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Health Care Reform: Compliance Checklist for Health Plan Changes

Health care reform, in the form of the Patient Protection and Affordable Care Act (ACA), brought many changes for employers and their health plans. The health care reform changes have staggered effective dates. Many of ACA's changes for health plans became effective for the first plan year beginning on or after Sept. 23, 2010. Other changes have later effective dates.

Sponsors of group health plans should be aware of the health care reform changes affecting their plans. To understand plan coverage and premium rates, sponsors should be familiar with the health care reform changes that are already in place for their plans. In addition, sponsors should be aware of future ACA changes that will affect plan coverage in the coming year.

This InterWest Insurance Services, Inc. Legislative Brief provides a compliance checklist for health care reform changes affecting health plan coverage.

GRANDFATHERED PLAN STATUS

☐ If you have a **grandfathered plan**, determine whether it will maintain its grandfathered status at renewal time.

- 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. A grandfathered plan's status will affect its compliance obligations from year to year.
- If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact your InterWest Insurance Services, Inc. representative if you have questions about changes you have made, or are considering making, to your plan.

☐ If you **move to a non-grandfathered plan**, confirm that the plan has all of the additional patient rights and benefits required by ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

☐ If you have a grandfathered plan, make sure to 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 explain to participants that the plan is not subject to some of the consumer protections of the health care reform law.
- Model language is available from the Department of Labor (DOL) at: www.dol.gov/ebsa/healthreform.

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PLAN AMENDMENTS – ALL PLANS

Dependent Coverage to Age 26

☐ Effective for the first plan year beginning on or after Sept. 23, 2010, your plan should 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 before Jan. 1, 2014.
- Other than the relationship between the child and the participant, your plan may not impose any eligibility restrictions on dependents under age 26, such as a requirement that the dependent be a full-time student or unmarried.
- The federal tax code was changed so that the value of this dependent coverage is excluded from an employee's income until the end of the tax year in which the child turns age 26. In addition, all states should now be in conformity with this federal tax law change.

Lifetime and Annual limits

☐ Effective for the first plan year beginning on or after Sept. 23, 2010, your plan must have **eliminated lifetime limits** on essential health benefits.

☐ Beginning **Jan. 1, 2014**, health plans will be prohibited from placing annual limits on essential health benefits. Until then, however, restricted annual limits are permitted. Unless your plan received an annual limit waiver, its annual limits on essential health benefits must comply with the following amounts for each applicable plan year:

- For plan years beginning on or after Sept. 23, 2010, a plan may impose a minimum annual limit of $750,000.
- For plan years beginning on or after Sept. 23, 2011, a plan may impose a minimum annual limit of $1.25 million.
- For plan years beginning on or after Sept. 23, 2012 (but before Jan. 1, 2014), a plan may impose a minimum annual limit of $2 million.
- The waiver program closed to applications effective Sept. 22, 2011**.** If your plan received a waiver, it must comply with the requirements of the waiver, including **providing a notice** informing current and eligible participants that the plan does not meet the minimum annual limits and has received a waiver of the requirement. HHS's model notice is available at: http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf.

Pre-Existing Condition Exclusions

☐ Effective for the first plan year beginning on or after Sept. 23, 2010, your plan must have eliminated **pre-existing condition exclusions** for children **under age 19**.

- Pre-existing condition exclusions will be eliminated altogether for plan years beginning on or after **Jan. 1, 2014**.

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Tax-Advantaged Medical Accounts

☐ Plans that include tax-advantaged medical accounts, such as **FSAs, HSAs, HRAs or Archer MSAs**, must be amended for new requirements.

- Plans that permit reimbursement of **over-the-counter medicine or drugs** must have been amended to provide that these expenses are reimbursable only with a doctor's prescription (except for insulin) if they are incurred after Dec. 31, 2010.
- Plans that cover expenses of dependents must have been amended to be consistent with any dependent eligibility changes related to the **age 26 rule** (note that HSA distribution rules have not been changed).
- **Beginning in 2013**, a health FSA offered through a cafeteria plan will have to limit the amount of salary reduction contributions that employees can make. Effective for taxable years beginning after Dec. 31, 2012, employees may not elect to contribute more than **$2,500 per year** to a health FSA. This amount will increase in future years to reflect cost-of-living increases.

Rescissions

☐ Your plan must have been amended to incorporate 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.
- Effective for plan years beginning on or after Sept. 23, 2010, rescissions are only permitted in cases of fraud or intentional misrepresentation of a material fact.
- Written notice of any rescission must be provided at least 30 days in advance.

PLAN AMENDMENTS – NON-GRANDFATHERED PLANS ONLY

Preventive Services

☐ Effective for plan years beginning on or after Sept. 23, 2010, your plan must cover recommended **preventive services** without cost-sharing requirements. However, if your plan is grandfathered, this requirement does not apply.

☐ Effective for plan years starting on or after **Aug. 1, 2012**, non-grandfathered plans must cover specific **preventive services for women** without cost-sharing requirements. These services include well-woman visits, STD screening and contraceptives. Exceptions to the contraceptives requirement apply to certain religious employers.

Claims and Appeals Procedures

☐ Non-grandfathered plans must have established an effective claims and appeal process by amending current claims procedures to incorporate new definitions and requirements. This requirement was generally effective for plan years beginning on or after Sept. 23, 2010, although some provisions have delayed effective dates.

- Revised definition of adverse benefit determination.
- Adopted procedures to provide full and fair review and avoid conflicts of interest.

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- Ensure plan is following appropriate external review process.
- Include additional information in notices to claimants, such as information identifying the claim, reasons for the denial, the description of the appeals process and information regarding available consumer assistance (delayed until plan years beginning on or after **July 1, 2011**).
- Provide notices in a culturally and linguistically appropriate manner (delayed until plan years beginning on or after **Jan. 1, 2012**).

Patient Protections

☐ Effective for plan years beginning on or after Sept. 23, 2010, your plan must 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 increased coinsurance or copayment requirements for out-of-network emergency services.

☐ Non-grandfathered plans must provide a notice of patient protections whenever the SPD or similar description of benefits is provided to a participant. Model language is available regarding this requirement from the DOL at: www.dol.gov/ebsa/healthreform.

OTHER REQUIREMENTS – ALL PLANS

Summary of Benefits and Coverage

☐ Plans and insurance issuers must provide a **Summary of Benefits and Coverage** (SBC) to participants and beneficiaries.

- The SBC is a concise document – no more than four double-sided pages - providing simple and consistent information about health plan benefits and coverage in plain language.
- A template for the SBC is available, along with instructions and examples for completing the template and a uniform glossary of terms, at http://cciio.cms.gov/resources/other/index.html#sbcug.

☐ Plans and issuers must start providing the SBC as follows:

- Issuers must provide the SBC to health plans effective **Sept. 23, 2012**.
- Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first day of the **first open enrollment period** that begins on or after **Sept. 23, 2012**.
- For participants who enroll in coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees), plans and issuers must provide the SBC beginning on the first day of the **first plan year** that begins on or after **Sept. 23, 2012**.

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60-Day Notice of Plan Changes

- ☐ Plans and issuers must provide **60 days' notice** of any **material modifications** to the plan that are not related to renewals of coverage. Notice can be provided in an updated SBC or a separate summary of material modifications.

Medical Loss Ratio (MLR) Rebates

- ☐ Fully insured plans may receive **rebates** in **August 2012** if they qualify for a rebate from their issuers due to the medical loss ratio (MLR) rules requiring insurance companies to spend a certain percentage of premium dollars on health care. The rebates must be used for the benefit of the plan's enrollees, which may include reducing enrollees' premium payments.

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