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BENEFITS ALERT: Health Care Reform

Preparing for 2014

Although the employer "pay or play" mandate has been delayed until 2015, many aspects of healthcare reform are still set to become effective as early as October of this year.

Marketplace Notice

Employers are required to provide a notice to participants by October 1, 2013 explaining the availability of the insurance marketplace and how it impacts current coverage. Although this is an employer requirement, detailed information in the notice about current coverage may cause employers to look to their multiemployer plans for assistance in preparing it.

Because participants may be confused by this notice, it may make sense to get ahead of this issue before October. Multiemployer plans may consider sending a separate notice or cover letter letting participants know that they will not be losing their current coverage and do not need to enroll in the marketplace.

If you need any assistance in explaining the marketplace to participants, preparing the notice, or in understanding how the marketplace works, please do not hesitate to call us.

90 Day Waiting Period

The 90 day waiting period is still effective January 1, 2014. Under this rule, once an employee becomes eligible for coverage, any waiting period before coverage becomes effective may not be longer than 90 days. Regulatory guidance has clarified that 90 days is 90 calendar days, and not, e.g., 3 months. Plans

with quarterly or similar coverage and eligibility periods should review their terms to make sure they do not run afoul of this rule.

Annual Limits

Beginning January 1, 2014, plans may no longer have annual limits on the amount of "essential health benefits".* Annual limits on these benefits are currently permitted, provided they are no less than $2 million. Self-insured plans should discuss with their actuary and investment advisor how this will impact funding and reserves, and what adjustments, if any, need to be made. Plans should also be sure that their Summary of Benefits Coverage and Summary Plan Descriptions are updated for this change.

** "Essential health benefits" include hospitalization, emergency, and prescription drug coverage.*

Pre-existing Conditions

Beginning January 1, 2014, plans may no longer exclude participants and their dependents, regardless of age, from coverage because of a pre-existing condition. Prior to this, only participants and dependents who were younger than 19 could not be denied coverage because of a pre-existing condition. Plans should be sure that their Summary Plan Descriptions are updated accordingly.

Next Steps

In addition to the suggested steps above, it may be helpful to set-up a time-line and action plan to prepare for, and implement, these upcoming changes. Please do not hesitate to call if you have any questions about, or require legal assistance in preparing for, these reforms.

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