



NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS



# NEW NATIONAL HEALTH INSURANCE LAW

## What It Means For You and Your Clients

# EMPLOYER ACTION PLAN (Revised 7/16/10)

The new health law requires all group health plans to meet new requirements. Many of these mandates begin for plan years beginning on or after September 23, 2010.

In order to comply with the new mandates for plan years beginning on or after September, 23, 2010, discuss the following items with your NAIFA member agent:

- ▲ Eligibility and desire to participate in the Early Retiree Reinsurance Program
- ▲ Implications of revising your current plan
- ▲ Employer Checklist

### EMPLOYER CHECKLIST — ALL PLANS

✓	<b>Early Retiree Reinsurance Program</b>	Plans that provide benefits to retirees between the ages of 55 and 64 are eligible for reimbursements for certain claims under this temporary program. HHS started accepting applications on June 29, 2010.
✓	<b>Lifetime Limits</b>	Group health plans are prohibited from placing lifetime dollar limits on essential health benefits. Plans will need to provide for a 30-day special enrollment period for those individuals who have met the lifetime limit, but are still eligible for coverage.
✓	<b>Annual Limits</b>	For plan years beginning on or after September 23, 2010 but before September 23, 2011, group health plans are prohibited from imposing annual dollar limits on essential health benefits greater than \$750,000.
✓	<b>Rescissions</b>	Group health plans may not rescind coverage after enrolling a participant, except in the event of fraud or intentional misrepresentation of material fact. A discontinuance of coverage is not a rescission if it has only a prospective effect, or is retroactive only to the extent it is attributable to a failure to pay required contributions. Note that 30 days advance written notice must be provided to each participant who would be affected by a rescission.
✓	<b>Pre-Ex Condition Exclusion for Children</b>	Group health plans may not impose preexisting condition exclusions for children under age 19.

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✓	<b>Coverage for Adult Children</b>	<p>Group health plans that provide dependent coverage are required to extend coverage to adult children up to age 26 with no conditions on dependency.</p> <p>Grandfathered plans may still exclude coverage for adult children who are eligible for other employment-based coverage, until January 1, 2014.</p> <p>A 30-day special enrollment period is required for adult children who previously became ineligible due to age.</p>
✓	<b>No Reimbursement for OTC Drugs</b>	<p>Flexible Spending Account and other similar programs may not reimburse non-prescribed over-the-counter drugs purchased on or after January 1, 2011.</p>
✓	<b>W-2 Reporting</b>	<p>Effective for the 2011 plan year (for W-2's typically issued in January 2012), employers are responsible for reporting the total cost of medical benefits provided on employees' Forms W-2. Employers should begin setting up payroll systems and gathering necessary cost data.</p>
✓	<b>Automatic Enrollment</b>	<p>Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible for coverage.</p> <p><b>Waiting on Guidance</b></p>
✓	<b>Grandfathered Status</b>	<p>Certain plans may be considered grandfathered and not subject to some requirements.</p> <p>If the plan is grandfathered, plan materials must include a grandfathered status statement. (The rules include model language.) Plan sponsors will need to retain documents to prove the terms of the plan in effect on March 23, 2010.</p>

### ADDITIONAL CHECKLIST FOR NON-GRANDFATHERED PLANS

✓	<b>Preventive Care</b>	<p>Employers may not impose cost sharing for preventive care. This means the employer must pay the full cost of preventive care, including immunizations, breast cancer screening and other services as recommended by the U.S. Preventive Services Task Force.</p>
✓	<b>Transparency Disclosure</b>	<p>Employers must submit to HHS Secretary (and make available to the public) information regarding claims payment policies, enrollment information, information on cost sharing and rating policies, information on out-of-network coverage and information on participant rights.</p> <p><b>Waiting on Guidance</b></p>



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✓	<b>Patient Protections</b>	Choice of Provider — In-network pediatricians and OB/GYNs. Plans must include a notice to individuals of these rights. (The rules include model language.)  Emergency Services at in network costs. Any other cost-sharing requirements (such as a deductible or out-of-pocket maximums) can only be imposed for emergency services if the requirement applies generally to out-of-network benefits.
✓	<b>Revised Appeals Process</b>	Plans must have an effective internal appeals process and must provide participants with information about the process. Plans must also have an external appeals process that, at a minimum, meets the Uniform External Review Model Reform promulgated by the National Association of Insurance Commissioners.  <b>Waiting on Guidance</b>
✓	<b>Non discrimination Rules Extended to Insured Plans</b>	Fully-insured health plans may not discriminate in favor of highly compensated employees. Similar rules previously applied to self-insured plans.

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