Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform ~ 9/23 Requirements

Issued: 9/13/2010

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Overview

In the six months since the passage of the Patient Protection and Affordable Care Act (PPACA) one thing has become abundantly clear...the law is both confusing and complex. Many of the provisions in the law will not take effect for several years and the laws and regulations for these provisions are still being developed. As changes and clarification become available, we will continue to update you with information and the implications of the state and federal mandates.

We are now experiencing the first wave of federal requirements for Reform.

New requirements take effect for plans beginning on and after September 23, 2010

The following changes impact all plans on their effective dates, or upon renewal - whether they are grandfathered or not:

- Members can add dependents up to age 26, regardless of student or marital status.
- Pre-existing exclusions for members under age 19 are removed.
- Lifetime limits are eliminated.
- Certain annual dollar limits are removed.
- Coverage changes (fraud or intentional misrepresentation) are rescinded

For plans that are not grandfathered, the following changes are also required:

- Removal of member cost sharing for in-network preventive benefits, as defined by the law.
- New internal claims appeal and external review processes.
- Patient protections - primary care physician selection, direct access to OB/GYN services, emergency services

For plans that are grandfathered:

- A subscriber can add a new family member to a grandfathered plan.

Grandfathered Plans

A grandfathered group health plan is a plan which was in effect on 3/23/2010, complies with disclosure and recordkeeping requirements, and has not made any plan changes that would cause grandfathered status to be lost. Voluntary compliance with any of the health care reform requirements will not take away your plan's grandfathered status if you choose to maintain it. (Please not that Optima will NOT be grandfathering any plans.)

Several things can cause a product to lose its "grandfather" status, including but not limited to:

- Choosing to significantly reduce benefits
- Increasing out-of-pocket spending for employees
- Changing from one insurer to another.

The federal rules (published 6/17/2010), which include examples to illustrate their application, can be found at the following internet link: http://www.hhs.gov/ociio/regulations/grandfather/index.html

We encourage you to review these requirements with your legal advisor and benefit consultant in deciding whether you wish your plan to have grandfathered status. If you wish your plan to be grandfathered, you must provide notice that you believe it is grandfathered under the Affordable Care Act.

Can a group make changes to its current benefit plan and maintain its grandfathered status?

Certain limited benefit changes allowed within the legislation and interim final regulation do not impact grandfathered status, but there are very few situations in which an alternative standard plan complies. As a result, only large groups that are eligible to customize their benefits will be allowed to change their benefits and retain grandfathered status if the changes are within the level of changes allowed by the legislation. Other changes allowed according to the interim final rules are:

- Changes in premiums of a policy or plan
- Changes required to comply with federal or state law
- Changes to increase benefits or voluntarily comply with provisions of the Patient Protection and Affordable Care Act
- Changes to plan structure, for example, switching from a health reimbursement arrangement to major medical coverage, or from insured to self-funded coverage
- Changes to a provider network
- Changes to accommodate mergers and acquisitions (as long as the merger or acquisition is not done solely to allow a group to move from one grandfathered plan to another when the plan change would reduce benefits or increase cost sharing in excess of that allowed by the regulations)
- Changes to a self-funded plan's third-party administrator

What changes would cause a group to lose grandfathered status?

Groups that are not eligible to customize their benefits will not be allowed to change benefits and retain grandfathering status. For a group that is eligible to customize benefits, the following changes would cause a loss of grandfathered status:

- Eliminate all (or substantially all) benefits to diagnose or treat a particular condition.

Grandfathered Plans Continued

- Increase coinsurance (or another percentage cost-sharing requirement) above the level that was set on March 23, 2010.
- Increase fixed-amount cost-sharing requirements other than copayments, such as a deductible or an out-of-pocket limit, by a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15%.
- Increase copayments above the level in effect on March 23, 2010, by an amount that exceeds the greater of (a) the sum of medical inflation plus 15%, or (b) $5 increased by medical inflation.
- Reduce employer contributions (calculated by cost or formula, such as hours worked) toward any tier of group health insurance coverage or a group health plan by more than 5% below the contribution rate on March 23, 2010.
- Impose an annual limit on the dollar value of benefits if an annual or lifetime limit had not been previously imposed on all benefits or, for plans that previously imposed a lifetime limit on all benefits, impose an overall annual dollar limit that is lower than the lifetime limit, or, for plans that previously imposed an annual limit on all benefits, decrease the dollar value of the annual limit.
- Issuer or plan sponsor does not disclose to participants and beneficiaries that the plan or coverage is a grandfathered health plan.
- Change from one insurer to another.

If a group commits to making a change after March 23, 2010, can the group change back?

According to the interim final regulations, it appears that groups that have changed benefits between March 23, 2010, and June 14, 2010, may have the opportunity to revoke or modify the changes and regain grandfathered status at their next renewal date in 2011.

Do employers now need to provide an external appeal process?

The health care reform law includes requirements for internal claims and appeals, and external reviews for fully insured and self-funded non-grandfathered plans. The law says that a plan must, at a minimum:

- Have an internal claims and appeals process.
- Provide notice of an external appeals process.
- Allow an enrollee to review his or her file, present evidence during the appeals process and continue to receive coverage pending outcome.
- Implement an external review process.

What will this mean for you?

- Under these rules, if your health plan denies coverage of a test - for example an MRI - you and your doctor can appeal that decision to the plan and, if the plan still refuses to cover the test, to an external reviewer. If the external reviewer agrees with you, your plan must pay for the test.
- If your plan decides to rescind your coverage altogether based on the fact that information on your application for coverage was not accurate, you can appeal that decision. If your appeal is successful, the plan must reinstate your coverage.

Grandfathered vs. Non-Grandfathered Provisions Chart

Provision	Grandfathered Plans	Non-Grandfathered Plans
Dependent coverage for adult children up to age 26	✓	✓
No pre-existing limitations for children under the age of 19 for group plans	✓	✓
No annual limits on certain types of benefits for group plans	✓	✓
No lifetime benefit maximum limits	✓	✓
100% coverage for preventive care in network		✓
No prior authorization for emergency services or higher cost sharing for out-of-network emergency services		✓
Coverage for routine patient costs for clinical trials of life threatening diseases		✓
Reporting the value of employer-sponsored coverage on W-2s (2011)	✓	✓
Automatic enrollment in long-term care program	✓	✓
Uniform explanation of coverage (2012)	✓	✓
Pre-enrollment document sent explaining benefits and exclusions (2012)	✓	✓
60-day notice for material modifications (2012), if not already disclosed in uniform explanation of coverage	✓	✓
90-day limit on waiting periods for coverage (2012)	✓	✓
Employer requirements to offer minimum essential coverage (50+ employees) (2014)	✓	✓
Nondiscrimination in favor of highly compensated employees		✓

The following provisions are effective beginning with plan years or policy years beginning on or after September 23, 2010.

Extension of Dependent Coverage to Age 26

Young adults will be allowed to stay on their parent's plan until they turn 26 years old. (In the case of grandfathered group health plans; this right does not apply if the young adult has available health coverage at work.)

Children under the age 26 that aged off of their parent's health plan or were not allowed to enroll because they did not meet their plan's dependents age requirements are eligible to enroll in the plan during the 30 day Special Enrollment Period (SEP). The SEP begins on the date of notification and will coincide with the policy renewal date.

Removal of pre-existing conditions for children

Any stipulations that prevent dependent children, up to the age of 19, from obtaining coverage for conditions that are considered "pre-existing" have been removed.

Annual and Lifetime Limits

Plans will no longer include annual or lifetime dollar limits nor will they include dollar limits on specific essential health benefits (i.e. hospital stays).

Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan during the 30 day SEP. The SEP begins on the date of notification and will coincide with the policy renewal date.

Recissions

In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny coverage when he or she got sick. The new law makes this practice illegal. Recission is still allowed in cases of fraud.

Preventive Care Visits

Certain in network preventive care services that meet the requirement of federal and state law, including certain screenings, immunizations and physician visits must be covered at 100% for **non-grandfathered plans**.

Please note that during the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and a member's provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by the provider, which will result in a member cost share.

The complete list of recommended preventive services that must be covered can be found at www.HealthCare.gov/center/regulations/prevention.html.

Patient Protections

Patient Protections under health care reform give health plan members certain rights for access to, and choice of providers. Plans must provide notice to members of their rights.

Non-grandfathered health plans that require primary care physicians for members must allow members to choose any available in-network PCP as their primary care physician, including a participating pediatrician for children.

Health insurers must also allow members to seek care from an in-network OB/GYN provider without requiring preauthorization or referral from a PCP.

Lastly, no pre-authorization can be required for in-network or out-of-network emergency services.

Required PPACA Notices

Here are a list of Notices that you must provide to all of your employees (and COBRA or state continuation enrollees), as required by the PPACA.

You can obtain and modify the notices on the Department of Labor Website (click the Notice name below). For your convenience, we have also compiled them as a **Sample Notice** on our website.

Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

Model Language Notice Patient Protection Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Model Language Notice Grandfathered Health Plan

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

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IMPORTANT: This document is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions and should NOT be used as legal advice for implementation activities. We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan.

Links - Further Reading

HR 3590 – Patient Protection and Affordable Care Act.

HR 4872 – Health Care and Education Reconciliation Act.

Health Reform

HHS – The U.S. Department of Health and Human Services.

IRS – The federal Internal Revenue Service.

As of September 23, 2010

Beginning with plan years or policy years beginning on or after September 23, 2010...

Examples:

- Group's plan year start date is July 1, 2010 then the changes must be implemented July 1, 2011.
- Group's plan year start date is September 1, 2010, then the changes must be implemented September 1, 2011.
- Group's plan year start date is October 1, 2010, then the changes must be implemented October 1, 2010.
- Group's plan year start date is December 1, 2010 then the changes will be implemented December 1, 2010.