

The Patient Protection and Affordable Care Act puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place by 2014. Many changes are effective on the first day of the **first plan year beginning on or after September 23, 2010**.

The insurance carriers will incorporate many of the required changes into their updated plan documents; however, **employers will be required to provide special enrollment opportunities as well as distribute several notices prior to renewal**.

At Stahl & Associates Insurance, our entire Employee Benefits Department is thoroughly committed to helping our clients plan ahead. We have compiled this compliance checklist to help our clients review the changes and requirements in advance of the 2010-2011 plan years and open enrollment season.

### **Plan Amendments**

Plan sponsors should take the following actions prior to the **first day of the plan year beginning on or after September 23, 2010** (unless a different effective date is noted below):

- Amend plans to **cover dependents up to age 26**.
  - Plans that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, is no longer a student, or is married.
  - Grandfathered plans (further defined on the next page) are only required to offer this coverage to adult children who are not eligible for their own employer provided coverage. Beginning in 2014, these dependent children must be allowed in all employer plans.
- Amend plans to **eliminate lifetime limits** on essential benefits and provide that individuals who previously reached the lifetime limit under the plan and who are otherwise eligible for coverage may re-enroll in the plan and will not be affected by the lifetime limit.
- Amend plans to either **eliminate or restrict annual limits** on essential benefits. Annual limits are being phased out over the next three years. For plan years beginning on or after September 23, 2010, a plan may impose a minimum annual limit of \$750,000.
- Amend plans to eliminate **pre-existing condition exclusions** for children under age 19. Pre-existing condition exclusions will be eliminated altogether for plan years beginning on or after January 1, 2014.
- Amend plans that include tax-advantaged medical accounts, such as **FSA's, HSA's, HRA's or Archer MSAs**, to reflect new requirements. Plans that permit reimbursement of over-the-counter medicine or drugs must be amended prior to January 1, 2011 to provide that these expenses are reimbursable only with a doctor's prescription (except for insulin) if they are incurred after December 31, 2010.
  - Starting in 2013, the federal limit will be \$2,500 for individual pretax contributions per year.

### **Plan Amendments (continued)**

In addition, sponsors of **non-grandfathered** plans (see information on Grandfathered Plan Status below) should also take the following actions prior to the **first day of the plan year beginning on or after September 23, 2010**:

- Amend plans to cover recommended preventive services with no cost-sharing requirements.
- Establish an effective claims appeal process by amending current claims procedures to incorporate new requirements.
- Amend fully-insured plans to eliminate impermissible discrimination in favor of highly compensated employees. Plans may no longer discriminate with respect to eligibility or benefits.
- Amend plans to include patient protections relating to access to primary care physicians, emergency services, pediatric care and OB/GYN services. *Model notices are attached.*

### **Grandfathered Plan Status**

A grandfathered plan is one that was in existence when health care reform was enacted on March 23, 2010, and is exempt from some of the health care reform requirements.

Grandfathered plans **do not have to comply** with the 4 plan amendment requirements regarding preventive services, claims appeal process, impermissible discrimination, patient protections.

- Plans will lose their grandfather status if they change carriers and/or choose to significantly cut benefits or increase out-of-pocket spending for consumers. Premium changes are not taken into account when determining whether or not a plan is grandfathered.
- Plans can make routine changes without losing grandfather status, including cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, or voluntarily adopting new consumer protections.
- If you have a grandfathered plan, you must include **information about the plan's grandfathered status** in plan materials describing the coverage under the plan, such as summary plan descriptions (SPDs) and open enrollment materials. *Model notice is attached.*
- Until 2014, a grandfathered plan need not offer coverage to a child up to age 26 if that child is eligible for employer-sponsored coverage.

## **EMPLOYER REQUIREMENTS**

### **1. Special Enrollment Opportunities**

Provide a 30-day special enrollment opportunity (and notice) to adult children eligible for coverage under the **age 26 rule**.

- The enrollment opportunity (and notice) must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.
- The coverage must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

Provide a 30-day special enrollment opportunity (and notice) to individuals who have **reached the lifetime limit** under the plan but are otherwise eligible for coverage.

- The enrollment opportunity (and notice) must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.
- The coverage must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

### **2. Participant Notices**

Employers should provide the following notices prior to the **first plan year beginning on or after September 23, 2010** (unless another deadline is noted below):

- Notice that eligibility for dependent coverage has been extended for children up to **age 26** (including any restrictions for grandfathered plans) and that a special enrollment period is available for eligible dependents. *A model notice is attached.*
- Notice to participants affected by a **lifetime limit** (including former participants that are otherwise eligible for coverage) that the lifetime limit no longer applies to them and they are eligible for a special enrollment opportunity if they are no longer enrolled in the plan. *A model notice is attached.*
- Notice to participants in **non-grandfathered plans** regarding the **patient protections** that are available relating to access to primary care physicians, emergency services, pediatric care and OB/GYN services. *A model notice is attached.*
- Prior to **January 1, 2011**, notice should be provided to employees that **over-the-counter medication and drugs** (except insulin) may only be reimbursed through medical account plans with a prescription.

**Other major health care reform provisions for 2010 and 2011:**

**2010**

**Employers:**

- The health reform law gives a **tax credit** to certain small employers (with fewer than 25 employees) that provide health care coverage to their employees, effective with tax years beginning in 2010. Please visit <http://www.stahlinsurance.com/3-simple-steps> to determine if you qualify for the Small Business Health Care Tax Credit.
- As of March 23, 2010, employers are required to provide rest breaks and accommodations for **nursing mothers**. An employer with less than 50 employees can be exempt. <http://www.dol.gov/whd/regs/compliance/whdfs73.pdf>

**2011**

**Employers:**

1. Must disclose the value of health coverage on employee W-2 form issued in 2012, reflecting the value of health benefits provided for the 2011 tax year.
2. Grants for small employers that establish wellness programs.
3. Ability to enroll employees in the CLASS Act federal long-term care insurance.

**Insurers:**

Required to spend at least 80% of premiums on medical services on small group plans and 85% for large group plans.

**Health care savings accounts:** Federal tax on those who spend health care savings account money on ineligible medical expenses increases from 10 percent to 20 percent.

**Additional reminders for this upcoming plan year:**

- Reminder regarding **Notice of Creditable Coverage for Medicare D:**
  1. Employers must send a Notice of Creditable Coverage for Medicare D to Medicare eligible plan participants and their Medicare eligible dependents annually prior to 11/15, **and**
  2. Employers must provide a Disclosure Statement to CMS each year online within 60 days of the new plan year regarding the status of the group medical plan and whether it includes creditable or non creditable prescription drug coverage.  
[https://www.cms.gov/CreditableCoverage/45\\_CCDisclosureForm.asp](https://www.cms.gov/CreditableCoverage/45_CCDisclosureForm.asp)
- Review your Section 125 plan document and amend if needed to include plan changes. Internal Revenue Code Section 125 requires that a cafeteria plan be in writing and be adopted on or before the first day of the first plan year to which it relates. This applies to amendments to the plan as well. In proposed regulations issued in 2007, the IRS stated that if a cafeteria plan does not comply with applicable requirements regarding content and timing of adoption, then the plan is not a cafeteria plan and all employees' elections of non-taxable benefits are not effective.
- Maintain employee Salary Redirection Agreements for Election of Pre-Tax Benefits.
- Request that employees review and update beneficiary forms for Life insurance annually.

*In the coming months, Stahl & Associates Insurance will continue to provide further communication regarding Health Care Reform. Please remember that we are available to help with your questions on Health Care Reform and how it affects your employee benefit plans. Contact your Account Executive with any questions.*

## Department of Labor MODEL NOTICE 1

**Grandfathered Health Plan  
Model Language**

To maintain status as a **grandfathered health plan**, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

This model notice is available as a Word Document on our website for easy customization and editing. Please go to [www.stahlinsurance.com](http://www.stahlinsurance.com) and click on the "Read Our Latest News" link.

The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information].

- [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.]
- [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]

**Department of Labor MODEL NOTICE 2****Notice of Opportunity to Enroll in connection with  
Extension of Dependent Coverage to Age 26  
Model Language**

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.

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The following model language can be used to satisfy the notice requirement:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in **[Insert name of group health plan or health insurance coverage]**. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to **[insert date that is the first day of the first plan year beginning on or after September 23, 2010.]** For more information contact the **[insert plan administrator or issuer]** at **[insert contact information]**.

## Department of Labor MODEL NOTICE 3

**Lifetime Limit No Longer Applies and Enrollment Opportunity  
Model Language**

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

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The following model language can be used to satisfy the notice requirement:

The lifetime limit on the dollar value of benefits under **[Insert name of group health plan or health insurance issuer]** no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the **[insert plan administrator or issuer]** at **[insert contact information]**.

**Department of Labor MODEL NOTICE 4****Patient Protection Model Disclosure**

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

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The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].