

**The Patient Protection and Affordable Care Act
An Action Item Checklist for the Upcoming Plan Year**

The Patient Protection and Affordable Care Act (as amended by the Health Care and Education Affordability Reconciliation Act) and recently issued implementing regulations (collectively known as PPACA or the Act) impose a number of new coverage and reporting mandates on self-insured and fully-insured group health plans, many of which apply to plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans). This checklist is designed to guide employer sponsors of group health plans as they consider what actions may be needed during the coming weeks and months in order to prepare for timely compliance with the Act's most immediate requirements.

- ITEM ONE: Determine whether the plan is a "group health plan" within the meaning of the Act, and if so, what separate benefit options are offered under the plan.**

- ITEM TWO: Consider whether any plan that provides retiree medical coverage will/should fall under the "retiree-only" exception to the definition of group health plan, which relieves retiree-only plans from obligations under most HIPAA portability and all PPACA mandated coverage requirements.**

- ITEM THREE: Decide whether it is important for the group health plan (or benefit option under the plan) to maintain grandfathered status.**
 - Determine whether plan is eligible for grandfathered status (*i.e.*, in existence on March 23, 2010), and if the plan lost grandfathered status prior to June 17, 2010, consider whether transitional relief is available.
 - Understand what additional mandates apply to plans that lose grandfathered status and consider how much the plan would need to change to comply, as well as the cost thereof.
 - Consider the feasibility of maintaining grandfathered status for the plan (or a benefit option under the plan) in light of the restrictions on changes to discretionary plan design and cost sharing.

- **ITEM FOUR: Timely amend group health plan documents to comply with new coverage mandates and to reflect any discretionary changes, including early adoption of later coverage mandates or voluntary adoption of coverage mandates that would not otherwise apply.**

Applicable to All Plans

- Adult child coverage
- No lifetime or annual limits
- No pre-existing conditions < 19 years
- No rescission

Applicable to Non-Grandfathered Plans Only

- Preventive care without cost sharing
- Mandated patient protections
- Internal and external claims processes
- No discrimination based on salary

- **ITEM FIVE: Timely update plan summaries and prepare employee communications for enrollment process:**

- **Grandfathered** group health plans:
 - Update summaries, open enrollment materials, and other materials given to participants to include the required "grandfather disclosures," *e.g.* a statement that the plan believes it is a grandfathered plan and that provides contact information for questions and complaints.
 - Prepare certification form for adult children to confirm ineligibility to enroll in any other employer sponsored health plan other than a parent's employer sponsored health plan.
- **Non-grandfathered** group health plans provide timely notice to participants of "choice of provider" patient protections.
- **All** group health plans:
 - Amend summaries and other plan materials given to participants to reflect compliance with applicable new coverage mandates and any discretionary plan changes.
 - Provide timely notice of applicable special enrollment opportunities (*see item six*).

- **ITEM SIX: Comply with new special enrollment requirements.**

- Special enrollment period of at least 30 days beginning ***not later than*** the first day of the first plan year beginning on or after September 23, 2010, must be offered to:
 - Employees with adult children under age 26 who previously lost, were never eligible for, or were denied coverage under the plan due to age.
 - Individuals who previously met the plan's lifetime limit but who are still otherwise eligible for coverage.
- Written notice of these special enrollment rights must be provided to eligible persons ***not later than*** the first day of the first plan year beginning on or after September 23, 2010.

- **ITEM SEVEN: Coordinate with third party administrators, insurers, and stop-loss carriers to ensure timely compliance with new coverage mandates, plan design changes, and recordkeeping and reporting requirements, and negotiate necessary changes to contracts.**

It will be very important to renegotiate service contracts with providers to allocate legal liability for mandates and clearly outline responsibilities.

- **ITEM EIGHT: Prepare for additional recordkeeping and reporting requirements:**
 - **Grandfathered** group health plans must maintain all documents supporting the position that the plan is grandfathered and make them available for review by participants and regulators.
 - For plan years beginning on or after September 23, 2010, **non-grandfathered** group health plans must report to Secretary of Health and Human Services (HHS) and the public on transparency in coverage and comply with annual reporting regarding quality of care.
 - **All** group health plans must provide timely notice of rescission of health coverage for reasons other than fraud or intentional misrepresentation of fact.

- **ITEM NINE: Consider additional action steps relating to health FSAs, HRAs, HSAs and Archer MSAs.**
 - Consider permitting employees to seek reimbursement under a health FSA, HRA or Archer MSA for adult child expenses any time after March 30, 2010, and amend affected plan by end of 2010 as necessary to reflect actual operation.
 - As part of open enrollment (and if calendar year plan that has a grace period, prior to the end of 2010), notify employees that effective January 1, 2011, over-the-counter drugs are no longer qualified medical expenses eligible for reimbursement under a health FSA, HRA, Archer MSA or HSA, unless prescribed or insulin, and amend affected plan by June 30, 2011.
 - Notify participants that tax distributions from HSAs for non-qualified medical expenses is increased from 10 percent to 20 percent.

For more information contact Mary Beth Braitman, Terry A. M. Mumford, Christopher Sears, Tara Sciscoe or Shalina Schaefer at (317) 236-2100.

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