

Employee Benefits & Executive Compensation Client Service Group

To: Our Clients and Friends

September 20, 2010

Check It Out and Check It Off: 2010 and 2011 Group Health Plan Checklist

Several new laws and regulations from 2010 require significant design changes to group health plans and impose new notice requirements on plan sponsors. Below is a checklist of these major changes which require implementation in 2010 or 2011 as well as a listing of enrollment and annual notices that group health plan sponsors should consider during open enrollment.

In addition, a reminder about the October 15 deadline for the Form 990 Relief Program for tax-exempt organizations, including VEBAs, is provided at the end of the Alert.

I. MANDATED DESIGN CHANGES

A. PATIENT PROTECTION AND AFFORDABLE CARE ACT

All Group Health Plans. A group health plan subject to the Patient Protection and Affordable Care Act, as amended ("PPACA") must comply with the following requirements, regardless of its status as a "grandfathered health plan," beginning with the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans):

- Dependent coverage until age 26.*** A group health plan providing dependent coverage for children must make such coverage available for children up to age 26 without regard to their financial dependency, residency, marital or student status. The cost and benefits associated with the dependent coverage cannot vary based on the age of the child (except for children age 26 or older). However, for plan years beginning before January 1, 2014, health plans that are grandfathered for purposes of PPACA do not have to extend coverage to adult children who are eligible to enroll in another employer-sponsored health plan (other than a group health plan of a parent).
- No lifetime limits.*** A group health plan may not impose lifetime limits on the dollar value of coverage provided under the plan.

- ***No annual limits on essential health benefits.*** Annual limits on the dollar value of essential health benefits are prohibited; however, under a three-year phased approach a group health plan may apply restricted annual limits for plan years beginning before January 1, 2014. For the plan year beginning on or after September 23, 2010 but before September 23, 2011, the annual must not be less than \$750,000.
- ***Rescission limitations.*** Plan coverage may be rescinded retroactively only in cases of fraud or intentional misrepresentation.
- ***No pre-existing condition exclusions.*** Pre-existing condition exclusions are not permitted with respect to covered individuals who are under 19 years of age. The prohibition of pre-existing condition exclusions will extend to all plan participants for plan years beginning on or after January 1, 2014.
- ***Non-prescription over-the-counter (“OTC”) drugs.*** Expenses incurred on or after January 1, 2011 for OTC drugs without a prescription (other than insulin) may not be reimbursed under a flexible spending account, health savings account or health reimbursement arrangement. Special rules apply to expenses paid through account debit cards.

Non-Grandfathered Plans. Group health plans that are not grandfathered for PPACA purposes must comply with the following additional requirements:

- ***Coverage of Preventive Care.*** A group health plan must provide benefits for preventive health services and may not impose any cost-sharing requirements on participants with respect to in-network preventive health services.
- ***Revised Internal Claims Procedures and New External Claims Procedures.*** Regulations impose new requirements on the internal claims procedures for adverse benefit determinations. In addition, if a claimant’s appeal of an adverse benefit determination is denied, he or she is entitled to an external review of that determination through an external review process.
- ***Patient Protections.*** The group health plan must implement the following patient protections:
 - If the group health plan requires or provides for designation of a participating primary care provider, each participant must be permitted to designate any in-network primary care physician (or pediatrician, in the case of a child) who is available to accept such individual.
 - Participants must be provided with direct access to in-network obstetrical or gynecological care without a referral.
 - Prior authorization or increased cost sharing for out-of-network emergency services is prohibited.

B. MENTAL HEALTH PARITY ACT

- Subject to certain limited exceptions, the Mental Health Parity Act prohibits a group health plan that provides mental health and substance abuse benefits from imposing special caps or limits on benefits related to mental health treatment or substance use disorders. Generally, treatment limits and cost sharing, including deductibles, co-pays, co-insurance and out-of-pocket expenses cannot be more restrictive than the most common or frequent rules that apply to substantially all medical and surgical benefits provided under the plan. If a plan offers out-of-network benefits for medical and surgical coverage, out-of-network benefits must also be offered for mental health and substance disorders. Although these requirements were effective in 2010 for most plans, detailed regulations were not issued until February 2, 2010. Therefore, a review of mental health and substance abuse benefits may be needed in order to ensure compliance with the regulations.

C. HITECH ACT

- The Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”) set forth new rules for protection of personal health information (“PHI”) held by providers, group health plans and other covered entities. Beginning on February 17, 2010, a plan’s business associates are: (i) directly responsible for their own compliance with HIPAA’s privacy and security requirements; (ii) required to provide the plan with notice of their own breach; and (iii) subject to the new enforcement provisions, in contrast to the prior rule which required only a contractual obligation to the plan. Group health plans must revise their business associate agreements to reflect these changes.

II. NEW NOTICE REQUIREMENTS

A. PATIENT PROTECTION AND AFFORDABLE CARE ACT

PPACA requires group health plans to provide certain notices relating to specific mandated plan design changes.

- Grandfathered Status.*** In order to maintain grandfathered status under PPACA, a group health plan must disclose, in any plan materials provided to a participant or beneficiary describing benefits under the plan, that the plan or coverage is a grandfathered health plan under PPACA. The notice must also include contact information for questions and complaints. Model language provided by the Department of Labor to satisfy this disclosure requirement is available at <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>.
- Enrollment Opportunity for Dependent Children Age 26.*** A plan must give each child whose coverage ended or who was denied coverage (or was not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26, an opportunity to enroll for plan coverage during a period of not less than 30 days and provide written notice of this enrollment opportunity. The notice and enrollment opportunity must be provided no later than the first day of the first plan

year beginning on or after September 23, 2010. Coverage must be effective no later than the first day of that plan year. The notice may be included with other enrollment materials that the plan distributes, provided the statement is prominent. Model language provided by the Department of Labor to comply with the required notice of this enrollment right is available at

<http://www.dol.gov/ebsa/dependentsmodelnotice.doc>.

- ***No Lifetime Limit and Enrollment Opportunity.*** A plan must give written notice to current participants who are not eligible for additional benefits because they previously reached the lifetime limit on benefits, notifying them that the limit no longer applies and that they are once again eligible for benefits under the plan. Individuals who are not plan participants or whose coverage ended by reason of reaching a lifetime limit under a plan must be given an opportunity to enroll in coverage during a period of not less than 30 days, with coverage effective no later than the first day of the applicable plan year. The notice and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Model language provided by the Department of Labor is available at <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>.

- ***New Patient Protections.*** A group health plan that is not grandfathered for PPACA purposes is required to notify participants of their rights (i) to choose a primary care provider or pediatrician if designation of a primary care physician is required; or (ii) obtain in-network obstetrical or gynecological care without prior authorization. The regulations provide that the notice must be provided whenever the plan provides a participant with a summary plan description or other similar description of benefits under the plan; however, the Department of Labor's model language states that notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Model language provided by the Department of Labor to satisfy this requirement is available at <http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>.

B. HITECH ACT

- HITECH imposes specific obligations on group health plans to promptly notify affected individuals, and in some cases, the U.S. Department of Health and Human Services and the media, in the event of a breach of unsecured PHI. Plans must also file an annual report with HHS disclosing all of such breaches for the year. Although technically effective in 2009, HHS established a non-enforcement period with respect to breaches discovered on or after February 10, 2010. With the expiration of the non-enforcement period, group health plans must comply with the breach notification requirements or face enforcement action and imposition of civil penalties by HHS.

III. EXISTING NOTICE REQUIREMENTS

A. ENROLLMENT NOTICES

- ***COBRA Notice.*** Plan administrators must provide written notice to each employee and his or her spouse when group health plan coverage first commences of his or her rights

under the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”). Additionally, plan administrators must provide notice to each qualified beneficiary of his or her right to elect continuing coverage under the plan upon the occurrence of a qualifying event. Each of these notices must contain specific information, and the Department of Labor has issued model notices.

- ***HIPAA Privacy Notice.*** If the group health plan is required to maintain a notice of privacy practices under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the notice must be distributed upon an individual’s enrollment in the plan. Notice of availability to receive another copy must be given every three years.
- ***Special Enrollment Rights.*** A group health plan must provide each employee who is eligible to enroll with a notice of his or her HIPAA special enrollment rights at or prior to the time of enrollment. This notice must describe the recently enacted rights afforded under the Children’s Health Insurance Program Reauthorization Act.
- ***Pre-existing Condition Exclusion Notice.*** If the plan contains pre-existing condition exclusions, subject to the PPACA limitations, a notice describing the exclusions and how prior creditable coverage can reduce the exclusion period must be provided to participants as part of any written enrollment materials. If there are no written enrollment materials, the notice must be provided as soon as possible after a request for enrollment is made by a participant.

B. ANNUAL NOTICES

The following notices must be provided to participants and beneficiaries each year. An employer may choose to include these notices in the plan’s annual open enrollment materials.

- ***Women’s Health and Cancer Rights Act Notice.*** The Women’s Health and Cancer Rights Act requires that a notice be sent to all participants describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy. This notice must be given to plan participants upon enrollment and then annually thereafter. The Department of Labor has developed model language to fulfill this requirement.
- ***Medicare Part D Notice.*** Group health plans providing prescription drug coverage must provide a notice to any individual covered by or eligible for the group health plan who is eligible for Medicare (an “eligible individual”). The notice must explain whether the plan’s prescription drug coverage is creditable. Coverage is creditable if it is actuarially equivalent to coverage available under the standard Medicare Part D program. In order to satisfy the distribution timing requirements, the notice is generally distributed upon an individual’s enrollment in the plan, each year during open enrollment and during the plan year if the status of the coverage changes (either for the plan as a whole or for the individual). Model notices are available from the Centers for Medicare and Medicaid.

- ***CHIP Premium Assistance Notice.*** Employers must also provide notices annually to employees regarding available State premium assistance programs that can help pay for coverage under the plan and how to apply for it. Employers with group health plans on a calendar year plan year are first required to provide these notices by the first day of the first plan year after February 4, 2010 (or by May 1, 2010, if later). A model notice from the Department of Labor is available at <http://www.dol.gov/ebsa/chipmodelnotice.doc>.

C. ERISA'S GENERAL NOTICE REQUIREMENT

- It is important to keep current with ERISA's general notice requirements, as to both timing and content. For example, changes in plan design must be reflected in summaries of material modifications or updated summary plan descriptions ("SPDs") timely distributed to eligible employees. If a change involves a material reduction in covered services or benefits, a summary of material modifications or an updated SPD must be furnished within 60 days after adoption. Restated SPDs must be furnished every five years if the plan has been amended within five years of publication of the most recent SPD, and every ten years if the information has not been changed. Open enrollment may present the best time to distribute these materials.

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OCTOBER 15 DEADLINE FOR REMEDIAL RELIEF PROGRAM FOR DELINQUENT FORM 990 FILERS

All VEBA's and tax-exempt organizations, other than churches and church-related organizations, are required to file an annual Form 990 with the IRS. Small tax-exempt organizations that prior to 2007 had not been subject to this filing requirement must file a Form 990-N. Any tax-exempt organization that fails to file for three consecutive years automatically loses its federal tax-exempt status.

A one-time relief program for tax-exempt organizations that face automatic revocation of tax-exempt status for failure to file is available for (i) organizations that were eligible to submit Form 990-N, and (ii) organizations that were eligible to file Form 990-EZ for the current and prior two tax periods.

Form 990-N: A tax-exempt organization is eligible to file a Form 990-N if its annual gross receipts are normally \$25,000 or less.

Form 990-EZ: A tax-exempt organization is eligible to file a Form 990-EZ:

- for the 2008 tax year, if gross receipts are less than \$1 million and total assets are less than \$2.5 million;
- for the 2009 tax year, if gross receipts are less than \$500,000, and total assets are less than \$1.25 million;
- for 2010 and later tax years, if gross receipts are less than \$200,000, and total assets are less than \$500,000.

The deadline for taking advantage of the relief program is October 15, 2010.

The *IRS Frequently Asked Questions* regarding the program are available at <http://www.irs.gov/charities/article/0,,id=225705,00.html>

The attorneys of the Employee Benefits and Executive Compensation group of Bryan Cave LLP are available to answer your questions.

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