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Re: Health Care Reform Year-End Review and Action Items

Dear Clients and Other Friends,

Autumn is here, bringing with it cooler weather and brightly-colored leaves. This year, however, autumn is also the time for health care reform and its array of year-end action items. With the passage of the Patient Protection and Affordable Care Act ("PPACA") and the accompanying Health Care and Education Reconciliation Act ("HCERA") earlier in 2010, many health care reform provisions become effective January 1, 2011 for calendar year plans.¹ As such, **grandfathered or not, all group health plans will need to implement year-end plan changes and certain amendments, as well as issue new notices to participants and beneficiaries.**

As the year-end approaches, plan sponsors have several planning issues to consider and many action items to complete. The following **checklist** provides a brief synopsis of these action items:

- Finalize grandfathering decisions:** Group health plan sponsors must decide which plans and policies will maintain grandfathered plan status in the 2011 plan year. For those who have not yet done so, now is the time to review the advantages, disadvantages and relative costs of grandfathering. It is important to finalize these decisions soon in order to have sufficient time for other year-end requirements. If your plan is fully-insured, this decision may be made for you, depending on whether your insurance carrier will offer your plan in grandfathered form.

If your plan will maintain grandfathered status in the 2011 plan year, you must provide notice to participants and beneficiaries that the group health plan is believed to be grandfathered. Notice of grandfathered status should be provided with open enrollment materials for the 2011 plan year and in any subsequent materials provided to participants describing benefits provided under the plan (while it remains grandfathered).

- Determine how to apply certain requirements:** Prior to amending group health plan documents, plan sponsors must decide how to apply various required and permissive changes.² One example is how to apply required coverage for adult children up to age 26. Plan sponsors *must* cover adult children until the attainment of age 26, regardless of student status or tax dependency. However, plan sponsors are *permitted* to exclude employer-provided health care reimbursements from an employee's federal gross income for adult children up to age 27. The interaction between the required coverage and permitted tax exclusion allows for flexibility in plan design. As plan sponsors implement each of the

¹ Most provisions are effective for Plan Years beginning on or after September 23, 2010, so if you do not have a calendar year plan, you may have to implement some of these changes before (or after) January 1.

² See our June 11, 2010 Client Letter for a summary of these changes, available at this web link: <http://www.khblaw.com/docs/2010-06-1-KHB-Q&As-Chngs.pdf>.

required changes, they should also carefully examine how to structure year-end amendments in a way that is feasible and efficient for group health plan administration.

- **Determine the extent of coordination between your group health plan and any other applicable plans, such as dental or vision plans:** In addition to determining how to apply requirements within a plan, plan sponsors should also carefully determine the extent of coordination between the group health plan and any other applicable plans, such as dental or vision plans. For example, the requirement to cover adult children up to age 26 changes the eligibility and coverage provisions in the group health plan. This change may result in the application of different eligibility and coverage rules in the group health plan as opposed to those applied under dental or vision plans. Moreover, such changes may result in more complex administration issues when the dental or vision plans are integrated under the same group health plan. In this situation, plan sponsors must decide how to administer the new rules:

- Maintain similar rules across all plans?
- Create different eligibility and coverage rules for different groups across plans?
- Change the plan design for separate election of benefits?

This is only one example of coordination issues. As in the previous action item, plan sponsors should examine the coordination between group health plans and any other applicable plans, ensuring that administration decisions are carefully drafted and implemented.

- **Determine whether group health plans qualify as “limited benefit” or “mini-med” plans, and, if so, whether to apply for a waiver of the restricted annual limits for the upcoming year:** Generally, these “mini-med” plans offer lower-cost coverage to part-time workers, seasonal employees and volunteers who may not otherwise be able to afford coverage. “Mini-med” plans are characterized by lower premiums and limited benefits. Employers sponsoring these plans should determine whether to apply for a waiver of the restricted annual limits for the coming plan year. If you choose to apply for a waiver, the application must be submitted to the Department of Labor at least 30 days before the first day of the upcoming plan year.

- **Consider adopting year-end amendments:** All group health plans, grandfathered and non-grandfathered, must be reviewed and amended where necessary for health care reform changes. For group health plans with a calendar year plan year, plan documents must be reviewed before January 1, 2011 for the following:

- Establish automatic enrollment in group health plans (for large employers with more than 200 employees);
- Provide for coverage of adult children up to age 26;
- Eliminate lifetime benefit limits and create a special enrollment opportunity;
- Revise pre-existing annual benefit limits for “essential health benefits” and new permitted limits;
- Remove pre-existing condition exclusions for children under age 19;
- Eliminate reimbursements for over-the-counter medications purchased without prescriptions; and
- Restrict the ability to rescind coverage.

Non-grandfathered plans are subject to additional requirements under PPACA, including:

- Comply with new requirements for internal claims and appeals;
- Establish external review procedures (for self-insured plans);
- Eliminate cost-sharing for in-network preventative services;
- Incorporate new nondiscrimination rules (applicable to fully-insured plans); and
- Provide for new patient protections (for example, primary provider designations and removal of emergency services pre-authorizations).

At the moment it is unclear exactly when plans need to be formally amended for the new rules. Plans must, however, be operated in accordance with the new rules beginning with the 2011 plan year and all applicable notices referenced in the next action item must be distributed to participants on or before the first day of the 2011 plan year.

If your plan is fully-insured, these changes may be made for you by your insurance carrier, depending on whether your plan will be maintained in grandfathered form. Whether your group health plans are fully-insured or self-insured, it is recommended that you confirm the applicable changes with your insurance carrier or third-party administrator. Also, plan sponsors should contact their benefits legal counsel to ensure that the group health plans are amended in good faith compliance.

- **Prepare and issue new notices to participants and beneficiaries:** In addition to amending plans and policies, plan sponsors must notify participants and beneficiaries of these changes. Depending upon the group health plan's grandfathered status and prior plan design, participants and beneficiaries must receive the following notices (as applicable):

- Grandfathered plan status notice;
- Automatic enrollment notice (official guidance to be issued);
- Lifetime benefit notice and special enrollment opportunity;
- Age 26 dependent child coverage notice and special enrollment opportunity; and/or
- Patient protections notice (*i.e.*, designation of primary care provider, pediatrician, OB/GYN).

The notices listed above that apply to your group health plans must be distributed to participants on or before the first day of the 2011 plan year. Model language has been issued for most of these notices.

Additionally, plan sponsors will be required to distribute new and improved Summary Plan Descriptions, including a summary of benefits and coverage, written in a culturally and linguistically appropriate manner. As yet, there is no model notice. Further guidance from the Departments of Labor, Treasury and Health and Human Services is anticipated in the coming months.

Plan sponsors should contact their insurance carriers or third-party administrators to determine who will prepare and distribute these notices. Plan sponsors may also want to contact their benefits legal counsel for assistance with these notice requirements.

- **Do not forget your Cafeteria Plans, FSAs and HRAs:** In addition to group health plans, Cafeteria Plans, Health Flexible Spending Arrangements (FSAs) and Health Care Reimbursement Arrangements (HRAs) will need attention. These plans are in many cases subject to several of the same requirements that apply to group health plans, including:
- Required coverage of adult children up to age 26;
 - Removal of cost-sharing provisions for preventative care;
 - Compliance with new requirements for internal claims, internal appeals and external review processes; and
 - Elimination of reimbursement of over-the-counter medications purchased without a prescription.

For example, cafeteria plans may need to be amended if the employer wants to provide tax-free premium payments for non-tax dependent children. In some cases, premium payments may be tax-free for federal tax purposes but not for state tax purposes.

As with group health plans, plan sponsors should review their plan documents for these required changes, as well as prepare and distribute notices to participants and beneficiaries. Plan sponsors should also check with their third-party administrators to discuss the implementation of these changes.

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As more regulations and official guidance is issued in the coming months, health and welfare benefit plans will continue to be affected by new requirements. It is important for plan sponsors to stay informed of these changes and to practice good faith compliance, especially concerning issues where guidance is yet unclear.

Whether you have a question about a particular issue or would like a comprehensive review of the year-end requirements that directly affect your plans, we would welcome the opportunity to assist you.

Sincerely,

Sonja Lemmer Martens

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