

Many Group Healthcare Plans Exempt from New Health Care Reform Legislation

Grandfathered Group Health Plans:

All group health plans that were in effect on the day of enactment are “grandfathered”. Specifically any grandfathered insured or self-insured group health plan would not have to comply with all of the health insurance reforms. It does not appear as if plans would lose this grandfathering protection even when new employees or family members join the plan, or the plan changes the benefit design. However, collectively bargained plans would lose grandfathering protection and be subject to the insurance reforms on the date on which the last of the collective bargaining agreements, which were ratified before the date of enactment, terminates.

The Only Elements of Reform Grandfathered Plans are Required to Comply With:

For plan years beginning on or after Sept. 23, 2010:

- No Lifetime Limits.
- Pre-existing conditions waiting periods for children must be eliminated.
- Dependent Coverage up to age 26 who do not have access to other employer-sponsored health insurance.

For Calendar Year 2011:

- W-2 Reporting: Employers must include the aggregate cost of employer sponsored coverage that is excludable from the employee’s gross income. The aggregate amount includes:
 - Health plan premium or premium equivalent (COBRA less 2%)
 - Reimbursements from FSA
 - Reimbursements or payments from HRA
 - Employer contributions to HSA
 - Premium cost for supplementary health insurance coverage (excluding dental and vision coverage)
- Over-the-counter: Eliminates over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA, FSA, HSA or Archer MSA.
- New Long-Term Care Program (CLASS Act): The Act creates a new voluntary public long-term care insurance program. Benefits are a daily or weekly cash benefit to help people with functional limitations purchase the services and supports needed to maintain personal and financial independence. CLASS will supplement, not supplant, traditional payers of long-term care (e.g., Medicaid and/or private long-term care insurance).

For Calendar Year 2012:

- Comparative Effectiveness Research Fee: A fee of \$2.00 per member (covered life) per calendar year to fund comparative effectiveness research for both insured and self funded plans.

For Calendar Year 2013:

- Plans required to prepare a new standardized Summary of Coverage in addition to other documentation requirement. Effective date: Standard must be developed by March 23, 2011 and plans must comply by **March 23, 2013**.
- FSA is limited to \$2,500 and indexed to inflation in future years.

For Calendar Year 2014:

- No annual limits except on non-essential benefits (as determined by the Secretary); through December 31, 2013; starting **January 1, 2014** no annual limits on any benefit.
- No pre-existing conditions waiting periods are allowed for Adults.
- Dependents up to age 26 must be allowed to be covered regardless of access to other coverage.
- Limit any waiting periods for coverage to 90 days.
- All new employees must be notified of the existence of the State Exchange as well as the potential availability of premium subsidies for qualified employees.
- Provide free choice vouchers to employees with incomes less than 400% of the Federal Poverty level whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee.
- Employers with 200 or more full-time employees must auto-enroll all employees in a benefit plan option annually and provide for an opt-out.