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Health Care Reform And Limited Medical Plans

With the passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010, we face a new era in health insurance. There are many details that still must be explained and much guidance to come from the government to fully interpret the scope of this historic legislation. There are, however, several things we do know about the Acts, and we feel it is appropriate—and necessary—to start discussing the bills' potential impact on the limited medical benefits industry.

Health care reform legislation may leave you with many questions about the future of limited medical plans, and it is extremely important that brokers begin considering its impact on their clients.

To begin to attempt to understand what the insurance brokerage community is facing in the next couple of months, a brief timeline detailing the key dates relevant to limited medical plans is depicted below:

- **March 23, 2010**—PPACA signed into law.
- **September 13, 2010**—New requirements begin to kick in six months after bills are signed.
- **September 24, 2010**—When grandfathered plans begin to renew, they become subject to new requirements.
- **October 10, 2010**—First full month that renewals will be affected by the new requirements.
- **January 2, 2011**—Big renewal date for calendar year-based plans—these plans are subject to new rules.

What Is a Grandfathered Plan?

A group health plan is a grandfathered plan if it had participants on March 23, 2010. A grandfathered plan will be treated as providing essential health benefits, which means they will be required to provide the mandated coverage to avoid the tax penalties which come into play after December 31, 2013. All group health plans—even those which have been grandfathered—will have to meet new requirements on or after September 23, 2010. These new requirements include:

- **Lifetime and Annual Limits**—These limits will no longer be allowed in group health plans. Restricted annual limits (to be defined) on essential health benefits will be permitted until January 1, 2014—but early guidance indicates that overly restrictive annual limits on coverage will be banned for certain plans so that insured persons are not denied coverage on necessary care because they have reached their annual limit. For example, plans with a \$5,000 annual maximum would have to remove that restriction for renewals after September 24, 2010. Plans written prior to that date would be allowed to operate as written until their next annual renewal in 2011.
- Dependent children can remain on parent's health plan until age 26.
- Coverage cannot be denied due to preexisting conditions.
- Insurers cannot rescind coverage, except in cases of fraud.
- Certain preventive services and immu-

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nizations will be required to be covered.

- All limited medical plans that were considered group health insurance plans; plans that issued letters of creditable coverage under HIPAA; and plans identified as limited major medical plans that function similarly to traditional group plans with co-pays, deductibles, coinsurance, and an annual overall maximum or a separate inpatient/outpatient maximum, will be subject to these new regulations starting September 23, 2010.

Who Is Subject to the New Rules and Who Is Exempt?

All group health insurance plans, including limited medical plans that issue creditable coverage letters or limited major medical plans, are subject to the new regulations. There are basically two types of limited medical benefit plans: coinsurance (sometimes referred to as co-pay based or expense incurred) and indemnity-based (sometimes called fixed indemnity)

insurance.

Fixed indemnity plans that don't issue creditable coverage letters or represent themselves as true group health insurance plans are exempt. Fixed indemnity plans are filed as supplemental and not subject to these new regulations, as opposed to the traditional group plans, which are.

Due to the nature of their benefit design and their filing status, we believe that fixed indemnity plans will be a viable benefit option for part-time workers after 2013. These plans do not issue HIPAA creditable coverage letters because if they were creditable coverage, they would have been considered a traditional group plan.

What will happen to groups renewing after September 13, 2010, that were on a limited medical plan subject to the health care reform rules regarding the removal of annual and lifetime limits?

1. They do not renew because the plans can't meet the new rules.
2. They get renewed with significant

rate increases.

3. They move to a fixed indemnity type limited medical plan.

Where Do We Go from Here?

Smart brokers will find new solutions and put their clients into limited medical coverage that will still exist after December 31, 2013. The attractive features of fixed indemnity plans, such as rate stability, flexibility with data files, enrollment expertise, missed premium collecting and payroll cycle billing, will continue to be offered. If you currently market limited medical plans or have customers utilizing limited medical plans, contact your carrier immediately to find out their product strategy as a result of health care reform. Ask how health care reform will affect renewals and if the company is still accepting new business. If you don't get straight answers, find a new limited medical partner!