

GRIST Report: Health care reform changes preparations for 2011 open enrollment

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Summary

The new health care reform law brings unique challenges to the 2011 open enrollment season – simply identifying and keeping track of multiple plan provisions affected by the law may prove difficult. This article provides a series of charts to help employers track issues that must be addressed during upcoming open enrollment periods. The charts identify the reform provisions most likely to affect employers sponsoring group health plans in 2011, briefly describe the topic, and provide a list of tasks employers should consider before 2011 open enrollment. The article also discusses some unclear deadlines that could affect 2011 open enrollment.

Preparing for 2011 open enrollment after health care reform

As employers begin preparing for the 2011 plan-year open enrollment period, they must consider issues raised by the new health care reform law, including several rules that clearly affect plan design and require advance preparation. Once employers decide how to implement these new rules, the resulting plan changes will require descriptions in enrollment materials, updates to other employee communications, amendments to plan documents, adjustments to administrative procedures and coordination with third-party vendors.

In this article. This article includes a series of charts organizing the most immediate health care reforms into three primary categories – eligibility, plan limits and benefits – commonly used in open enrollment materials and other employee communications, such as summary plan descriptions (SPDs), summaries of material modifications (SMMs) and summaries of material reductions (SMRs). The charts, which generally assume a calendar-year plan, identify health care reform provisions most likely to affect employers sponsoring group health plans in 2011, briefly describe the topic and provide a task list of items to consider before open enrollment. Links to resources providing more detailed explanations are included. Provisions with an asterisk apply only to new and nongrandfathered plans; other provisions apply to all group health plans (including collectively-bargained plans) regardless of grandfathered status. The article concludes with a discussion of unclear deadlines for some important health care reform issues.

Eligibility checklist

Topic	Description	To do list	Done
Age 26 mandate and expanded tax-free treatment GRISTs #20100106 , May 12, 2010, and #20100120 , May, 18, 2010	Health plans offering coverage to dependent children must extend eligibility to adult children to age 26. For plan years before 2014, grandfathered plans may limit extended coverage to adult children ineligible to enroll in another employer-sponsored plan. The health reform law also expands the tax-free nature of health plan coverage for these young adults, allowing tax-free treatment to continue – regardless of student or marital status – through the end of the year in which the child turns 26. Employers' payroll and tax-reporting operations will require adjustment.	Craft open enrollment materials to describe new eligibility terms; update other employee communications accordingly.	<input type="checkbox"/>
		Update administrative processes to offer adult children a special enrollment opportunity of at least 30 days, which may run concurrently with the general open enrollment period. Coverage, if elected, must be effective as of the first day of the plan year.	<input type="checkbox"/>
		Plans offering dependent child coverage must provide a one-time written notice about an adult child's special enrollment opportunity. The notice may be included in open enrollment materials if prominently placed.	<input type="checkbox"/>
		Grandfathered plans limiting coverage to adult children ineligible for another employer plan must state that requirement in employee communications. Employers may include an attestation, to be signed by the employee, representing that a dependent isn't eligible for other employer plan coverage.	<input type="checkbox"/>
		Coordinate revised eligibility category with vendors (including stop-loss carriers) and update vendor contracts as necessary.	<input type="checkbox"/>
		For insured plans, analyze and coordinate all applicable state mandates on dependent child coverage.	<input type="checkbox"/>

Plan limits checklist

Topic	Description	To do list	Done
Lifetime limit GRISTs #20100103 , April 29, 2010, and #20100155 , June 22, 2010	Insured and self-insured group health plans can't impose lifetime dollar limits on individual coverage, but may impose lifetime per-beneficiary limits on nonessential benefits.	Open enrollment materials must expressly state that plan has no lifetime dollar limit on the value of "total plan benefits" and that individuals previously affected by such limits are again eligible for plan benefits. Where applicable, describe per-beneficiary limits on nonessential benefits. Position this information prominently in enrollment materials. Update other employee communications accordingly.	<input type="checkbox"/>
		Update administrative processes to offer individuals who reached the lifetime limit a special enrollment opportunity running at least 30 days, which may be concurrent with the general open enrollment period. If elected, coverage must be effective as of the first day of the plan year.	<input type="checkbox"/>
		Plans must provide a notice about the individual special enrollment opportunity described above. While not specifically mentioned in the recent regulatory guidance, we believe this notice may be included in open enrollment materials.	<input type="checkbox"/>
		Coordinate with vendors and stop-loss carriers and update service contracts as necessary.	<input type="checkbox"/>
Annual limit GRISTs #20100081 , April 6, 2010, and #20100155 , June 22, 2010	Insured and self-insured group health plans generally cannot impose annual dollar limits on individual coverage, but may impose annual per-beneficiary limits on nonessential benefits. For plan years before 2014, plans can impose "restricted" annual dollar limits on essential health benefits. Recent regulatory guidance provides specific dollar amounts (increasing over the next three years) that qualify as permitted restricted annual dollar limits.	Craft open enrollment materials to describe permitted annual limits (\$750,000 minimum for 2011) for essential health benefits and describe any applicable per-beneficiary limit on nonessential benefits. Update other employee communications accordingly.	<input type="checkbox"/>
		Coordinate with vendors and stop-loss carriers and update service contracts as necessary.	<input type="checkbox"/>

Benefits checklist

Topic	Description	To do list	Done
Preventive services* GRIST #20100081 , April 6, 2010	No cost sharing permitted for preventive services such as immunizations and women's preventive care.	Craft open enrollment materials to delete cost sharing provisions for preventive services and update other employee communications accordingly.	<input type="checkbox"/>
		Coordinate with vendors and update vendor contracts as necessary.	<input type="checkbox"/>
Physician designations* GRIST #20100081 , April 6, 2010	Plans calling for designation of primary care physicians and pediatricians must ensure participants choices are not too restrictive.	Craft open enrollment materials to amend designation requirements and update other employee communications accordingly (see model language in recently issued regulations).	<input type="checkbox"/>
		If designation is part of an electronic enrollment process, reprogramming may be necessary.	<input type="checkbox"/>
		Coordinate with vendors and update vendor contracts as necessary.	<input type="checkbox"/>
OB/GYN preauthorization* GRIST #20100081 , April 6, 2010	Plans may not require a referral for OB/GYN services.	Craft open enrollment materials to delete these preauthorization and referral requirements and update other employee communications accordingly (see model language in recently issued regulations).	<input type="checkbox"/>
		Coordinate with vendors and update vendor contracts as necessary.	<input type="checkbox"/>
Emergency services* GRISTs #20100081 , April 6, 2010, and #20100155 , June 22, 2010	Emergency services coverage cannot require preauthorization, be limited to in-network providers or impose higher cost sharing for out-of-network services.	Craft open enrollment materials to delete preauthorizations, network limits and higher cost sharing; update other employee communications accordingly.	<input type="checkbox"/>
		Coordinate with vendors and update vendor contracts as necessary.	<input type="checkbox"/>

* **Only required for new and nongrandfathered plans.** A grandfathered plan is one in place *before* March 23, 2010, that meets certain limitations regarding plan changes made since that date.

Topic	Description	To do list	Done
Over-the-counter medications GRIST #20100153 , June 18, 2010	Starting Jan. 1, 2011, costs of over-the-counter medications will not be reimbursable from health flexible spending accounts (FSA), health savings accounts, Archer medical savings accounts or health reimbursement arrangements. Tax-free reimbursements will be available only for medicines or drugs (other than insulin) prescribed by a physician.	Coordinate with service providers, such as health FSA and payroll vendors, to determine their administrative capabilities regarding these reimbursements. Clarify expectations related to expenses vendors will reimburse and adjust service agreements to reflect new responsibilities.	<input type="checkbox"/>
		Craft descriptions of new limitations for inclusion in open enrollment materials if plan currently permits tax-free reimbursement for over-the-counter medications and drugs; update other employee communications accordingly and claim forms if necessary.	<input type="checkbox"/>
		With respect to health FSAs, consider differing implications this new rule may have on noncalendar year and calendar year plans with a post year-end grace period.	<input type="checkbox"/>
		Employers using debit cards to pay for certain medical expenses must coordinate with card vendors to ensure nonprescribed, over-the-counter medications and drugs (except insulin) can no longer be purchased with the debit card. Employee communications related to debit card use should reflect this change.	<input type="checkbox"/>
CLASS program GRIST #20100099 , April 22, 2010	Employers can voluntarily participate in the CLASS program, a national, government-run long-term care program set to begin Jan. 1, 2011. Because the law doesn't require the Department of Health & Human Services to release draft program details until 2012, transition rules or delayed implementation may occur.	Participating employers must automatically enroll employees and facilitate payroll deductions.	<input type="checkbox"/>
		Craft open enrollment materials to describe the program and related costs; update other employee communications accordingly.	<input type="checkbox"/>
		Coordinate with payroll vendors and update service contracts as necessary.	<input type="checkbox"/>

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Topic	Description	To do list	Done
Rescission GRISTs #20100081 , April 6, 2010; #20100120 , May, 18, 2010; and #20100155 , June 22, 2010	Insured and self-insured group health plans may not retroactively terminate coverage, except in limited situations, such as when the covered individual commits fraud against the plan or makes intentional misrepresentations. When rescission is permitted, plan must give prior notice.	Update employee communications to describe coverage cancellation practices meeting the new standards and update other employee communications accordingly.	<input type="checkbox"/>
		Work with vendors to ensure individuals will not be improperly dropped from coverage beginning in 2011.	<input type="checkbox"/>
		Prepare a notice of coverage rescission to distribute beginning in 2011. Notice content rules are not specified in the law, but should likely include plan name, notification of rescission, date coverage ends and reason for the rescission. Notice must be provided at least 30 calendar days before coverage is rescinded.	<input type="checkbox"/>
HSA and Archer MSA penalties for nonqualified distributions GRIST #20100081 , April 6, 2010	Beginning Jan. 1, 2011, individuals must pay income tax and a 20 percent penalty tax on improper distributions from health savings accounts and Archer medical savings accounts.	While compliance burdens fall on the account owner, employers may consider updating employee communications related to these accounts and describe the updated penalties.	<input type="checkbox"/>
		Employers working with financial institutions offering HSA or MSA accounts may want to confirm the third party is aware of these changes and will timely update explanatory materials.	<input type="checkbox"/>

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Some unknowns for 2011

Grandfathered plan status notice. To maintain status as a grandfathered health plan, any plan materials provided to a participant or beneficiary must include a [statement](#) describing benefits provided under the plan and the sponsor's belief that it is a grandfathered health plan, and provide contact information for questions and complaints. Although guidance on when or how this statement must be distributed has not been issued, employers believing their plan will retain grandfathered status in 2011 could include the statement in open enrollment materials to reduce the administrative burden of distributing the statement at a later date.

Automatic enrollment. Employers are still awaiting regulatory guidance specifying the effective date of the automatic health plan enrollment provision, which requires certain employer-plan sponsors to automatically enroll current and new full-time employees in one of their plans (subject to any permitted waiting period) and continue enrollment of any existing plan participants ([GRIST #20100081](#), April 6, 2010). Employers should work with legal counsel to determine when to make this change and will need to work with their payroll department, payroll

vendors, plan administrators and others to prepare for this new practice. In addition, employers will be required to distribute to employees a notice about the new automatic enrollment feature and provide an opportunity to opt out of coverage.

Material modification. Group health plans must give enrollees 60 days' prior notice of any material modifications, such as premium and cost-sharing increases or benefit reductions ([GRIST #20100120](#), May 18, 2010). Some practitioners believe this provision applies for plan years starting on or after March 23, 2010, while others believe plans have more time to comply. For plan changes effective at the start of a plan year, employers may satisfy this new obligation during open enrollment if employee communications are sent at least 60 days before the new plan year begins. However, employers should plan carefully and coordinate employee communication efforts with vendors, insurers, consultants and other relevant business partners to be sure notices are prepared and distributed in a timely manner.

Don't forget to update plan documents

Many of the changes outlined above will also require amending plan documents to reflect the new provisions. Employers should work with their advisers to ensure amendments are properly drafted and executed.

GRIST is prepared by Mercer's Washington Resource Group. For more information, contact WRG at +1 202 263 3950.

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