



BURNING BENEFITS NEWS

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August 12, 2010

IN THIS ISSUE:

IT'S "GO TIME" FOR CHANGES REQUIRED BY HEALTHCARE REFORM

Design changes required by the "Healthcare Reform Act" for calendar year plans must be communicated to employees no later than November 1, 2010 (e.g., during the fall open enrollment period). Many of the Healthcare Reform changes are effective January 1, 2011, for calendar year plans. Under Healthcare Reform, "material changes" must be communicated at least 60 days prior to the beginning of the plan year to which they relate. The effective date of this new 60-day notice is unclear. We recommend that clients take a conservative approach and communicate any changes required by Healthcare Reform no later than November 1, 2010. Better to be safe than sorry and comply this year.

In order to help comply with Healthcare Reform's numerous and complex requirements, we prepared this [checklist](#). It describes not only the required Healthcare Reform changes, but also changes required under proposed cafeteria plan rules, Michelle's Law, COBRA/ARRA, HIPAA/CHIPRA and the Mental Health Parity and Addiction Equity Act. These other changes may have been overlooked in the flurry of activity around Healthcare Reform. Please let us know if we can assist in your design changes and required plan changes, as well as any requisite notices.

REGULATIONS ISSUED ON PREVENTIVE SERVICES AND CLAIMS AND APPEALS PROCESSES

Following our June 28, 2010 webcast on Healthcare Reform, the DOL, IRS and HHS have jointly issued significant "interim final" regulations on preventive care rules and claims and appeals processes.

- **Preventive Care Rules:** <http://edocket.access.gpo.gov/2010/pdf/2010-17242.pdf>

Effective January 1, 2011 (for calendar year plans), non-grandfathered plans are required to provide a wide array of preventive care services with no cost sharing (e.g., no deductibles and no copayments).

ACTION: Plan documents must be amended, summary plans descriptions ("SPDs") updated, cost structures modified, and materials prepared for open enrollment. If this applies to your plan, it's "go-time!"

- **Claim and Appeal Processes (including external review):**
<http://edocket.access.gpo.gov/2010/pdf/2010-18043.pdf>

Non-grandfathered plans must meet significantly-changed claim and appeal rules beginning January 1, 2011 (for calendar year plans.) These rules include special external review requirements, and very stringent internal claim processes.

ACTION: Determine whether these rules apply to your plan. If so, take the necessary actions including amending your plan documents and updating your SPDs and other participant communications. Time is short. The need is critical.

We expect there to be several more pieces of guidance issued before year-end. We will notify you as they occur.

If you missed our June 28th webcast, you can still access it using the information below:

- Dial-in Access: 888-496-6260 or 480-629-9053
- Participant Code: 11544869
- Confirmation Number: 92561

Slides are available [here](#).

DOL ISSUES MODEL NOTICES UNDER HEALTHCARE REFORM

The DOL has issued several **model notices** under Healthcare Reform. You will want to incorporate these materials into your group health plan's summary plan description, open enrollment materials and other participant communications. This goes beyond your insurance contracts. This must be part of a coordinated process including your official ERISA plan documents, enrollment processes, and operational procedures. Time is very short. Legal attention is required in advance of your open enrollment this fall. Please contact Tim McGraw, Bob Stevenson or Mickey Bartlett promptly for assistance.

- **Grandfathered Status:** To maintain status as a grandfathered health plan, a plan must include a statement in any plan materials provided to a participant or beneficiary (i) describing the benefits provided under the plan, (ii) stating the plan is grandfathered, and (iii) providing contact information for questions or complaints. » [Model Notice](#)

- **Opportunity to Enroll Dependents to Age 26:** Dependent children under age 26 who were denied group health care coverage based on their age must be given the opportunity to enroll during an enrollment period of at least 30 days. Written notice of this opportunity to enroll must be provided in a prominent fashion with other enrollment materials that a plan distributes (e.g., open enrollment materials). For calendar year plans, coverage is effective January 1, 2011. » [Model Notice](#)
- **Lifetime Limit No Longer Applies + Enrollment Opportunity:** For plans that have a lifetime limit, written notice must be given that the lifetime limit will no longer apply to “essential health benefits” and that affected individuals are once again eligible for benefits. Individuals no longer enrolled due to exhausting the limit must be given written notice and the opportunity to enroll during an enrollment period of at least 30 days. Coverage is effective January 1, 2011, for calendar year plans. » [Model Notice](#)
- **Patient Protection:** If a medical plan requires designation of a primary care physician, the plan’s SPD must include written notice of an individual’s right to choose any available primary care provider including pediatricians. The SPD also must mention the right to obtain obstetrical or gynecological care without prior authorization. This notice must be provided no later than January 1, 2011, for calendar year plans. » [Model Notice](#)
- **Medicaid and Children’s Health Insurance Program:** Employees must be notified annually about premium assistance programs that some states offer under Medicaid and the Children’s Health Insurance Program. Written notice must be given to all employees residing in a state that offers assistance. The first notice is due by January 1, 2011, for calendar year plans. If included with other materials, the notice must appear separately and in a manner which ensures that employee could appreciate its significance. » [Model Notice](#)

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