CHELKO CONSULTING group
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Legislative Brief

Health Care Reform: Open Enrollment Compliance Checklist

Introduction

This Chelko Consulting Group Legislative Brief provides a compliance checklist for employers to review in advance of the 2011 plan year and open enrollment season. Please contact the Chelko Consulting Group for assistance.

Compliance Checklist

Grandfathered Plan Status

- ☐ Determine if you have a grandfathered plan.
  - A grandfathered plan is one that was in existence when health care reform was enacted on March 23, 2010.
  - Grandfathered plans are exempt from some of the health care reform requirements.
  - If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact your Chelko Consulting Group representative if you have questions about changes you have made, or are considering making, to your plan.

Plan Amendments – All Plans

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):

- ☐ Amend plans to **cover dependents up to age 26**.
  - If your plan is grandfathered, it is not required to cover adult children who are eligible for coverage sponsored by their employer for plan years beginning on or before January 1, 2014.
- ☐ Amend plans to **eliminate lifetime limits** on essential benefits and to 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.
  - For plan years beginning on or after September 23, 2011, a plan may impose a minimum annual limit of $1.25 million.
  - For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a plan may impose a minimum annual limit of $2 million.
- ☐ 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 **FSAs, HSAs, HRAs 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.

- Plans that cover expenses of dependents must be amended to be consistent with any dependent eligibility changes related to the **age 26 rule**.

☐ Amend plans to incorporate new rules regarding **rescissions**.

- A rescission is a termination of coverage that has a retroactive effect. However, a retroactive cancellation is not a rescission to the extent it is caused by a failure to pay premiums.
- Rescissions are only permitted in cases of fraud or intentional misrepresentation of a material fact.

Plan Amendments – Non-Grandfathered Plans Only

Plan sponsors of non-grandfathered plans 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 definitions and requirements.

- Revise definition of adverse benefit determination.
- Update deadline for notice regarding urgent care claims.
- Adopt procedures to provide full and fair review and avoid conflicts of interest.
- Provide culturally and linguistically appropriate notices regarding the process and options for assistance.
- Ensure plan is following appropriate external review process.

☐ Amend fully-insured plans to eliminate **impermissible discrimination** in favor of highly compensated employees.

- Plans may not longer discriminate with respect to eligibility or benefits.

☐ Amend plans to include **patient protections**.

- If the plan requires participants to choose a primary care provider, allow participant to choose any available participating primary care provider or pediatrician.
- Permit participants to obtain OB/GYN care without a pre-authorization or referral.
- Eliminate pre-authorization requirement for emergency services.
- Eliminate increase coinsurance or copayment requirements for out-of-network emergency services.

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.

Participant Notices

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. This information must inform participants that the plan is not subject to some of the consumer protections of the health care reform law. Model language is available regarding this requirement.

There are a number of other health care reform provisions that require notices to be provided to plan participants. **Model notices** are available for some of these notices at www.dol.gov/ebsa/healthreform/.

Employers should make sure they are prepared to provide the following notices prior to the **first plan year beginning on or after September 23, 2010** (unless another deadline is noted). To be thorough, plans should include these notices in their SPDs, as applicable.

- ☐ 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 available.
- ☐ 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 available.
- ☐ Notice to participants in non-grandfathered plans regarding the **patient protections** that are available. A model notice is available.
- ☐ 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.

Going forward, plans will be required to provide certain notices to plan participants, including the following:

- ☐ Written notice of any **rescission** must be provided at least 30 days in advance.
- ☐ Non-grandfathered plans must provide a culturally and linguistically appropriate notice to participants regarding the **new appeals process** and their options for assistance.

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