



Understanding Health Care Reform

Employee Benefits **ALERT**

Health Care Reform: Tips for Open Enrollment

The first round of health care reform changes under the Patient Protection and Affordable Care Act of 2010 (“PPACA”) goes into effect January 1, 2011 for *calendar year group health plans*. It’s now crunch time for employers pulling together their open enrollment materials for 2011.

In addition, plans with non-calendar year plan years may be required to comply with PPACA *before* January 1, 2011. Specifically, the PPACA provisions are effective as of the first day of the first plan year beginning on or after September 23, 2010.

Here’s a compliance tip list to help open enrollment go smoothly for the upcoming plan year. The compliance dates in the following list are for plans with calendar year plan years.

COVERAGE OF ADULT CHILDREN UNDER AGE 26

Notice and Special Enrollment: Group health plans that offer coverage to participants’ children must continue to offer coverage to the children until age 26, beginning January 1, 2011. Plans must give adult children under age 26 a one-time 30-day enrollment period and notice of the enrollment right. [Click here for the Model Notice](#). The special enrollment period can run concurrently with open enrollment. As long as the notice is prominent, employers can provide the notice with open enrollment materials to all participants and allow all eligible adult children to take advantage of the special 30-day enrollment period.

Consider conducting the special 30-day enrollment period at the same time as open enrollment, giving all participants notice of the special enrollment period for dependents and allowing all eligible dependents to enroll during this time.

Dental, Vision and Health FSAs: Although the new adult child coverage requirement does not apply to most stand-alone dental and vision plans, employers may find it simpler to have one definition of covered children that applies to all health-type benefits. The special enrollment notice and plan materials must be clear as to which benefit programs the new coverage provisions relate. Employers also should decide if the adult child coverage will apply to health care flexible spending account reimbursements.

Decide whether the new definition of dependent will apply to other group health plans such as dental and vision and health FSA reimbursements.

Application of Michelle’s Law: Michelle’s Law requires group health plans offering dependent coverage based on student status to extend coverage to college students who would otherwise lose coverage due to a medically necessary leave of absence. [Click here for Michelle’s Law Article](#). With the PPACA adult child coverage requirement, Michelle’s Law will no longer apply to group health plans that only cover children under age 26. However, for group health plans with dependent definitions that include additional categories of dependents (e.g., grandchildren of participants), Michelle’s law could still be relevant, and, if so, Michelle’s Law language should be retained in plan documents and SPDs.

Michelle’s Law will no longer apply to group health plans offering dependent coverage only to dependent children under age 26.

PROHIBITION ON LIFETIME LIMITS

Effective January 1, 2011, PPACA prohibits group health plans from imposing lifetime limits on the



WILLIAMS MULLEN
Employee Benefits Team

Catherine M. Marriott
Employee Benefits Chair
804.420.6901
kmarriott@williamsmullen.com

Brydon M. DeWitt
804.420.6917
bdewitt@williamsmullen.com

Elinor P. Hindsley
804.420.6469
ehindsley@williamsmullen.com

Steven B. Long
919.981.4085
slong@williamsmullen.com

Nona K. Massengill
804.420.6569
nmassengill@williamsmullen.com

Maria S. Stefanis
757.629.0664
mstefanis@williamsmullen.com

Ingrid A. Watson
757.473.5312
iwatson@williamsmullen.com

dollar value of health benefits. For participants and beneficiaries who have lost benefits under an employer group health plan because they reached the plan's lifetime limit, PPACA requires employers to give notice to these individuals that the lifetime limit no longer applies and to allow these individuals back into the plan during a one-time 30-day enrollment period, which can run concurrently with open enrollment. Rather than providing notice of the special enrollment period only to individuals whose coverage has ended due to imposition of a lifetime limit, it may be simpler to run the special enrollment period at the same time as open enrollment and to provide the notice to all employees with other open enrollment materials. [Click here for Lifetime Limit Model Notice.](#)

Consider running the special enrollment at the same time as open enrollment, and giving all participants notice of the special enrollment period for those affected by the imposition of the plan's former lifetime limit.

INTERNAL AND EXTERNAL CLAIMS PROCEDURES

PPACA requires employers to revise their internal group health plan (health, dental, vision, EAP, health FSA) claims procedures. [Click here for interim claims procedure regulations.](#) Changes include:

- Including rescissions of coverage in the definition of adverse benefit determination
- Shortening the time for responding to urgent care claims from 72 hours to 24 hours*
- Allowing participants access to additional documentation and information and to present evidence and testimony during the claims process
- Requiring the plan to take additional measures to avoid conflicts of interests
- Including additional information in adverse benefit determination notices* [Click here for model adverse benefit determination notice.](#) And [here.](#) And [here.](#)
- Strictly adhering to the claims procedure rules*
- Maintaining the claimant's coverage during the claims review process

In addition, group health plans must adopt an external review procedure. Separate interim compliance methods have been established for fully insured plans and self-insured plans. [See Joint Notice](#) and [EBSA Technical Release 2010-01](#)

* [DOL Technical Release 2010-02](#) granted a grace period for compliance for these provisions until July 1, 2011.

The revised internal claims procedure rules and new external review process should be described in group health plan SPDs, in any separate claims procedures document, and in any SMM prepared describing changes for 2011. Employers should discuss with group health plan insurers and TPAs how they intend to comply with the external claims review procedures so that the procedures can be accurately described in plan materials distributed during open enrollment.

Summary of Material Modifications (SMM)

Any SMM distributed to participants during open enrollment or thereafter, explaining changes to a calendar year group health plan for 2011, should include the following required changes under PPACA:

- Coverage of dependent children under age 26
- Prohibition on pre-existing condition limitations, annual and lifetime limits and rescissions. [Click here for relevant article](#)
- Prohibition of reimbursement for over-the-counter medicines from health FSAs, unless obtained with a prescription
- Claims procedures **for non-grandfathered plans only**
- Participants' rights relating to designation of primary care physicians and pediatricians and visits to ob/gyn providers **for non-grandfathered plans only**
- Required preventive care coverage **for non-grandfathered plans only** ([Click here for relevant article](#))
- Required emergency care coverage **for non-grandfathered plans only**

Although not an issue for 2011, employers should note that, beginning in 2012, participants must be provided with 60 days advance notice of material changes to a group health plan. This means that for calendar year group health plans with material changes for the 2012 plan year, employers must provide an SMM during open enrollment, and the open enrollment materials must be distributed no later than November 1, 2011 (60 days before the date the changes go into effect).

GRANDFATHERED PLAN STATUS

Any group health plan that is able to maintain grandfathered status ([Click here for Article on Grandfathered Status](#)) will only have to comply with the first three items in the list above. Grandfathered plans must provide notice to their participants of their grandfathered status. [Click here for Model Grandfathered Plan Notice](#)

Until the Department of Labor (DOL) issues final regulations, however, an insured grandfathered plan will not lose its grandfathered status solely due to a change in the rate of employer contributions if the plan sponsor and insurance issuer take the following steps:

- Upon renewal, the issuer requires the plan sponsor to make a representation regarding its contribution rate for the plan year covered by renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it); and
- The issuer's policies, certificates, or contracts of insurance disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year.

If the plan's policy was renewed in 2010, the above steps should be taken before January 1, 2011.

HEALTH FSA REIMBURSEMENT OF OVER-THE-COUNTER DRUGS EXPIRES

Effective January 1, 2011, a health flexible spending arrangement ("FSA") may not reimburse the costs of over-the-counter drugs that are purchased without a prescription. The January 1 restriction applies regardless of the FSA plan year and of any FSA grace period. Debit card reimbursements for over-the-counter drugs, however, may continue until January 15, 2011.

Plan sponsors should notify FSA participants that they may not receive reimbursement for over-the-counter drug expenses incurred after December 31, 2010. Plan documents must be amended by June 30, 2011. Again, Grandfathered plans must provide notice to their participants of their grandfathered status.

CHIPRA NOTICE AND OTHER GROUP HEALTH PLAN NOTICES REQUIRED TO BE PROVIDED ANNUALLY

In addition to the new requirements imposed during open enrollment by PPACA, employers should remember to provide participants with the following group health plan notices annually:

- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Notice: CHIPRA creates special enrollment rights for certain employees and their dependents when they become ineligible for Medicaid or a State Children's Health Insurance Program ("SCHIP"), and upon eligibility for a premi-

um assistance subsidy under Medicaid or SCHIP. Most group health plans were amended last year for this law. However, for calendar year plans, the annual notice requirement begins in 2011 (must be distributed no later than 1/1/2011). The notice can be included in open enrollment materials or the SPD as long as it is distributed annually. [Click here for Model CHIPRA Notice](#)

- Women's Health and Cancer Rights Act Notice
- Medicare Part D Noncreditable/Creditable Coverage Notice
- HIPAA Special Enrollment Notice

FORM 8928

Effective in 2010, plan sponsors must report to the IRS certain group health plan violations, such as COBRA, HIPAA and mental health parity failures, on new Form 8928. In addition, failures subject to Form 8928 reporting include many of the new PPACA requirements. The Internal Revenue Code imposes excise taxes on such violations, but until this year there had been no mechanism for reporting or paying the taxes. Failure to report violations and pay the tax will result in additional penalties and interest. No reporting and no tax, however, is required for a failure that is due to reasonable cause and is corrected within 30 days of the date the failure is discovered or should have been discovered by a person exercising reasonable diligence.

Plan sponsors should review health plan administration to determine whether any failures subject to Form 8928 have occurred in 2010. Any such failures should be promptly corrected. Failures not corrected on a timely basis must be reported on Form 8928 by the plan sponsor's deadline for filing its federal income tax return (without extensions).

COMPLIANCE DEADLINE FOR NON-CALENDAR YEAR PLANS

Non-calendar year plans must comply as of the first day of the first plan year beginning on or after September 23, 2010. Accordingly, a plan with a plan year beginning October 1 must be in compliance as of October 1, 2010 rather than January 1, 2011.

PPACA will require significant changes to employer sponsored health coverage beginning with plan years commencing on or after September 23, 2010. Please contact a member of the Williams Mullen Employee Benefits Practice for more information.

Contact any member of the Williams Mullen Employee Benefits Group if you have any questions regarding the coverage of preventative health services under the Patient Protection and Affordable Care Act. This information is provided as an educational service and is not meant to be and should not be construed as legal advice. Readers with particular needs on specific issues should retain the services of competent counsel.

Please direct all editorial inquiries to Catherine M. Marriott, Tel. 804.420.6901, E-mail: kmarriott@williamsmullen.com. Williams Mullen Understanding Health Care Reform Employer Alert, © 2010 Williams Mullen