500 for family coverage), indexed annually.	**Yes**

Changes With Various Effective Dates	Applies to Grandfathered Plans?
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. This change will be effective in accordance with (yet to be issued) DOL regulations, which will not be issued before 2014.	**Yes**
Nondiscrimination rules apply to insured plans Insured group health plans must pass eligibility and benefits tests that are similar to those that currently apply to self-insured plans**.** This change will be effective in accordance with (yet to be issued) IRS regulations.	**No**

The following are changes that are already effective.

Changes Already 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.	**Yes**, although until 2014 grandfathered plans may deny coverage if adult child eligible under their employer's plan.
No lifetime limits on "essential benefits" Lifetime limits on the dollar value of essential health benefits are prohibited.	**Yes**
Restricted annual limits on "essential benefits" Annual limits for essential benefits are prohibited for plan years beginning on or after January 1, 2014. Prior to plan years beginning before January 1, 2014, a plan may impose restricted annual limits on the dollar value of essential benefits, as determined by HHS 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 for children under age 19 Pre-existing condition exclusions are prohibited for children under age 19.	**Yes**
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 DOL model notice**.	**No**

No pre-authorization requirement for OB/GYN care No pre-authorization or referral is permitted for care from an obstetrician or a gynecologist. **See DOL model notice**.	**No**
No pre-authorization requirements for emergency services No pre-authorization of emergency services is permitted and plans must provide coverage for out-of-network providers (including no increased cost sharing).	**No**
Internal and external appeals process required The internal appeals process should incorporate DOL claims procedures. Expanded scope of claims is subject to the internal appeals process and plans must comply with expanded requirements for a full and fair review of claims and appeals. For external review procedures, insured plans must comply with the NAIC's Uniform External Review Model Act or, in its absence, standards set by HHS. Self-insured plans must comply with HHS standards.	**No**