The Impact of Health Care Reform on Group Health Plans

Congress recently passed and the President signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Bill of 2010, enacting wide-reaching health care reform. For purposes of this update, we refer to this legislation collectively as Health Care Reform. This update is a follow-up to the Health Care Reform update published on March 29, 2010. While the previous update provided a general overview of Health Care Reform, this update provides a summary of the key issues included in Health Care Reform which will affect employer’s group health plans over the next several years. While many of the Health Care Reform provisions are not scheduled to become effective for several years, certain changes are effective in the near future and will require immediate action on the part of employers with regard to their group health plans.

Group health plans in existence at the time Health Care Reform was enacted are “grandfathered,” meaning that they are exempt from certain of the Health Care Reform provisions. However, in the final version of Health Care Reform, the benefits of grandfathering were substantially reduced. It is widely believed that adding new employees to a plan does not jeopardize its grandfathered status. However, the extent to which a grandfathered plan may be amended without forfeiting grandfathered status is unclear. Under these circumstances, employers should be cautious about making plan design changes (beyond those required by the legislation) until definitive guidance is issued.

The following provisions will apply for plan years beginning six months after the enactment of Health Care Reform (January 1, 2011 for calendar year plans) unless otherwise indicated.

**Early Retiree Reinsurance Program**

Effective no later than 90 days following the enactment of Health Care Reform (i.e., June 21, 2010), a temporary reinsurance program will be created for employers providing health insurance coverage to retirees over age 55 but who are not eligible for Medicare. The program will reimburse participating employers for 80% of the cost of a retiree’s (or his or her spouse or dependent) medical claims between $15,000 and $90,000 (to be adjusted yearly). Payments from the reinsurance program must be used to lower the costs of the plan, including premiums, coinsurance and deductibles. This provision will terminate either in 2014 or earlier if the $5 billion appropriation has been fully utilized.

**Dependent Coverage Extended to Age 26**

Group health plans that provide dependent coverage for children must continue such coverage for the participant’s dependents until the child reaches age 26 regardless of the child’s marital or student status. Until January 1, 2014, grandfathered plans are not required to provide coverage to such dependents, if such dependent is eligible to enroll in another group health plan. After such date, all group health plans are...
required to provide such coverage regardless of a child’s eligibility for coverage under another employer’s plan.

**Pre-existing Condition Exclusions**

Group health plans (including grandfathered plans) will be prohibited from imposing any preexisting condition exclusions on plan participants who are under the age of 19. For all other group health plan participants (including participants in grandfathered plans) this prohibition will become effective beginning January 1, 2014.

**No Lifetime Limits**

Health Care Reform prohibits a lifetime limit on any participant or beneficiary for benefits which are considered “essential health benefits.”

**No Annual Limits**

A group health plan (including grandfathered plans) may not impose “unreasonable” annual dollar limits on essential health benefits. Beginning January 1, 2014, all group health plans will be prohibited from establishing annual limits on the dollar value of benefits for any participant or beneficiary.

**Prohibition on Coverage Cancellation**

Group health plans (including grandfathered plans) will be prohibited from retroactively cancelling health coverage except when the plan participant engages in fraud or intentional misrepresentation of material facts. In such limited instances, coverage may only be cancelled upon prior notice.

**Over-the-Counter Drug Prohibition**

Participants in flexible spending accounts, health savings accounts, or health reimbursement arrangements will no longer be permitted to use these accounts for pre-tax reimbursements of expenses incurred for over-the-counter items purchased without a prescription.

**Emergency Services**

Group health plans offering emergency service benefits must impose the same cost sharing requirements, including co-payment amounts or coinsurance rates, for services provided out-of-network as those for services provided in-network.

**Employer Reporting of Health Coverage**

The aggregate cost of an employee’s health coverage for each year will be required to be reported on the employee’s IRS Form W-2 (this affects W-2s issued beginning January, 2012). It appears that self-insured plans will compute the value of an employee’s coverage using rules similar to those used for COBRA continuation coverage.

**Required Claims and Appeals Procedures**

Group health plans (other than grandfathered plans) must implement new internal and external appeals and claims procedures. Plan participants must be provided with notice of the available internal and external appeals procedures and the availability of any state health insurance consumer assistance program that will assist plan participants with their appeals. During the appeals process, plan participants must be permitted to review their entire files, present evidence and testimony, and receive continued coverage pending the outcome of their appeal. External review processes must also comply with any applicable state laws (e.g., Uniform External Review Model Act) and standards established by the Secretary of Health and Human Services.

**Required Preventative Services**

Group health plans (other than grandfathered plans) must provide first-dollar coverage (i.e., no deductibles or copayments) for certain preventative care items including immunizations, child and adolescent health screenings, breast cancer screenings and mammograms.

**Expanded Disclosures**

Within twelve months of the enactment of Health Care Reform, group health plans will be subject to new
disclosure regulations regarding summary of benefits and coverage explanations to be issued by the Department of Labor. In general, these disclosures will need to be provided by the group health plan within 24 months of the enactment of Health Care Reform. In addition, employers will be required to notify participants of any material modifications to a group health plan at least 60 days prior to the effective date of such changes. A penalty of up to $1,000 per violation (treating each affected participant as a separate violation) may be imposed for failure to provide a group health plan summary or failure to timely provide a material modification notice.

Automatic Enrollment in an Employer Sponsored Health Plan

Effective upon the issuance of regulations by the Department of Labor, employers with more than 200 full-time employees will be required to enroll (subject to permitted waiting periods) new full-time employees automatically into health insurance plans (including grandfathered plans) offered by the employer. Employers must provide employees with adequate notice regarding the auto-enrollment and the opportunity to opt out of such coverage.

Notice of Coverage Options

Effective January 1, 2013, employers must provide written notice to employees of the existence of the state insurance exchange program and their right to purchase insurance through an exchange, the employee’s eligibility for a premium tax credit, and the implications with respect to employer contributions for those employee’s who elect coverage through an exchange program.

Flexible Spending Account

Beginning in taxable year 2013, individuals participating in a flexible spending account may contribute a maximum annual pre-tax amount of $2,500, adjusted annually for inflation, to use for health care expenses.

Employer Mandate

Although Health Care Reform does not require employers to provide health insurance coverage, beginning in 2014, an annual penalty of $2,000 per full-time employee will be assessed against large employers (i.e., employers with 50 or more full-time employees) who do not offer health benefits and who have at least one full-time employee enrolled in an insurance exchange receiving a premium tax credit. Large employers that offer "unaffordable" coverage will pay an annual penalty of $3,000 for each of their employees enrolled in an insurance exchange and obtaining subsidies to buy insurance. However, the first 30 full-time employees will not be included in either calculation. Employers with 50 or fewer full-time employees are exempt from the above penalties.

Vouchers

Effective as of 2014, employers who offer health coverage (and pay a portion of that coverage) will be required to provide free choice vouchers to employees whose household income does not exceed 400% of the federal poverty level and who do not participate in the employer’s health plan. An employee will qualify for the free choice voucher if the cost of his or her premium under the employer’s coverage is between 8%–9.8% of his or her household income. The voucher will equal the amount the employer would have paid on the employee’s behalf under the employer’s group health plan. The employer will not include the amount of the voucher in the employee’s compensation, but will be entitled to a deduction in the amount of the voucher. Employers providing free choice vouchers will not be subject to penalties for any month in which a qualifying employee receives premium credits in the exchange.

Waiting Periods

For plan years beginning on or after January 1, 2014, group health plans offering health coverage (including grandfathered plans) may not contain any waiting period in excess of 90 days.

Large Employer Reporting Requirements

Beginning in 2014, large employers will be required to file an annual report with the Department of Health and Human Services disclosing the health insurance coverage offered to full-time employees, and detailing the length of the waiting period, the premium for the lowest cost option, and the employer’s share of the total costs of benefits under the plan. Such report must also
include the names of all full-time employees receiving coverage.

**Wellness Programs**

Effective January 1, 2014, employers will be permitted to offer employees enhanced rewards (in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided) of up to 30% of the cost of employee-only coverage for participating in a wellness program and meeting certain health-related standards.

**Collective Bargaining Agreements**

Notwithstanding the effective dates described above, health plan coverage maintained pursuant to a collective bargaining agreement that was ratified before the date of the enactment of Health Care Reform will not be subject to the preceding changes until the date on which the collective bargaining agreement terminates.

The preceding changes will require that employers review and amend their plan documents, summary plan descriptions and enrollment materials. In addition, certain of these changes will require significant revisions to plans’ operational and administrative procedures.

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**Practice group contacts**

If you have questions regarding the information in this legal update, please contact the Dechert attorney with whom you regularly work, or any of the attorneys listed. Visit us at www.dechert.com/employeebenefits.

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