

Self-Funded Group Health Plan Renewals On or After September 23, 1010: What Changes Will Your Health Plan Need to Implement?

Below you will find a summary of provisions affecting self-funded group health plans and flexible spending account plans for 2010 and 2011. This summary does not address all provisions of PPACA, but is prepared for your information for upcoming self-funded and flexible spending account plan changes.

IMPORTANT: New Notices and Special Open Enrollment Opportunities must be provided no later than the first day of the first plan year beginning on or after September 23, 2010 as provided under the transitional rule.

One special open enrollment opportunity is for those individuals who reached a lifetime limit under a plan prior to the effective date of these rules, dropped coverage, and are otherwise still eligible under the plan. These individuals must be provided with a notice that the lifetime limit no longer applies, as well as an enrollment opportunity. The enrollment opportunity must last for at least 30 days. The other special open enrollment opportunity applies to dependent children up to age 26.

Anyone eligible for one of these enrollment opportunities must be treated as a special enrollee and given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment. Any difference in benefits or cost-sharing requirements constitutes a different benefit package. These individuals cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit. These notices may be provided to an employee on behalf of the employee's dependent. **Effective date of coverage** - For those enrolling under this transition rule, coverage must take effect no later than the first day of the first plan year beginning on or after September 23, 2010.

Model notices have been released by the Department of Labor (see list below for additional notices). Health Cost Solutions will be providing you with word documents that may be tailored to fit your plan as needed and included with enrollment materials or via payroll stuffers. For an additional fee, Health Cost Solutions will assist you with individual mail outs, should you choose not to distribute these notices with your open enrollment materials or via payroll stuffers.

Health Cost Solutions will be sending out more information for your review shortly regarding the recent guidance released about grandfathered plan status, preventive benefits and internal claims and appeals and external review processes.

Note: This information is presented for informational purposes and is not to be considered legal or tax advice. Consult a legal or tax professional for guidance.

All questions regarding this newsletter and health care reform issues should be directed to: HealthReform@hcsbenefits.com. To remove your name from our mailing list, please [click here](#).

As you will see from the outline below, grandfathered plans still have to comply with most of the provisions of PPACA. In fact, the more you read about grandfathered plan status, you will see that the regulations are basically written so that most plans will become disqualified from grandfathered plan status.

Required Features for Plans Renewing	Applies to Grandfathered Self-Funded Plan	Applies to Non-Grandfathered Self-Funded Plan
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On or After September 23, 2010		
<p>Special enrollment notice and enrollment opportunity for participants who have already reached a lifetime limit.</p> <ul style="list-style-type: none"> - Notice and enrollment opportunity must be given to individuals who have reached their lifetime limit and are otherwise still eligible for coverage. - Coverage to be effective no later than the first day of the first plan year beginning on or after September 23, 2010. 	X	X
<p>Special enrollment notice and enrollment opportunity for dependents to age 26.</p> <ul style="list-style-type: none"> - Notice and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after 9/23/10. - Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010. 	X	X
<p>Disclosure and Documentation of Grandfather Plan Status. <i>(Deadline or effective date not addressed in interim final regulation. We are seeking additional clarification from DOL, but would advise including this notice with other disclosures at renewal.)</i></p> <ul style="list-style-type: none"> - All grandfathered plans must include statement in materials given to participants addressing their benefits, that the plan believes it is a grandfathered plan and contact information for questions and complaints. - A grandfathered plan must maintain records documenting terms of the plan in connection with coverage in effect March 23, 2010 and make records available upon request. 	X	
<p>Notice of Rescission of Coverage</p> <ul style="list-style-type: none"> - Plan sponsors are now required to give 30 calendar day advanced notice before coverage can be rescinded (i.e. revoked retroactively) 	X	X
<p>Rescission of Coverage Prohibition</p> <ul style="list-style-type: none"> - Plans cannot rescind coverage of person unless that person has committed an act of fraud against the plan or an intentional misrepresentation of a material fact. 	X	X
<p>Plans cannot exclude pre-existing conditions for children under the age of 19 years.</p>	X	X

Required Features for Plans Renewing On or After September 23, 2010	Applies to Grandfathered Self-Funded Plan	Applies to Non-Grandfathered Self-Funded Plan
Plans cannot have lifetime maximums on essential health benefits for any individual	X	X
Plans cannot have annual maximums on essential health benefits for any individual - 3 year phase out period for annual limits.	X	X
Plans must provide dependent coverage up to dependent's 26th birthday - Regardless of marital status - Unless dependent covered by an employer sponsored health plan (if plan is grandfathered. Expires 2014)	X X X	X X
Coverage of Preventive Health Services with no cost sharing requirements - Evidence based items/services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventative Services Task Force - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention - Preventive care & screenings provided for in the comprehensive guidelines supported by the Health Resources & Services Administration for infants & children - Preventive care & screenings for women as provided by the Health Resources and Services Administration		X
Appeals Process for Individual and Group Health Plans - New requirements for internal claims appeal process & an external review process		X
Reporting on the Quality of Care to Secretary of HHS and enrollees - Whether or not the benefits under the plan & the provider reimbursement structures under the plan satisfy certain elements to improve health outcomes, prevent hospital re-admissions, improve patient safety & reduce medical errors, implement wellness & health promotion activities.		X
Transparency of Coverage Reporting - Reporting to the Secretary, public & State insurance commissioner on: claim payment policies & practices, periodic financial disclosures, data on enrollment/disenrollment, # of denied claims, rating practices, cost-sharing & payments for out-of-network coverage, & any other information as determined by the Secretary		X

Required Features for Plans Renewing On or After September 23, 2010	Applies to Grandfathered Self-Funded Plan	Applies to Non-Grandfathered Self-Funded Plan
Access to Clinical Trials <ul style="list-style-type: none"> - Plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items & services furnished in connection with "Approved Clinical Trials" 		X
Choice of Primary Care Provider <ul style="list-style-type: none"> - Plans that require beneficiaries to designate Primary Care Physicians must permit each beneficiary to designate any available provider. 		X
Coverage of Emergency Services <ul style="list-style-type: none"> - Emergency Services must be covered without need of prior authorization at the in-network benefit level, regardless of provider's participation in the network. 		X
Access to Pediatric Care <ul style="list-style-type: none"> - If PCP designation is required, a pediatrician may be selected as PCP if he/she participates in the network. 		X
Access to Obstetrical and Gynecological Care <ul style="list-style-type: none"> - No authorization or referrals necessary for OB or GYN care provided by in-network health care providers. 		X
Effective by January 1, 2011	Applies to Grandfathered Self-Funded Plan	Applies to Non-Grandfathered Self-Funded Plan
Reporting coverage costs for 2011 on W-2 <ul style="list-style-type: none"> - Employers must disclose value of benefit provided by employer for each employee's coverage on employee's W-2 - The only taxation of health benefits is scheduled to occur in 2018 when the excise tax on so-called high cost plans will take effect. The IRS will need to include clear communications in the instructions for the W-2 that the value of the health coverage is not to be taxed. 	X	X
Changes Affecting Consumer Driven Healthcare Effective by January 1, 2011	Flexible Spending Account Plans	HSA / MSA Account Plans
Flexible Spending Account Plans <ul style="list-style-type: none"> - Unless prescribed by a provider, over-the-counter medications are no longer qualifying medical expenses. 	X	
HSA/MSA Penalty Increase <ul style="list-style-type: none"> - Tax penalty on persons under age 65 for HSA/MSA withdrawals for non-qualified medical expenses increased to 20%. 		X