Group Health Plans Face More Changes Under the Affordable Care Act

On June 28, 2012, the U.S. Supreme Court issued its much-anticipated decision that upheld nearly all of the provisions of the Patient Protection and Affordable Care Act (PPACA). PPACA imposed many new requirements designed to expand the scope of coverage and benefits offered to employees and their dependents through group health plans. Many of the new requirements for group health plans were effective within the first year of PPACA's enactment. But PPACA will continue to unfold as federal agencies issue regulations and other guidance to implement additional provisions. This article summarizes the PPACA provisions already in effect for group health plans, and describes the provisions that plans must implement within the next few years. **PPACA Provisions Currently in Effect** Group health plans were required to comply with the following PPACA requirements effective with the first plan year that began on or after September 23, 2010:

- Lifetime and annual limits. With respect to benefits classified as essential health benefits (EHBs) a plan may not impose a lifetime limit on the dollar amount of benefits for any individual, and annual dollar limits are phased out over approximately three years. A plan's annual limits on essential health benefits may not exceed $750,000 for plan years beginning on or after September 23, 2010; $1,250,000 for plan years beginning on or after September 23, 2011; and $2,000,000 for plan years beginning on or after September 23, 2012 and before January 1, 2014. See below for a discussion of the scope of essential health benefits.
- Dependent coverage. If a plan covers employees' dependents, it must cover dependents until age 26. A plan must define a dependent based solely on the parent-child relationship (i.e., the definition may no longer consider whether a child resides with an employee or is a full-time student). However, plans grandfathered under the PPACA may exclude an adult dependent who is eligible to enroll in employer-sponsored health plan coverage other than through a parent.
- Restrictions on rescissions. A plan may not rescind the coverage of an individual once the individual is covered, unless the individual commits fraud, makes an intentional misrepresentation of a material fact, or fails to pay required premiums.
- Pre-existing conditions for children. A plan may not impose a pre-existing condition exclusion on any participant under age 19.

Additionally, group health plans that do not meet the definition of a grandfathered plan under PPACA are subject to the following requirements:

- Preventive services. A plan must cover certain designated preventive services with no copayment, coinsurance, or deductible if delivered by an in-network provider.
- Emergency services. A plan that covers emergency services must do so without requiring prior authorization and regardless of whether a provider is in-network.
- OB/GYN services. A plan may not require prior authorization for female participants to access OB/GYN care.
- Designation of primary care providers. A plan may not restrict a participant's designation of a primary care provider, and must allow children to designate an in-network pediatrician as a primary care provider.

- Internal claims and appeals processes. A plan must implement an effective internal appeals process of coverage determinations and comply with any applicable state external review process.

Upcoming Changes for Group Health Plans The following PPACA provisions will be effective for group health plans within the next year:

- Preventive services. The preventive services required to be covered by non-grandfathered plans will be determined by recommendations and guidelines published by various federal agencies within the Department of Health and Human Service (HHS). When the guidelines are changed, a group health plan is required to adjust its coverage accordingly effective with the plan year that begins one year after the new guidelines are effective. New guidelines for women's preventive services were published on August 1, 2011, which means that group health plans must cover the newly recommended services effective with the first plan year beginning on or after August 1, 2012.

- Summary of Benefits and Coverage. Effective with the plan year beginning after September 23, 2012, a plan must provide participants with a Summary of Benefits and Coverage (SBC). The SBC document that summarizes key provisions of the plan and presents the information in a standardized form designated by HHS. Plans subject to ERISA must provide the SBC in addition to the plan's Summary Plan Description (SPD). However, the SBC may be provided as a stand-alone document or in combination with other summary materials, including the SPD.

The following PPACA requirements will be effective with the first plan year beginning on or after January 1, 2014:

- Annual limits. Annual limits will be fully phased out, so that a plan may not impose an annual limit on the dollar amount of essential health benefits provided to any individual.

- Pre-existing conditions for adults. A plan may not impose any pre-existing condition exclusions.

- Waiting periods. A plan's waiting period for new participants may not exceed 90 days.

- Discrimination based on health status. A plan may not set eligibility rules based on certain health status factors, including medical condition, claims experience, or genetic information. However, a plan may provide premium discounts or rebates or modify copayments or deductibles for participants who participate in a wellness program that meets certain requirements, including a wellness program that requires individuals to satisfy a health-related standard.

- Coverage of essential health benefits. Non-grandfathered, fully insured plans in the small group market must cover all benefits that are designated as essential health benefits. A plan is in the small group market if the employer that sponsors the plan employed 100 or fewer employees in the prior year.

- Limits on cost-sharing. A plan's cost-sharing requirements, which include deductibles, copayments, co-insurance, and other similar charges, cannot exceed an amount equal to the maximum deductible amount permitted for a "high-deductible health plan" as defined by the Internal Revenue Code. For self-only coverage in 2012, that amount is $6,050. For coverage other than self-only coverage in 2012, that amount is $12,100. Both amounts are subject to an annual increase for inflation. These limits do not apply to premiums, balance billing amounts for non-network providers, or spending for non-covered services. Additionally, annual deductibles for plans in the small group market generally cannot exceed $4,000 (or $2,000 for a plan that covers a single individual). These amounts are also subject to an annual increase for inflation.

Awaiting Further Guidance Two key PPACA provisions that affect group health plans require further guidance from federal agencies before they are fully implemented. **Nondiscrimination in benefits and**

eligibility Non-grandfathered, insured group health plans must comply with a set of nondiscrimination rules that previously applied only to self-insured medical reimbursement plans. These rules provide that an applicable plan may not discriminate in favor of “highly compensated individuals” with respect to benefits or eligibility to participate in the plan. HHS, the Department of Labor, and the IRS have solicited public comments on various issues that future agency guidance should clarify, including the scope of nondiscriminatory “benefits” under a group health plan, the possibility of disaggregating a plan that covers employees in different geographic locations, and the application of these rules after the state health insurance exchanges and premium tax credits for individuals are available. The agencies stated that the nondiscrimination requirements will not be effective until further guidance is issued. **Essential health benefits** Despite that group health plans were required to apply the concept of EHBs as early as September 23, 2010 with respect to lifetime and annual limits, the scope of EHBs have still not been fully defined. PPACA requires HHS to define EHBs so that the scope of EHBs is equal to the scope of benefits provided under a “typical employer plan,” as determined by HHS. However, PPACA also provided that EHBs must include items and services within ten wide-ranging categories, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, and pediatric services. However, PPACA required HHS to define EHBs. On December 16, 2011, an HHS division issued a bulletin stating that HHS intends to let each State define EHBs by selecting a benchmark plan from a list of plans HHS believes best reflect a typical employer plan. The anticipated list of benchmark plans includes, for example, any of the largest three State employee health benefit plans by enrollment, and the largest insured commercial non-Medicaid HMO operating in the State. HHS acknowledges that one or more of the available benchmark plans may not cover all ten of the required EHB categories. A State that chooses one of these benchmark plans must supplement the benchmark plan to cover each of the ten categories. Despite that federal agencies have not yet issued this anticipated guidance, States are expected to select a benchmark plan for 2014 by the third quarter of 2012. If a State does not select a benchmark plan, HHS anticipates that the default benchmark plan will be the largest plan by enrollment in the largest insurance product in the State’s small group market, although HHS did not say when the default selection would apply to a State that fails to designate a benchmark plan. While some states have already designated their benchmark plans, it is likely that most States will not act until HHS has issued the anticipated guidance. The complexity and broad scope of PPACA will continue to present compliance challenges for group health plans into the future. If you have questions about any PPACA requirement or the impact of PPACA on your group health plan, please do not hesitate to call us at 816-421-4460.