

Benefits Alert

August 2010

Coming To An Internet Portal Near You: Health Insurance Options

If knowledge is power, the Department of Health and Human Services (HHS) is under orders to empower everyone. Tucked into the health care reform law is a provision that requires the HHS, in consultation with the states, to launch an Internet portal through which small businesses and individuals can identify affordable health insurance coverage options. The HHS took this portal live on July 1, 2010.

DARE TO COMPARE

To facilitate comparisons, the portal must present information in a standardized format. To the extent practicable, the portal must provide information on at least the following coverage

options:

- Health insurance offered by issuers, other than insurance that provides reimbursement for a single disease or condition (e.g., cancer insurance) or an unreasonably limited set of diseases or conditions.

- Medicaid coverage.
- Coverage under the Children's Health Insurance Program, otherwise known as CHIP.

- A state established temporary high-risk pool, if such a pool exists in a state.

- The federally established temporary high-risk pool.

The HHS said that the portal's July 1 launch provides basic information on seven data points:

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- issuers' corporate addresses and websites;

- administrative information (e.g., enrollment codes, enrollment data by product, product names and types, such as Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO));

- whether enrollment is currently open for each product;

- geographic availability information (e.g., product availability by ZIP code or county);

- customer service phone numbers;



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It's Not Your Grandfather's Health Plan...Or Is It?

Certain provisions of the recently enacted health care reform law don't apply to so-called grandfathered group health plans — group plans in which employees and dependents were enrolled on March 23, 2010. Grandfathered plans, for example, don't have to cover employees' dependents until they turn 26, if those dependents can get coverage on their own. On the other hand, grandfathered plans can't rescind coverage (see the third article in this newsletter). But there is a point at which grandfathered plans can lose that status and must, therefore, comply with the law as a whole. Interim final regulations, effective June 14, 2010, cast the dividing line between when grandfathered plans can maintain that status and when they lose that status.

GRANDFATHERED PLANS

Grandfathered plans can

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Coming To An Internet Portal Near You... (cont.)

- website links to issuers' brochure documents, such as benefits summaries and provider networks; and

- financial ratings, such as those offered by AM Best, Standard and Poor, and Moody's.

The July 1 portal also includes information on the small group market, including information on the reinsurance program and the IRS's tax credit program. An updated web portal, to launch on October 1, 2010, will contain

voluntarily increase benefits, conform their plans to required legal changes, and adopt the health care reform law's consumer protection provisions without losing their status. Plans can also add new employees or dependents, but anti-abuse rules apply to prevent business transactions (e.g., a merger) whose principal purpose is to grandfather employees' coverage.

Grandfathered plans must include a statement in all plan materials that describes the benefits provided, and that the plan believes it's grandfathered. The regs contain model language for this purpose. Plans must also maintain records documenting the terms of the plan coverage that was in effect on March 23, 2010, and any other documents necessary to verify or clarify their status as grandfathered plans. These documents include intervening and current plan documents; health insurance

more detailed information, including benefits and pricing information — premiums, cost-sharing options, types of services covered, coverage limitations, and exclusions. The HHS anticipates updating the portal at least annually; however, the portal will be updated as frequently as monthly to reflect changes in issuers' pricing and benefits information. Surf to www.healthcare.gov for the portal. ❖

policies, certificates, or contracts of insurance; summary plan descriptions; documentation of premiums or the cost of coverage; and documentation of required employee contribution rates. These records must be available for inspection by any state or federal official or employee.

Grandfathered plans aren't off the hook entirely. Although they don't have to comply with certain provisions of the health care reform law, they must continue to comply with current health-related laws, including:

- The Health Insurance Portability and Accountability Act's portability and non-discrimination requirements
- The Genetic Information Nondiscrimination Act
- The mental health parity provisions
- The Newborns' and Mothers' Health Protection Act
- The Women's Health and Cancer Rights Act
- Michelle's Law

HOW PLANS LOSE THEIR GRANDFATHERED STATUS

New group plans and policies entered into after March 23, 2010, aren't grandfathered. *Upshot:* Plan sponsors of fully insured plans must renew the coverage (i.e., they must keep the same issuer) they had on March 23, 2010, to maintain grandfathered status. The grandfathering rules apply separately to each benefit package in a group plan, so some packages could be grandfathered and others not.

Plans lose their grandfathered status if they eliminate all or substantially all benefits related to a particular condition

Regs Implement Health Care Reform Law's Consumer Protections

Interim final regulations, effective for plan years beginning September 23, 2010 (January 1, 2011, for calendar year plans), implement the health care reform law by establishing a so-called Patient's Bill of Rights. Under the regs, group health plans and health insurers can't place dollar limits on the value of essential benefits; employees must be allowed to choose their own in-network physicians; and many restric-

tions on seeking emergency care have been eliminated.

PROVISIONS APPLICABLE TO ALL PLANS

Prior regs, which are discussed in the second article in this newsletter, set the parameters for grandfathered group plans. These regs build on that prior release. Understanding how the two sets of regs fit together is key, since grandfathered plans don't have to comply with significant

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It's Not Your Grandfather's Health Plan...Or Is It? (cont.)

(e.g., a plan eliminates all benefits for HIV/AIDS, even though it's an infrequently used benefit). Likewise, a plan loses its status if it eliminates benefits for any element necessary to diagnose or treat a condition (e.g., a plan eliminates counseling, but maintains drug coverage for employees suffering from depression).

Health plans often increase employers' and employees' costs. With the exception of premiums, which plans are allowed to raise, you should pay particular attention to cost increases, since under the regs, the other way plans forfeit their grandfathered status is by raising costs above certain levels. Cost increases are measured from March 23, 2010.

- Plans lose their status if the employer's contribution decreases by more than 5%.

- Plans that increase employees' co-insurance percentage automatically lose their

status.

- Plans can make minor adjustments to deductibles and co-pays, but *significant* changes imperil plans' status. For *deductibles* and *annual out-of-pocket costs*, an increase causes a loss of status if the total percentage of the increase exceeds the rate of medical inflation, plus 15%. For *co-pays*, an increase causes a loss of status if the total increase exceeds \$5 adjusted upward by the rate of medical inflation (\$5 times the medical inflation rate, plus \$5), or a percentage using the rate of medical inflation, plus 15%, whichever is greater.

Plans that change overall annual or lifetime limits on essential benefits lose their status if: (1) plans impose an overall annual limit on the dollar value of essential benefits, when no overall annual limit or lifetime limit was previously imposed; (2) plans that impose an overall lifetime limit on the dollar

portions of these regs. This portion of the regs applies to all group health plans, *including* grandfathered plans. You should review your plan now to ensure that it will be in compliance.

- **No pre-existing conditions exclusions for children under 19.** The prohibition against denying coverage to children based on their pre-existing conditions includes benefit limitations (e.g., refusing to pay for chemotherapy because a child had cancer before the employee joined the plan), and outright denials of coverage. *Note:* This provision will be extended to *all* participants, regardless of

value of essential benefits, but no overall annual limit, adopt an overall annual limit that's lower than the lifetime limit; and (3) plans that impose an overall annual limit decrease the dollar value of that limit, regardless of whether an overall lifetime limit applies. *Note:* For plans that currently use annual limits, the consumer protection provisions allow for limited increases in annual limits.

Transition rules apply to plans that had plan or benefit changes pending as of March 23, 2010. In addition, for enforcement purposes, plans that make a good-faith effort to comply with a reasonable interpretation of the law may disregard changes to the plan's terms that have a modest impact on costs. Grandfathered plans have a grace period within which to revoke or modify any changes adopted prior to June 14, 2010, where the changes would cause the plan to lose its status. ❖

Regs Implement Health Care Reform Law's Consumer... (cont.)

age, starting with the 2014 plan year.

- **No rescissions of coverage.** Group plans can't rescind coverage, except in cases of fraud or an intentional misrepresentation of material facts. Plans must provide at least 30 days' advance notice to allow participants time to appeal or to find other coverage. Future cancellations or non-renewals of group policies aren't rescissions. For example, an employee loses coverage when he's moved to part-time status. Due to an oversight, he retains his health benefits. The plan may cancel his coverage prospectively, but can't rescind it retroactively to the date he became a part-time employee.

- **No lifetime limits on the dollar value of coverage.** Group plans can't impose lifetime limits on the dollar value of essential health benefits, as defined in the health care reform law (e.g., ambulatory patient services, emergency services, maternity and newborn care). Participants who have already reached their lifetime limits must be provided notice that the limits no longer apply, and that they're eligible to re-enroll in the plan. Participants then have a 30-day special enrollment period. Participants who re-enroll can't be charged more than similarly situated participants who didn't reach their lifetime limits. The notice and enrollment opportunity must be provided beginning on the first day of the first plan year beginning September 23, 2010. Notice and re-enrollment apply sepa-

rately to employees and their dependents. *Catch:* Health flexible spending accounts, health savings accounts, and health reimbursement accounts are exempted from this provision. Also, excluding all benefits for a medical condition isn't considered an impermissible limit.

- **Limited annual limits on the dollar value of coverage.** Grandfathered plans lose their status if they lower an annual limit or impose an overall annual limit on the dollar value of essential benefits, when no overall annual limit or lifetime limit was previously imposed. Until the 2014 plan year, plans that already have annual limits must impose these restricted annual limits: \$750,000 for plan years beginning September 23, 2010; \$1.25 million for plan years beginning September 23, 2011; and \$2 million for plan years beginning September 23, 2012. Plans can use higher maximums, if they choose. Plans that currently have lower annual limits than \$750,000 can seek waivers if they can show that there would be a significant increase in premiums or loss of coverage if they were to raise the limit. *Same catch:* Excluding all benefits for a medical condition isn't considered an impermissible limit.

PROVISIONS APPLICABLE TO NEW PLANS

This portion of the regs applies to new group health plans and to grandfathered plans that lose their status. Grandfathered plans can voluntarily adopt these provisions without losing

their status.

- **Choosing in-network doctors.** Group plans that require participants to designate a primary care physician, including pediatricians and gynecologists, must allow participants to choose any available in-network provider. Women don't need referrals to see their in-network gynecologists. The right to choose an in-network pediatrician or gynecologist extends to non-physicians who are authorized to practice under state law. Plans must provide participants with notice, and the regs contain model language for this purpose. Notice must be provided with a summary plan description. *Catch:* Plans can still require referrals and prior authorizations for specific services and can exclude coverage for specific conditions (e.g., food allergies).

- **Emergency services.** Participants can go to any in-network or out-of-network hospital without prior authorization to receive emergency care. *Catches:* Deductibles and out-of-pocket maximums that apply to out-of-network providers in general continue to apply to out-of-network emergency services. And while the regs prohibit plans from charging higher co-pays or co-insurance for an out-of-network hospital, out-of-network hospitals can still balance bill. The regs contain a formula for determining the amounts plans must pay before participants become liable for balance billing. Also, plans can still require notification after services are provided. ❖