

# PRESS RELEASE

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## **Amalgamated Life Executive Urges Self-Funded Plans to Be Prepared for Changes Under the Patient Protection and Affordable Care Act**

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Amalgamated Life Insurance Company, one of the nation's leading privately-held companies offering comprehensive solutions under its family of companies, has a message for self-funded plans relating to the recently enacted Patient Protection and Affordable Care Act ("The Act"). Borrowing the motto made famous by the Boy Scouts, it is simply to, "Be prepared."

According to Amalgamated Life Executive Vice President Michael Hirsch, "While self-funded plans will retain their traditional cost, flexibility and overall structural advantages over fully-insured plans, there are several new requirements introduced by the new legislation of which they should take note. One, in particular, is the prohibition on maintaining lifetime limits and restrictions on maintaining annual limits."

### "Key Changes"

Under The Act and effective for plan years beginning after 9/23/10, all self-insured health plans, along with other group health plans, are prohibited from establishing lifetime limits on benefits. Additionally, from 9/23/10 up to 2014, all self-insured and other plans may only establish a *reasonable annual limit* on the dollar value of benefits relating to the scope of essential health benefits. Beginning in 2014, *any limits* on the dollar value of benefits will be prohibited.

"In order to comply with these changes, and protect against potentially catastrophic losses, self-insured plans should be reviewing their medical stop loss insurance options," continued Hirsch.

Another significant change imposed by The Act is the extension of dependent coverage. Effective 9/23/10, all plans will have to extend the coverage to dependents up to age 26, regardless of whether they are married and/or students. For grandfathered plans, and prior to 2014, this extension of coverage will only be required for dependent children not covered by a plan from their own employers.

Effective 9/23/10, The Act prohibits exclusions relating to preexisting conditions for plan enrollees under the age of 19. As of 1/1/14, there will be a blanket prohibition of preexisting condition exclusions for enrollees regardless of their age.

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Further, effective 1/1/14, all plans can no longer establish eligibility rules based on such factors as claims experience, medical history, genetic information, disabilities, etc.

## “Heightened Accountability”

The Act introduces new responsibilities on plans for prevention, wellness, plan explanations, reporting and transparency. Regarding prevention and wellness initiatives, plans offering premium discounts or other incentives for individuals participating in wellness programs which do not require that they meet a certain health factor standard, must be even-handed in this condition for all similar beneficiaries. An offer of discounts and rewards based on meeting a certain health factor can only be made under certain conditions (i.e., if the premium discount is less than 30%, if the wellness program is likely to improve health and/or prevent disease among the participating individuals, and if the program is offered at least once a year). These requirements are effective for plan years beginning after 1/1/14.

The Act also requires plans to provide a clear and accurate explanation of benefits and coverage to plan enrollees and applicants. This mandated “explanation of benefits” must include a succinct (not longer than four pages) summary of benefits and coverage (the elements of which The Act delineates), and be written in a language and with terminology easily understood by the plan’s average enrollee. This requirement becomes effective for plan years beginning after 9/23/12.

All non-grandfathered plans also will be required to report to the U.S. Department of Health and Human Services (HHS) and plan enrollees, all information on wellness and prevention programs that improve health conditions through effective case management, care coordination, disease management, medication, patient safety, and initiatives designed to prevent hospital readmissions. The date for this reporting requirement has not yet been set. Under The Act, and effective 9/13/10, the HHS will also require plans to provide complete details of their coverage and claims history to the HHS, State insurance departments and the general public. To help assure their compliance with reporting requirements, plans will have to adopt new health information technology standards which facilitate uniform standards for electronic transmission between plans and providers.

## “More Reliance on TPAs and Medical Case Management”

“The Patient Protection and Affordable Care Act has placed increased responsibility on plans to be more diligent both on administration and health care utilization,” said Hirsch. “I see the role of third-party administrators (TPAs) in assisting plans with compliance as critical. Similarly, I think we will see more plans avail themselves of high quality medical case management to make sure that members get quality care and equally important, enable them to be responsible consumers. With this broader mandate of health coverage, we all have a greater responsibility to do our part to help contain spiraling health care costs.”

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## “Questions Still Unanswered”

“For collectively bargained plans, it is still not clear when they will have to comply with the new legislation,” stated Hirsch. “Will they be required to comply on the same timeframe as other plans or on the expiration of their bargaining agreements?”

Hirsch added, “As unions have long been in the forefront of the national health care movement, they will be under pressure to continue providing the best level of benefits to their members independent of compliance dates under the new law.”

Hirsch had some final words of advice for self-funded plans. “It’s important that plans rely on their advisors, benefit consultants and in the case of Taft Hartley plans, their fund attorneys for a full explanation of the new requirements. Amalgamated Life is one important resource for our clients, guiding them and their plans through the complexities of this new legislation.”

Hirsch continued, “While many of the changes become effective in the future, self-funded plans need to be proactive today; exploring their options for medical stop loss insurance, evaluating their third-party administrators to assess their capabilities for assisting with the new regulations and finally, taking steps to better contain health risks through effective medical management.”

He added, “Every self-funded plan is different and has different needs. What self-funded plans continue to have over fully-insured plans – even in the face of a major insurance overhaul – is a structural advantage which is likely to help them remain successful in the new health care reform environment.”

For more information about the Patient Protection and Affordable Care Act, contact: Executive Vice President John Thornton at 914-367-5511.

## **About Amalgamated Life Insurance Company**

Founded in 1943, Amalgamated Life Insurance located in White Plains, NY is now one of the nation’s leading privately-held companies. Under the direction of President and Chief Executive Officer David J. Walsh, the Company has maintained an unwavering commitment to the highest standards of service quality, earning it an “A” (Excellent) rating from A.M. Best Company for the past 35 consecutive years. Amalgamated Life is part of the Amalgamated family of companies which also includes: a property and casualty insurance brokerage, a third-party administration company, a medical management firm, a computer outsourcing company, and a printing and graphics company. For more information, visit: [www.amalgamatedlife.com](http://www.amalgamatedlife.com).