

The Affordable Care Act

The Patient Protection and Affordable Care Act (Affordable Care Act) was signed into law on March 23, 2010. The Affordable Care Act added certain market reform provisions to ERISA, making those provisions applicable to employment-based group health plans. These provisions provide additional protections for benefits under employment-based group health plans. They include extending dependent coverage to age 26; prohibiting preexisting condition exclusions for all individuals and prohibiting the imposition of lifetime and annual limits on essential health benefits. As of 2014, most of the Affordable Care Act protections are now in effect. The Departments of Labor, Health and Human Services, and the Treasury (Departments) were tasked with issuing guidance for the market reform provisions. The Departments continue to work with employers, issuers, States, providers and other stakeholders to help them come into compliance with the law and are working with families and individuals to help them understand the law and benefit from it, as intended.

Under the Affordable Care Act, plans can make some routine changes and generally keep the coverage under their plan the same as it was on March 23, 2010. These grandfathered health plans are required to comply with some but not all of the market reform provisions under ERISA.

What is grandfathered status and how does a grandfathered plan lose its status?

Generally, grandfathered plans are plans that were in existence, and in which at least one individual was enrolled, on March 23, 2010. Grandfathered health plans are exempt from many but not all Affordable Care Act market reforms.

Grandfathered plans lose their status if the plan makes one of the following six changes:

- 1) Elimination of all or substantially all benefits to diagnose or treat a particular condition.
- 2) Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%).
- 3) Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points.
- 4) Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, \$5 plus medical inflation).
- 5) Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points.

- 6) Imposition of annual limits on the dollar value of all benefits below specified amounts.

Additionally, plans must include a statement in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan, that the plan or coverage believes it is a grandfathered health plan and it must provide contact information for questions and complaints.

Which provisions of the Affordable Care Act apply to a grandfathered health plan?

Grandfathered health plans are exempt from many, but not all Affordable Care Act market reforms. Some of the new provisions applicable to grandfathered plans include:

- prohibition on preexisting condition exclusions
- prohibition on excessive waiting periods
- prohibition on lifetime/restricted annual limits
- prohibition on rescissions
- extension of dependent coverage
- summary of benefits and coverage and uniform glossary

Some of the new provisions not applicable to grandfathered plans include:

- coverage of preventive services
- internal claims and appeals and external review
- patient protections

When do the provisions in the Affordable Care Act become applicable?

The following provisions became effective for plan years beginning on or after September 23, 2010.

- prohibition on preexisting condition exclusions - only for individuals under age 19

- prohibition on lifetime limits (and restrictions on annual limits)
- prohibition on rescissions
- coverage of preventive services
- extension of dependent coverage
- internal claims and appeals and external review
- patient protections

The Summary of Benefits and Coverage and Uniform Glossary requirement became effective as of September 23, 2012.

Other provisions became effective for plan years beginning on or after January 1, 2014.

- prohibition on preexisting condition exclusions - for all individuals
- wellness programs
- prohibition on excessive waiting periods
- prohibition on annual limits

Can plans require dependent children to be full-time students in order to receive coverage to the age of 26?

No. Plans that offer dependent coverage for children are required to make the coverage available until a child reaches the age of 26. Plans and issuers that offer dependent coverage of children must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. This provision applies to all group health plans regardless of grandfather status and became effective for plan years beginning on or after September 23, 2010.

Can plans impose preexisting condition exclusions on new enrollees?

No. Group health plans are prohibited from imposing any preexisting condition exclusion. This prohibition generally is effective for plan years beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition became effective for plan years beginning on or after September 23, 2010. This provision applies to all group health plans regardless of grandfathered status.

Can plans place lifetime or annual limits on the dollar value of essential health benefits?

Generally group health plans are prohibited from offering coverage that establishes any lifetime or annual limits on the dollar value of essential health benefits. This prohibition became effective for plan years beginning on or after September 23, 2010 for lifetime limits and January 1, 2014 for annual limits. For more information regarding what benefits are considered essential health benefits, visit HealthCare.gov. This provision applies to all group health plans regardless of grandfathered status.

Are plans prohibited from rescinding group health plan coverage?

In general, a rescission is a retroactive cancellation of coverage. A group health plan or a health insurance issuer can only rescind coverage in the case of fraud or an intentional misrepresentation of a material fact, regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. Plans and issuers must provide at least 30 days advance written notice to each participant who would be affected by the rescission. The prohibition against rescissions became applicable for plan years beginning on or after September 23, 2010 and applies to all group health plans regardless of grandfathered status.

Are plans required to provide preventive services?

Group health plans must provide benefits for certain recommended preventive services and generally may not impose any cost-sharing for such services. The recommended services, including immunizations and colonoscopies, are set forth by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. A complete list of recommendations and guidelines that specify the services that are required to be covered can be found at HealthCare.gov/center/regulations/prevention.html. The preventive services provision became applicable for plan years beginning on or after September 23, 2010, and does not apply to grandfathered plans.

My plan requires participants to designate, among others, a primary care provider. Is my plan required to comply with certain requirements related to this designation?

If a group health plan requires the participant to choose a participating primary care provider, the plan or issuer must allow the participant to choose any participating primary care provider who is available to accept the participant. With respect to a child, the plan or issuer must allow the designation of a

pediatrician as a child's primary care provider if the provider participates in the network of the plan or issuer. Furthermore, plans or issuers may not require authorization or referral for a female participant who seeks coverage for OB/GYN care provided by an OB/GYN specialist. The plan must provide a notice informing the participants of the terms of the plan or health insurance coverage regarding designation of a primary care provider. This provision became applicable for plan years beginning on or after September 23, 2010, and does not apply to grandfathered health plans.

Can plans continue to limit payments for out-of-network emergency room services?

A group health plan that provides emergency services benefits must cover emergency services without preauthorization, even if the hospital or provider is out-of-network. If the emergency services are provided out-of-network, special rules related to cost-sharing requirements apply. Copayment amount or coinsurance rates cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. Additionally, any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, can only be imposed with respect to out-of-network emergency services if the cost-sharing requirement generally applies to out-of-network benefits. This provision became applicable for plan years beginning on or after September 23, 2010, and does not apply to grandfathered health plans.

Are all employment-based wellness programs subject to Affordable Care Act requirements?

No. Many employers offer a wide range of programs to promote health and prevent disease. For example, some employers may choose to provide or subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage employee walking and exercise, pay for gym memberships, or ban smoking on employer facilities and campuses. A wellness program is subject to the Affordable Care Act and HIPAA nondiscrimination rules only if it is, or is part of, a group health plan. If an employer operates a wellness program separate from its group health plan(s), the program may be subject to other Federal or State nondiscrimination laws, but it is generally not subject to the HIPAA nondiscrimination regulations.

For a detailed discussion of the Affordable Care Act and HIPAA nondiscrimination requirements that may apply to wellness programs offered in connection with employment-based group health plan coverage, see page 27. These provisions apply to both grandfathered and non-grandfathered plans and became applicable for plan years beginning on or after January 1, 2014.

What requirements apply under the Affordable Care Act regarding the claims and appeals processes that must be made available under a group health plan?

All group health plans must maintain internal claims and appeals processes set forth in the Department of Labor Claims Procedure rules. Additional protections were added to ensure that participants have access to an effective appeals process. The scope of adverse benefit determinations eligible for internal claims and appeals now includes a rescission of coverage. If an initial adverse benefit determination is an urgent care claim, the claimant must be notified of the benefit determination no later than 72 hours after the receipt of the claim.

If the plan denies the claim after the internal appeal, the Affordable Care Act requires participants be given the opportunity to seek external review. Plans must implement an effective review process that meets the minimum requirements set forth in the regulations. The internal claims and appeals and external review provisions do not apply to grandfathered plans and are applicable for plan years beginning on or after September 23, 2010.

What is the Summary of Benefits and Coverage and when must it be provided?

Plans must provide a Summary of Benefits and Coverage (SBC) that accurately describes the benefits and coverage under the applicable plan. The SBC is a uniform template that uses clear, plain language to summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations. Plans and issuers must provide the SBC to participants and beneficiaries at certain times (including with written application materials, at renewal, upon special enrollment and upon request). This provision became applicable, generally, for plan years beginning on or after September 23, 2012, and applies to all group health plans regardless of grandfathered status.

Can employers or plans require participants and beneficiaries to be in a waiting period before allowing them to enroll in a group health plan?

Any waiting period that exceeds 90 days is prohibited. A waiting period is defined as the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. This provision became applicable for plan years beginning on or after January 1, 2014, and applies to all group health plans regardless of grandfather status.

What is the Marketplace and where can I learn more about it?

The Marketplace offers “one-stop shopping” for employees to find and compare private health insurance options that meet certain Federal requirements. It simplifies the search for individual health insurance by gathering all of the health plan options into one Website and presenting the price and benefit information in simple terms. By purchasing insurance in the Marketplace, some employees may be eligible for a tax credit that lowers monthly premiums or out-of-pocket expenses. Persons eligible for COBRA due to a loss of employer-sponsored coverage may choose to purchase less expensive coverage from the Marketplace and may also qualify for the tax credits. Employees can also apply for Federal health coverage programs such as Medicaid and the Children’s Health Insurance Program through the Marketplace. For more information on the Marketplace, visit HealthCare.gov.

Where can I get more information about the Affordable Care Act?

For more detailed information regarding the requirements under the Affordable Care Act, visit the Employee Benefits Security Administration’s Affordable Care Act Web page at dol.gov/ebsa/healthreform or contact 1-866-444-3272.