



Health Care Reform Management Alert Series

Issue 8

Checklist of Plan Changes Needed for Upcoming Plan Year

This is the eighth issue in our series of alerts for employers on selected topics in health care reform. (Our general summary of health care reform and other issues in this series can be accessed by clicking [here](#).) This series of Health Care Reform Management Alerts is designed to provide a more in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Patient Protection and Affordable Care Act (PPACA), as modified by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively the "Act") requires all group health plans to comply with certain mandates, some of which are phased in over time. This issue highlights the changes both grandfathered and non-grandfathered plans will need to consider for plan years beginning on or after September 23, 2010.

Mandated Changes and Other Considerations for the Upcoming Plan Year

Certain plan design changes must be made for the upcoming plan year even if the plan is grandfathered. Other provisions of the Act may impact design and administration so sponsors will want to consider them now.

The first chart below applies to grandfathered and non-grandfathered plans. The second chart lists those issues that only will apply to non-grandfathered plans. To the extent any of these items results in plan changes, employees will need to be notified, plan documents and open enrollment materials will need to be updated and administration will need to be changed accordingly.

All Plans (Grandfathered and Non-Grandfathered Plans) (for plan years beginning on or after September 23, 2010)	
<input type="checkbox"/> Early Retiree Reinsurance Program	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 announced on June 29, 2010 that it has started accepting applications to certify eligible plans. (HHS is not yet accepting actual claims for reimbursement.) Consider whether you want to apply, and gather information to complete the application. The application as well as updated Frequently Asked Questions are available on the HHS website by clicking here . The updated Frequently Asked Questions provide detail on specific issues, and we recommend reviewing them if you are planning on participating in this program. For more information, review our previous alert, Issue 2, by clicking here .
<input type="checkbox"/> Lifetime Limits on Essential Health Benefits	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. For more information, review our previous alert, Issue 7, by clicking here .
<input type="checkbox"/> Annual Limits on Essential Health Benefits	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 less than \$750,000. For more information, review our previous alert, Issue 7, by clicking here .
<input type="checkbox"/> Rescissions	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. For more information, review our previous alert, Issue 7, by clicking here .
<input type="checkbox"/> Preexisting Condition Exclusion for Children Under Age 19	Group health plans may not impose preexisting condition exclusions for children under age 19. For more information, review our previous alert, Issue 7, by clicking here .

All Plans (Grandfathered and Non-Grandfathered Plans) (for plan years beginning on or after September 23, 2010)	
<input type="checkbox"/> Coverage for Adult Children	<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>NOTE: Grandfathered plans may still exclude coverage for adult children who are eligible for other employment-based coverage, until January 1, 2014.</p> <p>Note a 30-day special enrollment period is required for adult children who previously became ineligible due to age. For more information, review our previous alerts, Issue 1 by clicking here, and Issue 3 by clicking here.</p>
<input type="checkbox"/> No Reimbursement for Over-the-Counter Drugs	<p>Flexible Spending Account and other similar programs may not reimburse non-prescribed over-the-counter drugs purchased on or after January 1, 2011. For more information, review our previous alert, Issue 4, by clicking here.</p>
<input type="checkbox"/> W-2 Reporting of Value of Benefits	<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>
<input type="checkbox"/> Automatic Enrollment	<p>Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible for coverage.</p> <p>NOTE: The Act does not provide a delayed effective date for this provision, but states it will be effective in accordance with Department of Labor regulations which have not been issued to date. Employers should be on the lookout for guidance on this issue to be ready to implement this provision when necessary. Seyfarth Shaw will issue a Management Alert in this series as soon as possible after issuance of this guidance.</p>
<input type="checkbox"/> Grandfathered Status	<p>Certain plans may be considered grandfathered and not subject to the requirements discussed below. For more information, review our previous alert, Issue 5, by clicking here. If the plan is grandfathered, any plan materials describing terms of coverage must include a statement that the plan is considered grandfathered. (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>

Non-Grandfathered Plans Only (New Plans and Plans That Lose Grandfathered Status) (for plan years beginning on or after September 23, 2010)	
<input type="checkbox"/> First Dollar Coverage for Preventive Care	<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. Guidance on this provision is expected soon.</p>
<input type="checkbox"/> Patient Protections	<p><i>Choice of Provider.</i> Plans that require participants to designate an in-network primary care provider must permit any available participating network primary care provider to be designated. The plan must permit in-network pediatricians to be designated as the primary care provider for children. Female participants must be permitted to seek care from an in-network OB/GYN without prior authorization or referral. Summary plan descriptions and other similar descriptions of benefits must include a notice to individuals of these rights. (The rules include model language.)</p> <p><i>Emergency Services.</i> Plans may not require prior authorization for hospital emergency room services (even if out-of-network) and cannot include administrative requirements or limitations of benefits for out-of-network emergency services that are more restrictive than those applying to emergency services from in-network providers for emergency services. Copayment amounts and coinsurance rates for out-of-network emergency services cannot be greater than if the services were provided in-network. 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.</p> <p>For more information, review our previous alert, Issue 7, by clicking here.</p>
<input type="checkbox"/> Transparency Disclosure	<p>Employers must submit to the Secretary of HHS (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. To date, HHS has not issued guidance on this disclosure.</p>

Non-Grandfathered Plans Only (New Plans and Plans That Lose Grandfathered Status) (for plan years beginning on or after September 23, 2010)	
<input type="checkbox"/> Revised Appeals Process	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. Guidance on this issue is expected soon.
<input type="checkbox"/> Nondiscrimination Rules Extended to Insured Plans	Fully-insured health plans may not discriminate in favor of highly-compensated employees. (Similar nondiscrimination requirements applied to self-insured health plans before the Act was adopted.)

Employer Action Plan

- Decide whether you want to participate in the Early Retiree Reinsurance Program and, if so, submit an application.
- Decide if your plan will maintain grandfathered status and, if so, revise the plan and participant communication materials to include the required grandfathering language, and make sure procedures are in place to meet the document retention requirements.
- Review current plan provisions against checklist above and determine if changes are necessary.
- Coordinate with insurers and third party administrators regarding implementing changes.
- Identify whether any individuals have met the current lifetime or annual limits and are still eligible to participate in the plan.
- Ensure open enrollment process will accommodate the 30-day special enrollment periods for adult dependent children and individuals who had previously met annual or lifetime limits.
- Prepare summaries of material modifications, updated summary plan descriptions or other employee communications regarding changes for the upcoming plan year.

For further details, or if you have any questions regarding the requirements for the upcoming plan year, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at www.seyfarth.com/employeebenefits, or send your questions to HealthReform@seyfarth.com.

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