Step by Step Guide to Planning for the 2014 Employer Health Insurance Mandate

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Timeline

- March 23, 2010- PPACA enacted
- June 28, 2012- Supreme Court declares individual mandate a legal tax but Medicaid expansion can't be forced on states
- November 6, 2012- national elections
- December 28, 2012- IRS releases proposed regulations
- January 1, 2013- "pay for" taxes take effect
- Today- learn basic concepts
- Remainder of 2013- determine law's applicability and plan for impact
- January 1, 2014- employer mandate takes effect

The Mandate

- Beginning January 1, 2014 ***large employers*** will become subject to nondeductible ***penalties*** unless they ***offer*** qualifying and affordable group health insurance to their ***full-time*** employees
- ***Small*** employers exempt from mandate
- Coverage of ***part-time*** employees not required
- ***Large*** employer and ***full-time*** employee determinations for 2014 based on 2013 demographics

Planning Steps

1. Determine 2013 testing universe
2. Calculate whether small employer exemption applies
3. Take interim snapshot of current full-time employees and consider changes in employment practices
4. Make final determination of "deemed" 2014 full-time employees
5. Work with benefits advisor to determine best approach to providing coverage to full-time employees

Step 1: Testing Universe

- "Employer" includes all related employer entities
  - Use rules of IRC section 414
- "Employees" all inclusive, apply common law test
  - Include everyone on payroll except self-employed owners or >2% S corp shareholders
  - Include workers not on payroll but subject to employer direction and control (1099 independent contractors, staffing company workers)
- "Hours" includes hours worked and any hours paid while not working (holiday, vacation, jury duty, etc.)

Step 2: Small or Large Test

- 50 or more full-time employees + "full time equivalents" in prior year = large for next year
- Full-time employee = average 30 or more hours per week or 130 hours per month
  - 52 weeks x 30 hours divided by 12 = 130 hours/month
- Solely for small or large determination part-time employees converted into "full-time equivalents" (FTEs)
- Calculation made for each ***month*** in prior year then averaged to determine status for the following year

Small or Large Calculation

Determine full-time employees and FTEs for each ***month*** in prior year:

1. List all employees for the month (include "related" companies)
2. List each employee's hours
3. Determine the number of employees with 130 or more hours = "actual" full-time employees
4. Total the hours for all other employees (don't count more than 120 hours for any one employee) = total "part-time" hours
5. Divide total part-time hours by 120 = number of "full-time equivalents" (FTEs) (carry to first decimal point)
6. Add number of "actual" full-time employees to the number of FTEs = testing "number" for that month

Small or Large Calculation

Determine the ***average number*** of full-time employees and FTEs:

1. Add the monthly totals, divide by 12 and round down to the next lowest whole number
2. If the resulting number is ***49 or less*** the employer is "small" and exempt from the mandate for following year
3. If the resulting number is ***50 or higher*** the employer is "large" and subject to the mandate for the following year (unless the seasonal employer exception applies)

Monthly Calculation Example

For the month of January 2013 employer had 72 employees:

12 salaried and hourly employees who worked 130 or more hours ("actual" full time employees)

10 hourly employees who worked between 121 and 129 hours (limit to 120 hours each = 1,200 total part-time hours for this group)

50 hourly employees who each worked 120 or fewer hours and collectively worked 4,000 hours

Total FTE hours = 1,200 + 4,000 = 5,200
Divide 5,200 hours by 120 = 43.3 FTEs
Add 12 "actual" full time = ***55.3 full-time and FTEs for January 2013***

Special 2013 Transition Rule

- Special transition rule for small vs large testing in 2013
  - Instead of all 12 months of 2013 can use ***any 6 or more consecutive month period*** in 2013
  - 28 possible 6 or more monthly testing periods
  - Recommendation: continue testing among all 28 iterations until you find one <50 that demonstrates exemption
  - Make permanent record of test results and underlying data to support exemption in case IRS proposes a penalty
- Note: future years exemption test will require using all 12 months
  - Will need interim/estimated testing to prepare for adverse consequences when or if 50 threshold exceeded

Seasonal Worker Exception

- If employer fails the <50 test may still be exempt if:
  - Workforce exceeded 50 for no more than 120 days or 4 months
  - 100% of the employees in excess of 50 for those 120 days or 4 months were seasonal workers
- Employer can chose any 120 days or 4 months, not required to be consecutive
  - Suggestion: test as many combinations of 4 months as needed to demonstrate exemption
- "Seasonal" workers include those in agriculture, retail during holidays and "other" reasonably determined seasonal businesses (summer help in resort areas)

Exempt Small Employer- Stop Here

- If exempt small employer for 2014 stop here
- Determine whether to offer health insurance and to whom without regard to the employer mandate
- Other health care reforms will apply to coverage offered
- Be mindful that offering affordable coverage to lower income employees will make them ineligible for exchange subsidies
- Also be mindful that non-discrimination requirements will apply when IRS issues regulations (probably 2015)

Step 3: Take Snapshot of Full-Time Employees

- If “large” use data developed accumulated for small exemption to take snapshot of current full-time employees
- Full-time employees = employees who worked on average 30 or more hours per week (130 hours per month) during the snapshot period reviewed
- Determine whether it makes business sense to impose a cap on the number of hours employees (or categories of employees) will be permitted to work for the remainder of 2013 in order to control/minimize the number of employees who will be “deemed” to be full-time in 2014

Step 4: Make Final 2014 Full-Time Employee Determination

- Use IRS optional "look back" methodology for determining what every ongoing employee's status will be in 2014
  - Test the employee's hours during a 2013 "measurement period"
  - Analyze the data, make the status determination and notify and enroll full-time employees during an optional "administrative period" in late 2013
  - Based on hours of employment during the measurement period treat employees as full-time or part-time during the 2014 "stability period"

Sample Methodology

- For full 12 month measurement and stability periods for a calendar year health plan consider using:
  - Measurement period 11/1/2012 to 10/31/2013 (12 months)
  - Administrative period 11/1/2013 to 12/31/2013 (2 months)
  - Stability period calendar year 2014 (12 months)
- Example:
  - During the measurement period employee F works an average of 32 hours/week and employee P works an average of 28 hours/week
  - Final calculations of average hours of F and P are made during 2 month administrative period
  - During the following stability period employee F will be "deemed" to be a full-time employee and P will be "deemed" to be a part-time employee irrespective of the number of hours actually worked during the stability period

Special Transition Rule for 2013

- Measurement and stability periods must generally be the same length (ideally 12 months each)
- Transition rule: employers may elect a 2013 measurement period shorter than the 2014 stability period if measurement period:
  - At least 6 consecutive months long
  - Ends <90 days before 1/1/2014
  - Begins no later than July 1, 2013
- 18 possible qualifying measurement periods in 2013

Prepare Final Full-Time Analysis

- After running the 18 iterations prepare a final analysis and report (with supporting payroll data)
- Keep report as proof of which 2014 employees are "deemed" to be full-time (and can subject the employer to penalties)
- Use report to rebut any IRS assertion of penalties with respect to any employees "deemed" to be part-time for 2014

Step 5: Work With Benefits Advisor

- Identify cost of minimum qualifying coverage that needs to be offered to "deemed" full-time employees to avoid penalties
  - Many employers may offer both bare bones minimum qualifying coverage and traditional more comprehensive coverage
- To qualify for penalty avoidance offering must
  - cover ***minimum essential benefits***
  - provide ***minimum value***
  - be ***affordable***

Minimum Essential Benefits

- Employer's health insurance offering must provide coverage for ***minimum essential benefits*** (IRS term "minimum essential coverage" or MEC***)*** including:
  - Physician services
  - Hospitalization
  - Pharmacy
  - Imaging
- Similarly, individuals/employees must purchase coverage for ***minimum essential benefits*** to comply with the individual mandate
- In the exchanges individual and small group products must cover ***Essential Health Benefits (EHB)***

Actuarial Value (Metal Levels)

- Employer's offering must provide at least a ***60% minimum actuarial value***
- Actuarial value (AV) is a relative measure of a plan's "generosity"
  - A plan providing 60% AV would be expected to cover 60% of the cost of covered services of a standard population
  - Employee would cover remaining 40% (co-pays, deductibles, non-covered benefits)
  - HHS and IRS will provide AV calculators and safe harbors
- For comparison shopping 4 levels of AV:
  - Bronze 60% (the base level for employer mandate)
  - Silver 70% (the base level for Exchange subsidies)
  - Gold 80%
  - Platinum 90%

Who Must Be Offered Coverage?

- Full-time employees and their dependent children (until age 26)
- No requirement to offer spouse coverage
- Transition period for dependent coverage: no penalties will apply for 2014 due to failure to offer dependent coverage if dependent coverage is offered in 2015
- Offering must be communicated to full-time employees so they have an effective opportunity to participate
  - Recommendation: keep receipts or other acknowledgement from all full-time employees to support "offer"

5% Margin of Error

- Statute requires offering coverage to ALL full- time employees
  - So missing 1 employee could be very costly
  - Missing 1 of 10,000 could = $20M penalty
- 5% margin of error allowed by IRS regulations
- Employer not subject to penalty for a particular month if less than 5% of full-time employees are not offered coverage (or 5 employees if greater than 5%)
  - Could miss 500 of 10,000 but not 501
- Coverage failure does not have to be inadvertent
  - But probably best to not purposely exclude 5%
  - Save 5% in case of actual administrative error

Affordability of Coverage

- Statute says coverage is affordable if the employee's premium is no more than 9.5% of the employee's ***household*** income
  - No practical way for an employer to know household income (employed spouses and dependents)
- IRS temporarily allowing use of employee's W-2 Box 1 (gross wages subject to income tax) as = household income
- Box 1 is AFTER pre-tax items such as 401(k) and cafeteria plan deductions
- Affordability is measured on ***employee-only*** coverage under the lowest cost 60% minimum value (Bronze) plan offered by the employer

Affordability Safe Harbors

- 3 IRS safe harbors on affordability of the employees premium for employee-only coverage:
  - 9.5% of Box 1 wages
  - 9.5% of lowest hourly wage x 130 hours per month
  - 9.5% of Federal Poverty Level (FPL)
- Examples
  - Employee earns $50,000 (Box 1), employee-only coverage affordable at $4,750/year premium (about $400/month)
  - Employee paid $9.00 per hour, coverage affordable at $111.15/month ($9.00 x 130 x 9.5%)
  - Under current FPL of $11,490 coverage affordable at $90.96/month (probably about $94/month by 2014)
    - Use this as a design based safe harbor?

Federal Poverty Level (FPL)

- Intent of health care reform:
  - Individuals and households under 133% FPL would be covered by Medicaid (Supreme Court overturned Federal coercion)
  - Individuals and households between 133% and 400% FPL would receive government subsidized coverage from an exchange
  - Employer penalties would pay for the subsidies
- Exchange subsidy limits employee's premium for Silver coverage to 2%- 9.5% of household income on an inverse sliding scale
  - 100%-133% FPL household pays 2% of its income for a Silver plan, government pays the balance
  - From 300%-400% FPL household pays 9.5% of its income for a Silver plan, government pays the balance

Premium Tax Credit Table

- Percentage of household income contribution towards Silver (70%) coverage on health care exchange:
  - Less than 133% FPL 2%
  - From 133% to 150% 3% to 4%
  - From 150% to 200% 4% to 6.3%
  - From 200% to 250% 6.3 % to 8.05%
  - From 250% to 300% 8.05% to 9.5%
  - From 300% to 400% 9.5%
- Use linear sliding scale
  - For example 225% FPL is half way between 200%-250%
  - Household income contribution half way between 6.3% and 8.05% = 7.04%

Premium Tax Credit

- Above 400% FPL there are no government subsidies
  - Note 70% of US households are under 400% FPL
- Employers can only be penalized with respect to employees receiving exchange subsidies
- From penalty standpoint employer only concerned about full-time employees with household income between 100% and 400% FPL

2013 Federal Poverty Levels (FPL)

- One person household
  - FPL $11,490
  - 133% FPL $15,282
  - 400% FPL $45,960
- Two person household
  - FPL $15,510
  - 133% FPL $20,628
  - 400% FPL $62,040
- Four person household
  - FPL $23.550
  - 133% FPL $31,321
  - 400% FPL $94,200

Employer Penalties

- "Large" employer penalty exposure:
  - ***Inadequate/Unaffordable $3,000 annual penalty***: offer coverage for minimum essential benefits but less than 60% AV or unaffordable = $250 monthly penalty for each full-time employee getting subsidized coverage from an exchange ("tack-hammer penalty")
  - ***No coverage $2,000 annual penalty***: offer no coverage for minimum essential benefits, one or more employees receive exchange subsidy = $166.67 monthly penalty X all full-time employee in excess of 30 (even penalized on employees getting employer or other coverage)("sledgehammer penalty")

Employer Penalties

- Both penalties require at least one full-time employee receive subsidized coverage from an exchange
  - Subsidized coverage available between 100% and 400% of FPL
  - Under 100% FPL supposedly covered by Medicaid?
- Penalties only apply with respect to full-time employees (part-time employees ***cannot*** generate employer penalties)
- The $3,000 Inadequate/Unaffordable penalty cannot exceed what the $2,000 No Coverage penalty would have been
- Penalties are calculated monthly but paid annually in arrears
- Penalties are non-deductible (as opposed to employer provided health insurance)

"No Penalty" Examples

- Large employer offers "adequate" and "affordable" coverage to at least 95% of full-time employees in 2014 (and offers coverage to dependent children in 2015)
- Large employer is subject to the mandate due to large part time workforce but has <30 full-time employees (***No coverage penalty*** only applies to number of full-time employees in excess of 30)

"No Penalty" Examples

- Employer limits all lower income employees (less than 400% FPL) to less than 30 hours/week (no full-time employee can qualify for subsidized coverage)
- Employer's full-time employees <400% FPL are all covered by spouse, Tricare, Medicare or Medicaid or choose to remain uninsured [RISKY]

Inadequate/Unaffordable Penalty Example

- Employer has 100 full-time employees, offers adequate but unaffordable coverage
- 30 employees obtain coverage from spouse, Tricare, Medicare or Medicaid
- 30 employees >400 FPL buy coverage from employer
- 30 employees refuse to purchase any coverage (potentially subject to the individual mandate penalty)
- 10 employees under 400% FPL purchase subsidized coverage on the exchange
- ***Inadequate/Unaffordable Penalty***:
  - $3,000 x 10 employees receiving subsidies = **$30,000**

No Coverage Penalty Example

- Same facts as above except employer does not offer any coverage
- Since at least one employee received subsidized exchange coverage the penalty is:
  $2,000 x (100 full-time employees-30) = **$140,000**
- Recommendation: large employers will generally be better off offering unaffordable coverage for minimum essential benefits than dropping coverage altogether

Penalty Limitation Example

- The Inadequate/Unaffordable penalty cannot be more than the No Coverage Penalty
- Employer has 80 half-time and 40 full-time employees
- Covered by mandate (40 full-time + 40 FTEs exceeds 50)
- Employer offers no coverage
- All 40 full-time employees are under 400% FPL and purchase subsidized coverage on the exchange
- Penalty lesser of :
  $3,000 x 40 full-time employees receiving subsidies = $120,000
  $2,000 x (40 total full-time employees-30) = **$20,000**
- Recommendation: if not offering coverage limit number of full-time employees to 30 or less (make all other employees part-time)

Offering affordable insurance can be harmful to lower income employees

- Exchange subsidies unavailable if employee offered "affordable" self-only coverage through employer
  - Subsidized exchange premium as low as 2% of income
  - Affordable employer coverage can be up to 9.5% of income
- Example (using estimated numbers):
  - Employee age 33 earns $34,575 as breadwinner for a family of 4 (150% FPL)
  - Silver family plan premium from exchange $13,000
  - Subsidized exchange premium 4% of income = $1,383
  - Government pays $11,617 difference
  - Employer "affordable" coverage 9.5% = $3,284

What happens above 400% FPL?

- Employee age 57 earns $95,000 as breadwinner for a family of 4 (406% FPL)
- Unsubsidized premium $25,193
- Government subsidy = $-0- (earnings >400% FPL)
- Likely result: family will remain uninsured unless employer offers heavily subsidized coverage

Word of Caution in Strategizing for Penalty Mitigation

- ERISA Section 510- employers may not …"discharge, fine, suspend, expel or discriminate against a participant or beneficiary…for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan…"
- ACA Section 1558- "No employer shall discharge or in any manner discriminate against any employee with respect to…compensation, terms, conditions or other privileges of employment because the employee…" has received a premium tax credit (subsidy) or is a whistleblower

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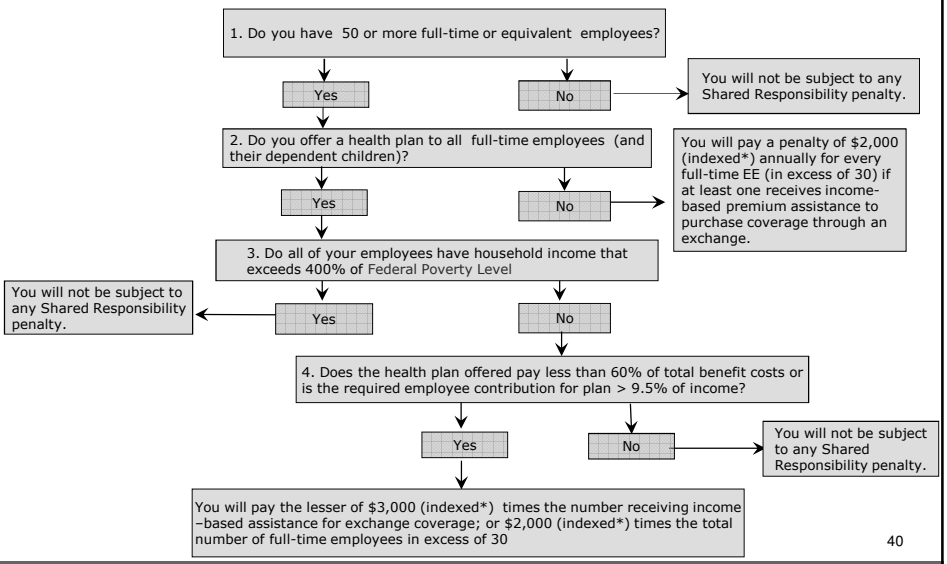
Flowchart on Employer Mandate



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Assessment and Collection Procedures

- HHS will notify employer when employee applies for subsidized exchange coverage
  - employer will have opportunity to "contest" subsidy
- In January each year employers will file new reports with IRS that report (on monthly basis) employee full or part time status, whether offered adequate and affordable coverage, cost of coverage, etc.
- Employees report premium subsidies on their individual tax returns (beginning with 2014 returns due by 10/15/2015)

Assessment and Collection Procedures

- IRS will match data from HHS, employer and employees (probably by November of following year) and send a proposed penalty assessment to employer
- Employer will have an opportunity to dispute/clarify the facts that led to the proposed assessment
- Ultimately IRS will bill the employer for the penalties (separate from other tax returns)
- Query: will GAAP require calculation/accrual of estimated penalties long before IRS assessment?

Parallel Individual Mandate

- Separate from employer mandate to ***offer*** coverage, individuals will be penalized for not ***purchasing*** coverage
- Individual mandate penalty greater of flat dollar amount or specified percentage of income in excess of income tax filing threshold:
  - 2014 $95 or 1% of excess
  - 2015 $325 or 2% of excess
  - 2016 $695 or 2.5% of excess
- Exceptions/exemptions from individual mandate:
  - lowest cost plan exceeds 8% of household adjusted gross income
  - gap in coverage for 3 months or less
- IRS prevented by statute from collecting individual penalty via tax liens and levies (only from refunds)

How K&C Can Assist with Employer Mandate Planning

- Confirm correct determination of testing population
- Analyze data, determine small employer exemption and prepare report for employer's permanent files
- Analyze data, determine initial full-time population and strategize on changes in employment practices to avoid/minimize penalty exposure
- Analyze data and prepare final full-time employee report for employer's permanent files
- Strategize with benefits advisor on best approach to meeting mandate and avoiding penalties

Questions?

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Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions

INTRODUCTION

This self-compliance tool is useful for group health plans, plan sponsors, plan administrators, health insurance issuers, and other parties to determine whether a group health plan is in compliance with some of the provisions of Part 7 of ERISA.

The requirements described in the Part 7 tool generally apply to group health plans and group health insurance issuers. However, references in this tool are generally limited to "group health plans" or "plans" for convenience.

While this self-compliance tool does not necessarily cover all the specifics of these laws, it is intended to assist those involved in operating a group health plan to understand the laws and related responsibilities. It provides an informal explanation of the statutes and the most recent regulations and interpretations and includes citations to the underlying legal provisions. The information is presented as general guidance, however, and should not be considered legal advice or a substitute for any regulations or interpretive guidance issued by EBSA. In addition, some of the provisions discussed involve issues for which the rules have not yet been finalized. Proposed rules, interim final rules, and transition periods generally are noted. Periodically check the Department of Labor's Website (www.dol.gov/ebsa) under Laws & Regulations for publication of final rules.

Cumulative List of Self-Compliance Tool Questions for HIPAA and Other Health Care-Related Statutes Added to Part 7 of ERISA

I. Determining Compliance with the HIPAA Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the HIPAA provisions in Part 7 of ERISA.

	YES	NO	N/A
SECTION A - Limits on Preexisting Condition Exclusions If the plan imposes a preexisting condition exclusion period, the plan must comply with this section. **NOTE:** These provisions are affected by section 2704 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. (For information regarding the Affordable Care Act, please visit our website at **www.dol.gov/ebsa/healthreform**). **Definition:** Generally, a preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. *See ERISA section 701(b)(1); 29 CFR 2590.701-3(a)(1).* **Tip:** Some preexisting condition exclusions are clearly designated as such in the plan documents. Others are not. Check for *hidden* preexisting condition exclusion provisions. A hidden preexisting condition exclusion is not designated as a preexisting condition exclusion, but restricts benefits based on when a condition arose in relation to the effective date of coverage.			

	YES	NO	N/A
◆ **Example:** A plan excludes coverage for cosmetic surgery unless the surgery is required by reason of an accidental injury occurring after the effective date of coverage. This plan provision operates as a preexisting condition exclusion because only people who were injured while covered under the plan receive benefits for treatment. People who were injured while they had no coverage (or while they had prior coverage) do not receive benefits for treatment. Accordingly, this plan provision limits benefits relating to a condition because the condition was present before the effective date of coverage, and is considered a preexisting condition exclusion. A plan imposing a preexisting condition exclusion is required to comply with all the rules described in this **SECTION A**. Therefore, if the plan is not mindful that a provision operates as a preexisting condition exclusion, there could be multiple violations of this **SECTION A**. **Tip:** To comply with HIPAA, a plan imposing a *hidden* preexisting condition exclusion can rewrite its plan provision so that it is not a preexisting condition exclusion (i.e., benefits are not limited based on whether the condition arose before an individual's effective date of coverage) or the plan must limit the preexisting condition exclusion to comply with the rules of this **SECTION A.** If the plan does not impose a preexisting condition exclusion period, including a *hidden* preexisting condition exclusion period, check "N/A" and skip to **SECTION B**			☐
Question 1 – Six-month look-back period **Does the plan comply with the 6-month look-back rule?** ..... ◆ A preexisting condition exclusion may apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period ending on an individual's "enrollment date." *See ERISA section 701(a)(1); 29 CFR 2590.701-3(a)(2)(i).* **Definitions:** An individual's enrollment date is the earlier of: (1) the first day of coverage; or (2) the first day of any waiting period for coverage. (Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of the plan. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such enrollment date is not a waiting period.) Therefore, if the plan has a waiting period, the 6-month look-back period ends on the first day of the waiting period, not the first day of coverage. *See ERISA sections 701(b)(1) and (4); 29 CFR 2590.701-3(a)(3).* **Tip:** If the plan has a waiting period for coverage, ensure that the 6-month look-back period is measured from the first day of the waiting period, not the first day of coverage.	☐	☐	

	YES	NO	N/A
Question 2 – Twelve/eighteen-month look-forward period **Does the plan comply with HIPAA's 12-month (or 18-month) look-forward rule?** ..... ◆ The maximum preexisting condition exclusion period is 12 months (18 months for late enrollees), measured from an individual's enrollment date. *See ERISA section 701(a)(2); 29 CFR 2590.701-3(a)(2)(ii).* **Tip:** If the plan has a waiting period, the 12-month (or 18-month) look-forward period must begin on the first day of the waiting period, not the first day of coverage. Therefore, the preexisting condition exclusion period runs concurrently with the waiting period, rather than beginning after the waiting period ends.	☐	☐	
Question 3 – Offsetting the length of preexisting condition exclusions by creditable coverage **Does the plan offset the length of its preexisting condition exclusion by an individual's creditable coverage?** ..... ◆ The length of the plan's preexisting condition exclusion must be offset by the number of days of an individual's creditable coverage. However, days of coverage prior to a "significant break in coverage" are not required to be counted as creditable coverage. Under Federal law, a significant break in coverage is a period of 63 days or more without any health coverage. *See ERISA section 701(a)(3); 29 CFR 2590.701-3(a)(2)(iii).* **Definition:** Creditable coverage means coverage of an individual under any of the following: ◆ A group health plan (including COBRA coverage), ◆ Health insurance coverage, ◆ Medicare, ◆ Medicaid, ◆ TRICARE, ◆ The Indian Health Service, ◆ A State health risk benefit pool, ◆ The Federal Employee Health Benefit Program, ◆ A public health plan, ◆ Peace Corps Act health benefits, or ◆ The State Children's Health Insurance Program. *See ERISA section 701(c); 29 CFR 2590.701-4(a)(1).*	☐	☐	
Question 4 – Preexisting condition exclusion on genetic information **Does the plan comply with HIPAA by not imposing a preexisting condition exclusion with respect to genetic information?** ..... ◆ Genetic information alone cannot be treated as a preexisting condition in the absence of a diagnosis of a condition related to such information. *See ERISA section 701(a)(1) and (b)(1); 29 CFR 2590.701-3(b)(6).*	☐	☐	

	YES	NO	N/A
Question 5 – Preexisting condition exclusion on newborns **Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on newborns?** ..... ◆ A plan generally may not impose a preexisting condition exclusion on a child who enrolls in creditable coverage within 30 days of birth. *See ERISA section 701(d)(1); 29 CFR 2590.701-3(b)(1).* **Tip:** Even if a child is not covered under the plan within 30 days of birth, the child still cannot be subject to a preexisting condition exclusion if he or she was enrolled in any creditable coverage within 30 days of birth and does not incur a subsequent 63-day break in coverage.	☐	☐	
Question 6 – Preexisting condition exclusion on children adopted or placed for adoption **Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on adopted children or children placed for adoption?** ..... ◆ A plan generally may not impose a preexisting condition exclusion on a child who enrolls in creditable coverage within 30 days of adoption or placement for adoption. *See ERISA section 701(d)(2); 29 CFR 2590.701-3(b)(2).*	☐	☐	
Question 7 – Preexisting condition exclusion on pregnancy **Does the plan comply with HIPAA by not imposing a preexisting condition exclusion on pregnancy?** ..... ◆ A plan may not impose a preexisting condition exclusion relating to pregnancy. *See ERISA section 701(d)(3); 29 CFR 2590.701-3(b)(5).* **Tip:** A plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan is a preexisting condition exclusion and is prohibited. *See 29 CFR 2590.701-3(a)(1)(ii) Example 5.*	☐	☐	
Question 8 – General notices of preexisting condition exclusion **Does the plan provide adequate and timely general notices of preexisting condition exclusions?** ..... ◆ A group health plan may not impose a preexisting condition exclusion with respect to a participant or dependent before notifying the participant, in writing, of: ❖ The existence and terms of any preexisting condition exclusion under the plan. This includes the length of the plan's look-back period, the maximum preexisting condition exclusion period under the plan, and how the plan will reduce this maximum by creditable coverage.	☐	☐	

	YES	NO	N/A
❖ A description of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) through a certificate of creditable coverage or through other means. This must include: (1) a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary; and (2) a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary. ❖ A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion. *See 29 CFR 2590.701-3(c)(2).* ◆ The general notice is required to be provided as part of any written application materials distributed for enrollment. If a plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice. *See 29 CFR 2590.701-3(c)(1).* **Tips:** Ensure that the general notice is both complete and timely. The plan can include its general notice of preexisting condition exclusion in the summary plan description (SPD) if the SPD is provided as part of the application materials. If not, this general notice must be provided separately to be timely. A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*			
<u>Question 9 – Determination of creditable coverage</u> **Does the plan comply with the requirements relating to determination of individuals' creditable coverage?** ..... ◆ If a plan receives creditable coverage information from an individual, the plan is required to make a determination regarding the amount of the individual's creditable coverage and the length of any preexisting condition exclusion that remains. This determination must be made within a reasonable time following the receipt of the creditable coverage information. Whether this determination is made within a reasonable time depends on all the relevant facts and circumstances, including whether the plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care. *See 29 CFR 2590.701-3(d)(1).* ◆ A plan may not impose any limit on the amount of time an individual has to present a certificate or other evidence of creditable coverage. *See 29 CFR 2590.701-3(d)(2).*	☐	☐	

	YES	NO	N/A
Question 10 – Individual notices of preexisting condition exclusions **Does the plan provide adequate and timely individual notices of preexisting condition exclusion?** ..... ◆ After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage *(See 29 CFR 2590.701-3(d)),* the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. *See 29 CFR 2590.701-3(e).* ◆ **Exception:** A plan is not required to provide this notice if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. *See 29 CFR 2590.701-3(e).* ◆ The notice must disclose: ❖ The determination of the length of any preexisting condition exclusion that applies to the individual (including the last day on which the preexisting condition exclusion applies); ❖ The basis for the determination, including the source and substance of any information on which the plan relied; ❖ An explanation of the individual's right to submit additional evidence of creditable coverage; and ❖ A description of any applicable appeal procedures established by the plan. *See 29 CFR 2590.701-3(e)(2).* ◆ The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice. *See 29 CFR 2590.701-3(e)(1).* **Tips:** Ensure that individual notices are complete and timely as well. A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*	☐	☐	
Question 11 – Reconsideration **If the plan determines that an individual does not have the creditable coverage claimed, and the plan wants to modify an initial determination of creditable coverage, does the plan comply with the rules relating to reconsideration?** ..... ◆ A plan may modify an initial determination of an individual's creditable coverage if the plan determines that the individual did not have the claimed creditable coverage, provided that: ❖ A notice of the new determination is provided to the individual; and ❖ Until the new notice is provided, the plan, for purposes of approving access to medical services, acts in a manner consistent with the initial determination of creditable coverage. *See 29 CFR 2590.701-3(f).*	☐	☐	

	YES	NO	N/A
SECTION B - Compliance with the Certificate of Creditable Coverage Provisions Regardless of whether the plan imposes a preexisting condition exclusion, the plan is required to issue certificates of creditable coverage when coverage ceases and upon request. To be complete, under 29 CFR 2590.701-5(a)(3)(ii), each certificate must include: 1. Date issued; 2. Name of plan; 3. The individual's name and identification information (**Note: Dependent information can be included on the same certificate with the participant information or on a separate certificate. The plan is required to have used reasonable efforts to get dependent information. *See 29 CFR 2590.701-5(a)(5)(i));* 4. Plan administrator name, address, and telephone number; 5. Telephone number for further information (if different); 6. Individual's creditable coverage information: ❖ Either: (1) that the individual has at least 18 months of creditable coverage; or (2) the date any waiting period (or affiliation period) began and the date creditable coverage began. ❖ Also, either: (1) the date creditable coverage ended; or (2) that creditable coverage is continuing. ❖ Automatic certificates of creditable coverage should reflect the last period of continuous coverage. ❖ Requested certificates should reflect periods of continuous coverage that an individual had in the 24 months prior to the date of the request (up to 18 months of creditable coverage). *See 29 CFR 2590.701-5(a)(3)(iii).* 7. An educational statement regarding HIPAA, which explains: ❖ The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage); ❖ Special enrollment rights; ❖ The prohibitions against discrimination based on any health factor; ❖ The right to individual health coverage; ❖ The fact that State law may require issuers to provide additional protections to individuals in that State; and ❖ Where to get more information. **Tips:** Remember to include information about waiting periods and dependents. If a plan imposes a waiting period, the date the waiting period began is required to be reflected on the certificate. In addition, if the certificate applies to more than one person (such as a participant and dependents), the dependents' creditable coverage information is required to be reflected on the certificate (or the plan can issue a separate certificate to each dependent). (**Note: If a dependent's last known address is different from the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address.) A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*			

	YES	NO	N/A
** **Special Accountability Rule for Insured Plans:** ◆ Under a special accountability rule in ERISA section 701(e)(1)(C) and 29 CFR 2590.701-5(a)(1)(iii), a health insurance issuer, rather than the plan, may be responsible for providing certificates of creditable coverage by virtue of an agreement between the two that makes the issuer responsible. In this case, the issuer, but not the plan, violates the certificate requirements of section 701(e) if a certificate is not provided in compliance with these rules. (**Note: An agreement with a third-party administrator (TPA) that is not insuring benefits will not transfer responsibility from the plan.) ◆ Despite this special accountability rule, other responsibilities, such as a plan administrator's duty to monitor compliance with a contract, remain unaffected. Accordingly, this section of the self-compliance tool is organized differently to take into account this special accountability rule.			
Question 12 – Automatic certificates of creditable coverage upon loss of coverage **Does the plan provide complete and timely certificates of creditable coverage to individuals automatically upon loss of coverage?** ..... ◆ Plans are required to provide each participant and dependent covered under the plan an automatic certificate, free of charge, when coverage ceases. (If the plan is insured and there is an agreement with the issuer that the issuer is responsible for providing the certificates, check "N/A" and go to **Question 13.**) ◆ Under 29 CFR 2590.701-5(a)(2)(ii), plans and issuers must furnish an automatic certificate of creditable coverage: ❖ To an individual who is entitled to elect COBRA, at a time no later than when a notice is required to be provided for a qualifying event under COBRA (usually not more than 44 days); ❖ To an individual who loses coverage under the plan and who is not entitled to elect COBRA, within a reasonable time after coverage ceases; and ❖ To an individual who ceases COBRA, within a reasonable time after COBRA coverage ceases (or after the expiration of any grace period for nonpayment of premiums).	☐	☐	☐
Question 13 – Automatic certificate upon loss of coverage – *Issuer Responsibility* **If there is an agreement between the plan and the issuer stating that the issuer is responsible for providing certificates of creditable coverage, does the issuer provide complete and timely certificates?** ..... ◆ Even if the plan is not responsible for issuing certificates of creditable coverage, the plan should monitor issuer compliance with the certification provisions. ◆ If the plan is self-insured, or if there is no such agreement between the plan and the issuer, check "N/A" and skip to **Question 14.**	☐	☐	☐

	YES	NO	N/A
Question 14 – Certificates of creditable coverage upon request **Does the plan provide complete certificates of creditable coverage upon request?** ..... (If the plan is insured and the issuer is responsible for issuing certificates pursuant to an agreement, check "N/A" and go to **Question 15.**) ◆ Certificates of creditable coverage must be provided free of charge to individuals who request a certificate while covered under the plan and for up to 24 months after coverage ends. *See ERISA section 701(e)(1)(A); 29 CFR 2590.701-5(a)(2)(iii).* ◆ Requested certificates must be provided, at the earliest time that a plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate of creditable coverage. *See 29 CFR 2590.701-5(a)(2)(iii).*	☐	☐	☐
Question 15 – Certificates upon request – Issuer Responsibility **If the plan is insured and there is an agreement between the plan and the issuer stating that the issuer is responsible for providing certificates of creditable coverage, does the issuer provide complete certificates?** ..... ◆ Even if the plan is not responsible for issuing certificates of creditable coverage, the plan should monitor issuer compliance with the certification provisions. ◆ If the plan is self-insured, or if there is no such agreement between the plan and the issuer, check "N/A" and skip to **Question 16.**	☐	☐	☐
Question 16 – Written Procedure for Requesting Certificates **Does the plan have a written procedure for individuals to request and receive certificates of creditable coverage?** ..... ◆ The plan must have a written procedure for individuals to request and receive certificates of creditable coverage. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address). *See 29 CFR 2590.701-5(a)(4)(ii).*	☐	☐	☐
SECTION C – Compliance with the Special Enrollment Provisions Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events, regardless of any late enrollment provisions, if enrollment is requested within 30 days (or 60 days in the case of the special enrollment rights added by the Children's Health Insurance Program Reauthorization Act of 2009, discussed in **Question 19**) of the event. The plan must provide for special enrollment, as follows:			

	YES	NO	N/A
Question 17 – Special enrollment upon loss of other coverage **Does the plan provide full special enrollment rights upon loss of other coverage?** ..... ◆ A plan must permit loss-of-coverage special enrollment upon: (1) loss of eligibility for group health plan coverage or health insurance coverage; and (2) termination of employer contributions toward group health plan coverage. *See ERISA section 701(f)(1); 29 CFR 2590.701-6(a).* ◆ When a current employee loses eligibility for coverage, the plan must permit the employee and any dependents to special enroll. *See 29 CFR 2590.701-6(a)(2)(i).* ◆ When a dependent of a current employee loses eligibility for coverage, the plan must permit the dependent and the employee to special enroll. *See 29 CFR 2590.701-6(a)(2)(ii).* **Examples:** Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in the number of hours of employment - voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, reduction in hours, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding a lifetime limit on all benefits. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause - such as for fraud. *See 29 CFR 2590.701-6(a)(3)(i).* ◆ When employer contributions toward an employee's or dependent's coverage terminates, the plan must permit special enrollment, even if the employee or dependent did not lose eligibility for coverage. *See 29 CFR 2590.701-6(a)(3)(ii).* ◆ Plans must allow an employee a period of at least 30 days to request enrollment. *See 29 CFR 2590.701-6(a)(4)(i).* ◆ Coverage must become effective no later than the first day of the first month following a completed request for enrollment. *See 29 CFR 2590.701-6(a)(4)(ii).* **Tip**: Ensure that the plan permits special enrollment upon all of the loss of coverage events described above.	☐	☐	
Question 18 – Dependent special enrollment **Does the plan provide full special enrollment rights to individuals upon marriage, birth, adoption, and placement for adoption?** ..... ◆ Plans must generally permit current employees to enroll upon marriage and upon birth, adoption, or placement for adoption of a dependent child. *See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).* ◆ Plans must generally permit a participant's spouse **and** new dependents to enroll upon marriage, birth, adoption, and placement for adoption. *See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).*	☐	☐	

	YES	NO	N/A
◆ Plans must allow an individual a period of at least 30 days to request enrollment. *See 29 CFR 2590.701-6(b)(3)(i).* ◆ In the case of marriage, coverage must become effective no later than the first day of the month following a completed request for enrollment. *See 29 CFR 2590.701-6(b)(3)(iii)(A).* ◆ In the case of birth, adoption, or placement for adoption, coverage must become effective as of the date of the birth, adoption, or placement for adoption. *See 29 CFR 2590.701-6(b)(3)(iii)(B).* **Tips:** Remember to allow all eligible employees, spouses, and new dependents to enroll upon these events. Also, ensure that the effective date of coverage complies with HIPAA, keeping in mind that some effective dates of coverage are retroactive.			
Question 19 – Special enrollment rights provided through CHIPRA **Does the plan provide full special enrollment rights as required under CHIPRA?** ..... Under the following conditions a group health plan must allow an employee or dependent (who is otherwise eligible) to enroll, regardless of any late enrollment provisions, if enrollment is requested within 60 days: ◆ *When an employee or dependent's Medicaid or CHIP coverage is terminated.* When an employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act and coverage of the employee or dependent is terminated as a result of loss of eligibility, a group health plan must allow special enrollment. The employee or dependent must request special enrollment within 60 days after the date of termination of Medicaid or CHIP coverage. *See ERISA section 701(f)(3).* ◆ *Upon Eligibility for Employment Assistance under Medicaid or CHIP.* When an employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage under a Medicaid plan or State CHIP plan, the group health plan must allow special enrollment. The employee or dependent must request special enrollment within 60 days after the employee or dependent is determined to be eligible for assistance. *See ERISA section 701(f)(3).* NOTE: In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice of eligibility (referred to as the Employer CHIP Notice) to each employee to inform them of possible opportunities available in the state in which they reside for premium assistance for health coverage of employees or dependents. A model notice is available at **www.dol.gov/ebsa**.	☐	☐	

	YES	NO	N/A
Question 20 – Treatment of special enrollees **Does the plan treat special enrollees the same as individuals who enroll when first eligible, for purposes of eligibility for benefit packages, premiums, and imposing a preexisting condition exclusion?** ..... ◆ If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. *See 29 CFR 2590.701-6(d)(1).* ◆ Special enrollees must be offered the same benefit packages available to similarly situated individuals who enroll when first eligible. (Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package.) In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied cannot exceed that applied to other similarly situated individuals who enroll when first eligible. *See 29 CFR 2590.701-6(d)(2).*	☐	☐	
Question 21 – Notice of special enrollment rights **Does the plan provide timely and adequate notices of special enrollment rights?** ..... ◆ On or before the time an employee is offered the opportunity to enroll in the plan, the plan must provide the employee with a description of special enrollment rights. **Tip:** Ensure that the special enrollment notice is provided at or before the time an employee is initially offered the opportunity to enroll in the plan. This may mean breaking it off from the SPD. The plan can include its special enrollment notice in the SPD if the SPD is provided at or before the initial enrollment opportunity (for example, as part of the application materials). If not, the special enrollment notice must be provided separately to be timely. A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*	☐	☐	
SECTION D – Compliance with the HIPAA Nondiscrimination Provisions Overview. HIPAA prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors. These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability. *See ERISA section 702; 29 CFR 2590.702.*			

	YES	NO	N/A
Similarly Situated Individuals. It is important to recognize that the nondiscrimination rules prohibit discrimination within a group of similarly situated individuals. Under 29 CFR 2590.702(d), plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the groups are not based on a health factor. If distinguishing among groups of participants, plans and issuers must base distinctions on bona fide employment-based classifications consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age of dependent children, or any other factor that is not a health factor. However, see section 2714 of the PHS Act, as amended by the Patient Protection and Affordable Care Act, for rules on defining dependents under the plan. (For information regarding the Affordable Care Act, please visit our website at **www.dol.gov/ebsa/healthreform**). **Exception for benign discrimination:** The nondiscrimination rules do not prohibit a plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor, such as a disability. *See 29 CFR 2590.702(g).* Check to see that the plan complies with HIPAA's nondiscrimination provisions as follows:			
Question 22 – Nondiscrimination in eligibility **Does the plan allow individuals eligibility and continued eligibility under the plan regardless of any adverse health factor?** ..... ◆ Examples of plan provisions that violate ERISA section 702(a) because they discriminate in eligibility based on a health factor include: ❖ Plan provisions that require "evidence of insurability," such as passing a physical exam, providing a certification of good health, or demonstrating good health through answers to a health care questionnaire in order to enroll. *See 29 CFR 2590.702(b)(1).* ◆ Also, note that it may be permissible for plans to require individuals to complete physical exams or health care questionnaires for purposes other than for determining eligibility to enroll in the plan, such as for determining an appro-priate blended, aggregate group rate for providing coverage to the plan as a whole. *See 29 CFR 2590.702(b)(1)(iii) Example 1.* **Tip:** Eliminate plan provisions that deny individuals eligibility or continued eligibility under the plan based on a health factor, even if such provisions apply only to late enrollees.	☐	☐	

	YES	NO	N/A
Question 23 – Nondiscrimination in benefits **Does the plan uniformly provide benefits to participants and beneficiaries, without directing any benefit restrictions at individual participants and beneficiaries based on a health factor?** ..... ◆ A plan is not required to provide any benefits, but benefits provided must be uniformly available and any benefit restrictions must be applied uniformly to all similarly situated individuals and cannot be directed at any individual participants or beneficiaries based on a health factor. If benefit exclusions or limitations are applied only to certain individuals based on a health factor, this would violate ERISA section 702(a) and 29 CFR 2590.702(b)(2). ◆ Examples of plan provisions that would be permissible under ERISA section 702(a) include: ❖ Limits or exclusions for certain types of treatments or drugs, ❖ Limitations based on medical necessity or experimental treatment, and ❖ Cost-sharing, if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor. ◆ A plan amendment applicable to all similarly situated individuals and made effective no earlier than the first day of the next plan year is not considered directed at individual participants and beneficiaries. *See 29 CFR 2590.702(b)(2)(i)(C).*	☐	☐	
Question 24 – Source-of-injury restrictions **If the plan imposes a source-of-injury restriction, does it comply with the HIPAA nondiscrimination provisions?** ..... ◆ Plans may exclude benefits for the treatment of certain injuries based on the source of that injury, except that plans may not exclude benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition. *See 29 CFR 2590.702(b)(2)(iii)*. An example of a permissible source-of-injury exclusion would include: ❖ A plan provision that provides benefits for head injuries generally, but excludes benefits for head injuries sustained while participating in bungee jumping, as long as the injuries do not result from a medical condition or domestic violence. ◆ An impermissible source-of-injury exclusion would include: ❖ A plan provision that generally provides coverage for medical/surgical benefits, including hospital stays that are medically necessary, but excludes benefits for self-inflicted injuries or attempted suicide. This is impermissible because the plan provision excludes benefits for treatment of injuries that may result from a medical condition (depression). ◆ If the plan does not impose a source-of-injury restriction, check "N/A" and skip to **Question 25.**	☐	☐	☐

	YES	NO	N/A
Question 25 – Nondiscrimination in premiums or contributions **Does the plan comply with HIPAA's nondiscrimination rules regarding individual premium or contribution rates?** ..... ◆ Under ERISA section 702(b) and 29 CFR 2590.702(c), plans may not require an individual to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor. For example, it would be impermissible for a plan to require certain full-time employees to pay a higher premium than other full-time employees based on their prior claims experience. ◆ Nonetheless, the nondiscrimination rules do not prohibit a plan from providing a reward based on adherence to a wellness program. *See ERISA section 702(b)(2)(B); 29 CFR 2590.702(b)(2)(ii) and (c)(3).* Final rules for wellness programs were published on December 13, 2006, at 71 FR 75014. *See proposed regulations issued by the Departments on November 26, 2012 at 77 FR 70620.* These rules permit rewards that are not contingent on an individual meeting a standard related to a health factor. In addition, these rules permit rewards that are contingent on an individual meeting a standard related to a health factor if: ❖ The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor is limited – generally, it must not exceed 20 percent of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. ❖ The program must be reasonably designed to promote health and prevent disease. ❖ The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year. ❖ The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard. ❖ The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard). A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.* To help evaluate whether this exception is available, refer to Section E on page 16. Once you have completed Section E, return to this page to continue with **Question 26**, below.	☐	☐	
Question 26 – List billing **Is there compliance with the list billing provisions?** ..... ◆ Under 29 CFR 2590.702(c)(2)(ii), plans and issuers may not charge or quote an employer a different premium for an individual in a group of similarly situated individuals based on a health factor. This practice is commonly referred to as list billing. If an issuer is list billing an employer and the plan is passing the separate and different rates on to the individual participants and beneficiaries, both the	☐	☐	

	YES	NO	N/A
plan and the issuer are violating the prohibition against discrimination in premium rates. This does not prevent plans and issuers from taking the health factors of each individual into account in establishing a blended/aggregate rate for providing coverage to the plan.			
Question 27 – Nonconfinement clauses **Is the plan free of any nonconfinement clauses?** ..... ◆ Typically, a nonconfinement clause will deny or delay eligibility for some or all benefits if an individual is confined to a hospital or other health care institution. Sometimes nonconfinement clauses also deny or delay eligibility if an individual cannot perform ordinary life activities. Often a nonconfinement clause is imposed only with respect to dependents, but they may also be imposed with respect to employees. 29 CFR 2590.702(e)(1) explains that these nonconfinement clauses violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums). **Tip:** Delete all nonconfinement clauses.	☐	☐	
Question 28 – Actively-at-work clauses **Is the plan free of any impermissible actively-at-work clauses?** ..... ◆ Typically, actively-at-work provisions delay eligibility for benefits based on an individual being absent from work. 29 CFR 2590.702(e)(2) explains that actively-at-work provisions generally violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums or contributions), unless absence from work due to a health factor is treated, for purposes of the plan, as if the individual is at work. Nonetheless, an exception provides that a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before eligibility commences. Further, plans may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in 29 CFR 2590.702(d). For example, a plan that treats full-time and part-time employees differently for other employment-based purposes, such as eligibility for other employee benefits, may distinguish in rules for eligibility under the plan between full-time and part-time employees. **Tip:** Carefully examine any actively-at-work provision to ensure consistency with HIPAA.	☐	☐	
SECTION E – Compliance with the Wellness Program Provisions Use the following questions to help determine whether the plan offers a program of health promotion or disease prevention that is required to comply with the Department's final wellness program regulations and, if so, whether the program is in compliance with the regulations. *See proposed regulations issued by the Departments on November 26, 2012 at 77 FR 70620.*			

	YES	NO	N/A
Question 29 – Does the plan have a wellness program? ..... ◆ A wide range of wellness programs exist to promote health and prevent disease. However, these programs are not always labeled "wellness programs." Examples include: a program that reduces individuals' cost-sharing for complying with a preventive care plan; a diagnostic testing program for health problems; and rewards for attending educational classes, following healthy lifestyle recommendations, or meeting certain biometric targets (such as weight, cholesterol, nicotine use, or blood pressure targets). **Tip:** Ignore the labels – wellness programs can be called many things. Other common names include: disease management programs, smoking cessation programs, and case management programs.	☐	☐	
Question 30 – Is the wellness program part of a group health plan? ..... ◆ The wellness program is only subject to Part 7 of ERISA if it is part of a group health plan. If the employer operates the wellness program as an employment policy separate from the group health plan, the program may be covered by other laws, but it is not subject to the group health plan rules discussed here. **Example:** An employer institutes a policy that any employee who smokes will be fired. Here, the plan is not acting, so the wellness program rules do not apply. (But see 29 CFR 2590.702, which clarifies that compliance with the HIPAA nondiscrimination rules, including the wellness program rules, is not determinative of compliance with any other provision of ERISA or any other State or Federal law, such as the Americans with Disabilities Act.)	☐	☐	
Question 31 – Does the program discriminate based on a health factor? ..... ◆ A plan discriminates based on a health factor if it requires an individual to meet a standard related to a health factor in order to obtain a reward. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. **Example 1**: Plan participants who have a cholesterol level under 200 will receive a premium reduction of 20 percent. In this Example 1, the plan requires individuals to meet a standard related to a health factor in order to obtain a reward. **Example 2:** A plan requires all eligible employees to complete a health risk assessment to enroll in the plan. Employee answers are fed into a computer that identifies risk factors and sends educational information to the employee's home address. In this Example 2, the requirement to complete the assessment does not, itself, discriminate based on a health factor. However, if the plan used individuals' specific health information to discriminate in individual eligibility, benefits, or premiums, there would be discrimination based on a health factor.	☐	☐	

	YES	NO	N/A
If you answered "No" to **ANY** of the above questions, **STOP**. The plan does not maintain a program subject to the group health plan wellness program rules. If you are completing this section as part of a review of your plan, please return to **Question 26**.			
Question 32 – If the program discriminates based on a health factor, is the program saved by the benign discrimination provisions? ..... ◆ The Department's regulations at 29 CFR 2590.702(g) permit discrimination ***in favor*** of an individual based on a health factor. **Example:** A plan grants participants who have diabetes a waiver of the plan's annual deductible if they enroll in a disease management program that consists of attending educational classes and following their doctor's recommendations regarding exercise and medication. *This is benign discrimination because the program is offering a reward to individuals based on an adverse health factor.* **Tip:** The benign discrimination exception is ***NOT*** available if the plan asks diabetics to meet a standard related to a health factor (such as maintaining a certain body mass index (BMI)) in order to get a reward. In this case, an ***intervening discrimination*** is introduced and the plan cannot rely solely on the benign discrimination exception.	☐	☐	
If you answered "Yes" to the previous question, **STOP**. There are no violations of the wellness program rules. If you are completing this section as part of a review of your plan, please return to **Question 26**. If you answered "No" to the previous question, the wellness program must meet the following 5 criteria.			
Question 33 – Compliance Criteria **A. Is the amount of the reward offered under the plan limited to 20 percent of the applicable cost of coverage? (29 CFR 2590.702(f)(2)(i))** ..... Keep in mind these considerations when analyzing the reward amount: **Who is eligible to participate in the wellness program?** If only employees are eligible to participate, the amount of the reward must not exceed 20 percent of the cost of employee-only coverage under the plan. If employees and any class of dependents are eligible to participate, the reward must not exceed 20 percent of the cost of coverage in which an employee and any dependents are enrolled. **Does the plan have more than one wellness program?** The 20 percent limitation on the amount of the reward applies to all of a plan's wellness programs *that require individuals to meet a standard related to a health factor.*	☐	☐	

	YES	NO	N/A
Example: If the plan has two wellness programs with standards related to a health factor, a 20 percent reward for meeting a BMI target and a 10 percent reward for meeting a cholesterol target, it must decrease the total reward available from 30 percent to 20 percent. However, if instead, the program offered a 10 percent reward for meeting a body mass index target, a 10 percent reward for meeting a cholesterol target, and a 10 percent reward for completing a health risk assessment (regardless of any individual's specific health information), the rewards do not need to be adjusted because the 10 percent reward for completing the health risk assessment does not require individuals to meet a standard related to a health factor.			
B. Is the plan reasonably designed to promote health or prevent disease? (29 CFR 2590.702(f)(2)(ii))	☐	☐	
The program must be reasonably designed to promote health or prevent disease. The program should have a reasonable chance of improving the health of or preventing disease in participating individuals, not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease.			
C. Are individuals who are eligible to participate given a chance to qualify at least once per year? (29 CFR 2590.702(f)(2)(iii))	☐	☐	
D. Is the reward available to all similarly situated individuals? Does the program offer a reasonable alternative standard? (29 CFR 2590.702(f)(2)(iv))	☐	☐	
The wellness program rules require that the reward be available to all similarly situated individuals. A component of meeting this criterion is that the program must have a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period: * It is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; or * It is medically inadvisable to attempt to satisfy the otherwise applicable standard. It is permissible for the plan or issuer to seek verification, such as a statement from the individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.			
E. Does the plan disclose the availability of a reasonable alternative in all plan materials describing the program? (29 CFR 2590.702(f)(2)(v))	☐	☐	
The plan or issuer must disclose the availability of a reasonable alternative standard *in all plan materials describing the program*. If plan materials merely mention that the program is available, without describing its terms, this disclosure is not required. **Tip:** The disclosure does not have to say what the reasonable alternative standard is in advance. The plan can individually tailor the standard for each individual, on a case-by-case basis.			

	YES	NO	N/A
The following sample language can be used to satisfy this requirement: "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward."			

If you answered "Yes" to **all** of the 5 questions on wellness program criteria, there are no violations of the HIPAA wellness program rules.

If you answered "No" to **any** of the 5 questions on wellness program criteria, the plan has a wellness program compliance issue. Specifically,

Violation of the general benefit discrimination rule (29 CFR 2590.702(b)(2)(i)) – If the wellness program varies benefits, including cost-sharing mechanisms (such as deductible, copayment, or coinsurance) based on whether an individual meets a standard related to a health factor and the program does not satisfy the requirements of 29 CFR 2590.702(f), the plan is impermissibly discriminating in benefits based on a health factor. The wellness program exception at 29 CFR 2590.702(b)(2)(ii) is not satisfied and the plan is in violation of 29 CFR 2590.702(b)(2)(i).

Violation of general premium discrimination rule (29 CFR 2590.702(c)(1)) – If the wellness program varies the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual meets a standard related to a health factor and the program does not satisfy the requirements of 29 CFR 2590.702(f), the plan is impermissibly discriminating in premiums based on a health factor. The wellness program exception at 29 CFR 2590.702(c)(3) is not satisfied and the plan is in violation of 29 CFR 2590.702(c)(1).

SECTION F – Compliance with the HMO Affiliation Period Provisions If the plan provides benefits through an HMO and imposes an HMO affiliation period in lieu of a preexisting condition exclusion period, answer **Question 34.** If the plan does not provide benefits through an HMO, or if there is no HMO affiliation period, check "N/A" and go to **Section G.**			☐
Question 34 – HMO affiliation period provisions **Does the plan comply with the limits on HMO affiliation periods?** ..... ◆ An affiliation period is a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits. ◆ A group health plan offering coverage through an HMO may impose an affiliation period only if: ❖ No preexisting condition exclusion is imposed; ❖ No premium is charged to a participant or beneficiary for the affiliation period; ❖ The affiliation period is applied uniformly without regard to any health factor;	☐	☐	

	YES	NO	N/A
❖ The affiliation period does not exceed 2 months (or 3 months for late enrollees); ❖ The affiliation period begins on an individual's "enrollment date"; and ❖ The affiliation period runs concurrently with any waiting period. *See ERISA section 701(g); 29 CFR 2590.701-7.*			
SECTION G – Compliance with the MEWA or Multiemployer Plan Guaranteed Renewability Provisions If the plan is a multiple employer welfare arrangement (MEWA) or a multiemployer plan, it is required to provide guaranteed renewability of coverage in accordance with ERISA section 703. If the plan is a MEWA or multiemployer plan, it must comply with **Question 35.** If the plan is not a MEWA or multiemployer plan, check "N/A" and go to **Part II** of this self-compliance tool.			☐
Question 35 – Multiemployer plan and MEWA guaranteed renewability **If the plan is a multiemployer plan, or a MEWA, does the plan provide guaranteed renewability?** ..... ◆ Group health plans that are multiemployer plans or MEWAs may not deny an employer continued access to the same or different coverage, other than: ❖ For nonpayment of contributions; ❖ For fraud or other intentional misrepresentation by the employer; ❖ For noncompliance with material plan provisions; ❖ Because the plan is ceasing to offer coverage in a geographic area; ❖ In the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health-related factor in relation to such individuals or dependents; or ❖ For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such agreement. *See ERISA section 703.* **Note: The Public Health Service (PHS) Act contains different guaranteed renewability requirements for issuers.	☐	☐	

II. Determining Compliance with the Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA) Provisions in Part 7 of ERISA (together, the mental health parity provisions)			
If you answer "No" to any of the questions below, the group health plan is in violation of the mental health parity provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
If the plan provides either mental health or substance use disorder benefits[1], in addition to medical/surgical benefits, the plan may be subject to the mental health parity provisions in Part 7 of ERISA. (Note, if under an arrangement(s) to provide medical care by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and mental health or substance use disorder benefits, the mental health parity requirements apply separately with respect to each combination of medical/surgical benefits and mental health/substance use disorder benefits and all such combinations are considered to be a single group health plan. *See 29 CFR 2590.712(e).*) If this is the case, answer Questions 36-43. If the plan does not provide mental health or substance use disorder benefits, check "N/A" here and skip to Part III of this checklist. Also, the plan may be exempt from the mental health parity provisions under the small employer (50 employees or fewer) exception or the increased cost exception. (To be eligible for the increased cost exception, the plan must have filed a notice with EBSA and notified participants and beneficiaries.) If the plan is exempt, check "N/A" here and skip to Part III of this checklist.			☐
Question 36 – Does the plan comply with the mental health parity requirements for lifetime dollar limits on mental health/substance use disorder benefits? ..... ◆ A plan may not impose a lifetime dollar limit on mental health/substance use disorder benefits that is lower than the lifetime dollar limit imposed on medical/surgical benefits. *See 29 CFR 2590.712(b).* (Only limits on what the plan is willing to pay are taken into account, as contrasted with limits on what an individual may be charged.) **NOTE:** These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime dollar limits on essential health benefits, which includes mental health and substance use disorder services. (For information regarding the Affordable Care Act, please visit our website at **www.dol.gov/ebsa/healthreform**).	☐	☐	
Question 37 – Does the plan comply with the mental health parity requirements for annual dollar limits on mental health/substance use disorder benefits? ..... ◆ A plan may not impose an annual dollar limit on mental health/substance use disorder benefits that is lower than the annual dollar limit imposed on medical/surgical benefits. *See 29 CFR 2590.712(b).* (Again, only limits on what the plan is willing to pay are taken into account, as contrasted with limits on what an individual may be charged.)	☐	☐	

[1] Mental health and substance use disorder benefits are defined under the terms of the plan, in accordance with applicable Federal and State law. Any condition or disorder defined by the plan as being or as not being a mental health condition or substance use disorder must be defined in a manner consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the DSM or ICD or State guidelines).

	YES	NO	N/A
Tip: There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 41**. A plan may impose annual dollar out-of-pocket limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits. **NOTE:** These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits annual dollar limits on essential health benefits, which includes mental health and substance use disorder services. (For information regarding the Affordable Care Act, please visit our website at **www.dol.gov/ebsa/healthreform**).			
Question 38 – Does the plan comply with the mental health parity requirements for parity in financial requirements and quantitative treatment limitations? ..... ◆ A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(2).* ❖ Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 29 CFR 2590.712(c)(1)(ii).* ❖ Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 29 CFR 2590.712(c)(1)(ii).* ❖ The six classifications of benefits are: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs. *See 29 CFR 2590.712(c)(2)(ii).* (**Note:** see below discussion of enforcement safe harbor for determining parity with respect to outpatient benefits provided under two sub-classifications.) ◆ Under the plan, any financial requirement or quantitative treatment limitation that applies to mental health/substance use disorder benefits within a particular classification **cannot be more restrictive** than the predominant requirement or limitation that applies to substantially all medical/surgical benefits within the same classification. *See 29 CFR 2590.712(c)(2).* Detailed steps for applying these rules are set forth below: ❖ To determine compliance each type of financial requirement or quantitative treatment limitation within a coverage unit[2] must be analyzed separately within each classification. *See 29 CFR 2590.712(c)(2)(i).* If a plan applies different	☐	☐	

[2] Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, and employee plus spouse. *See 29 CFR 2590.712(c)(1)(iv).*

	YES	NO	N/A
levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits (for example, a $250 deductible for self-only and a $500 deductible for family coverage), the predominant level is determined separately for each coverage unit. *See 29 CFR 2590.712(c)(3)(ii).* ❖ First determine if a particular type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in the relevant classification of benefits. ❖ Generally, a financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits if it applies to two-thirds or more of the medical/surgical benefits. *See 29 CFR 2590.712(c)(3)(i)(A).* This two-thirds calculation is based on the dollar amount of plan payments expected to be paid for the year. *See 29 CFR 2590.712(c)(3)(i)(C).* (Any reasonable method can be used for this calculation. *See 29 CFR 2590.712(c)(3)(i)(E).)* ❖ If the type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or quantitative treatment limitation that applies to medical/surgical benefits subject to that type of financial requirement or quantitative treatment limitation in that classification of benefits. (**Note**: If the type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to mental health/substance use disorder benefits in that classification.) ❖ Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation. *See 29 CFR 2590.712(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level.[3] *See 29 CFR 2590.712(c)(3)(i)(B)(2).* **Safe Harbor:** ◆ Until the issuance of final regulations, for purposes of determining parity for outpatient benefits (in-network and out-of network), the Departments have established an enforcement safe harbor under which no enforcement action will be taken against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits and (2) all other outpatient items and services, for purposes of applying the financial requirement and quantitative treatment limitation rules. ❖ After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health/substance use disorder benefits in any sub-classification (i.e., office visits			

[3] For a simpler method of compliance, a plan may treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

	YES	NO	N/A
or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the interim final rules. ❖ Other than as permitted under this enforcement policy and except as permitted under the interim final rules for multi-tiered prescription drug benefits, sub-classifications are not permitted when applying the financial requirement and quantitative treatment limitation rules under MHPAEA. Accordingly, and as stated in the preamble to the interim final rules, separate sub-classifications for generalists and specialists are not permitted. (See **Question 39** for more information regarding specialists and generalists.) **Special rule for prescription drug benefits:** ◆ There is a special rule for multi-tiered prescription drug benefits. A plan complies with the mental health parity provisions if the plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed for medical/surgical or mental health/substance use disorder benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 29 CFR 2590.712(c)(3)(iii).* **Tip:** Ensure that the plan does not impose cost-sharing requirements or quantitative treatment limitations that are applicable **only** to mental health/substance use disorder benefits.			
Question 39 – If the plan imposes a higher, specialist financial requirement, such as a copay, on mental health/substance use disorder benefits, can the plan demonstrate that the specialist level of the financial requirement is the predominant level that applies to substantially all medical/surgical benefits within the classification? ..... ◆ The six classifications outlined in **Question 38** are the only classifications that may be used when determining the predominant financial requirements or quantitative treatment limitations that apply to substantially all medical/surgical benefits. *See 29 CFR 2590.712(c)(2)(ii).* A plan may not use a separate sub-classification under these classifications for generalists and specialists. *See preamble language at 75 FR 5413.* **Tip:** A plan may still be able to impose the specialist level of a financial requirement or quantitative treatment limitation if it is the predominant level that applies to substantially all medical/surgical benefits within a classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the outpatient, in-network classification, the plan may apply the specialist level copay to mental health/substance use disorder benefits in the outpatient, in-network classification. *See ACA Implementation FAQ Part VII, Question 7.*	☐	☐	

	YES	NO	N/A
Question 40 – Does the plan comply with the mental health parity requirements for coverage in all classifications? ..... ◆ If a plan provides mental health/substance use disorder benefits in any classification of benefits (the classifications are listed in **Question 38**), mental health/substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 29 CFR 2590.712(c)(2)(ii)(A).* ◆ In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health/substance use disorder benefits. *See 29 CFR 2590.712(c)(2)(ii)(A).* **Tip:** If the plan does not contract with a network of providers, all benefits are out-of-network. If a plan that has no network imposes a financial requirement or treatment limitation on in-patient or outpatient benefits, the plan is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 29 CFR 2590.712(c)(2)(ii)(C), Example 1.*	☐	☐	
Question 41 – Does the plan comply with the mental health parity provisions on cumulative financial requirements or cumulative quantitative treatment limitations? ..... ◆ A plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health/substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(3)(v).* ❖ Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 29 CFR 2590.712(a).* ❖ Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 29 CFR 2590.712(a).* ◆ For example, a plan may not impose an annual $250 deductible on all medical/surgical benefits and a separate $250 deductible on all mental health/substance use disorder benefits.	☐	☐	

	YES	NO	N/A
Question 42 – Does the plan comply with the mental health parity provisions for parity within nonquantitative treatment limitations?.....	☐	☐	

- Nonquantitative treatment limitations (NQTLs) include:
  - Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
  - Formulary design for prescription drugs;
  - Standards for provider admission to participate in a network, including reimbursement rates;
  - Plan methods for determining usual, customary, and reasonable charges;
  - Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
  - Exclusions based on failure to complete a course of treatment.

  This is an **illustrative, nonexhaustive** list. *See 29 CFR 2590.712(c)(4)(ii).*

General rules:

- A plan may not impose an NQTL with respect to mental health/substance use disorder benefits in any classification (such as inpatient, out-of-network) unless, under the terms of the plan (as written and in operation), any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health/substance use disorder benefits in the classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference. *See 29 CFR 2590.712(c)(4)(i).*

- A group health plan may consider a wide array of factors in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) mental health/substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. *See ACA Implementation FAQ Part VII, Question 4.*

	YES	NO	N/A
Examples: The Departments have published several examples that help illustrate how the MHPAEA regulations apply to some common plan NQTLs, including: 1) The penalty for failure to obtain preauthorization is more punitive with respect to mental health/substance use disorder benefits than with respect to medical/surgical benefits. *See 2590.712(c)(4)(iii), Example 2.* 2) The plan uses an employee assistance program as a gatekeeper to obtaining mental health or substance use disorder benefits. *See 2590.712(c)(4)(iii), Example 5.* 3) Utilization management practices that differ among different plan benefits. *See ACA Implementation FAQ Part VII, Questions 4, 5, and 6.* **Tip:** Do not focus on results. Look at the **underlying processes and strategies** used in applying NQTLs (such as utilization review and standards for network admission). Are there arbitrary or discriminatory differences between those for medical/surgical benefits versus those for mental health/substance use disorder benefits? Are differences justified based on clinically appropriate standards of care? **Questions You Might Ask:** 1) Has the plan documented its analysis that its NQTL processes and strategies (such as utilization review) are comparable across medical/surgical and mental health/substance use disorder benefits? 2) If there are differences in these processes and strategies, has the plan documented the recognized, clinically appropriate standards that would permit a difference under the Departments' regulations? **Additional Illustrations.** Set forth below are additional illustrations of how a plan may have differences in NQTLs but may still comply with the Departments' regulations, based on the facts and circumstances involved: ◆ Plan X covers neuropsychological testing but only for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing the clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which they will cover this service and the rationale for excluding certain diagnoses? ◆ Plan Y applies concurrent review to inpatient psychiatric care and retrospective review for general medical hospitalizations that are reimbursed based on diagnosis related group (DRG) codes. The plan explains that DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Thus, it appears that concurrent management by the plan is clinically appropriate and permissible for psychiatric hospitalizations as long as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review.			

	YES	NO	N/A
◆ Master's degree training and state licensing requirements often vary. Plan Z consistently applies its standard that any provider must meet whatever is the most stringent licensing requirement standard related to supervised clinical experience requirements in order to participate in the network. Therefore, Plan Z requires master's-level therapists to have post-degree, supervised clinical experience in order to join their provider network. There is no parallel requirement for master's-level general medical providers because their licensing does require supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training. The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.			
Question 43 – Does the plan comply with the mental health parity disclosure requirements? ..... ◆ The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health/substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request. *See 29 CFR 2590.712(d)(1).* ◆ The plan administrator (or health insurance issuer) must make available the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health/substance use disorder benefits to any participant or beneficiary in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the claims procedure rule). *See 29 CFR 2590.712(d)(2).* ◆ If coverage is denied based on medical necessity, medical necessity criteria for the mental health/substance use disorder benefits at issue and for medical/surgical benefits in the same classification must be provided within 30 days of the request to the participant, beneficiary, or provider or other individual if acting as an authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1); ACA Implementation FAQ Part V, Question 10.*	☐	☐	

III. Determining Compliance with the Newborns' Act Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the Newborns' Act provisions in Part 7 of ERISA.

	YES	NO	N/A
Section A – Newborns' Act Substantive Provisions The substantive provisions of the Newborns' Act apply only to certain plans, as follows: If the plan does not provide benefits for hospital stays in connection with childbirth, check "N/A" and go to **Part IV** of this self-compliance tool. (Note: Under the Pregnancy Discrimination Act, most plans are required to cover maternity benefits.) ..			☐
Special applicability rule for *insured coverage* that provides benefits for hospital stays in connection with childbirth: If the plan provides benefits for hospital stays in connection with childbirth, the plan is insured**,** and the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If this is the case, answer the questions in **SECTION A and SECTION B**.			
If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act. If this is the case, check "N/A" and skip to **SECTION B**			☐
Self-insured coverage that provides benefits for hospital stays in connection with childbirth: If the plan provides benefits for hospital stays in connection with childbirth and is *self-insured,* the Federal Newborns' Act applies. Answer the questions in **SECTION A and SECTION B.**			
Question 44 – General 48/96-hour stay rule **Does the plan comply with the general 48/96-hour rule?** ..... ◆ Plans generally may not restrict benefits for a hospital length of stay in connection with childbirth to less than 48 hours in the case of a vaginal delivery *(See ERISA section 711(a)(1)(A)(i)),* or less than 96 hours in the case of a cesarean section *(See ERISA section 711(a)(1)(A)(ii)).* ◆ Therefore, a plan cannot deny a mother or her newborn benefits within a 48/96-hour stay based on medical necessity. (A plan may require a mother to notify the plan of a pregnancy to obtain more favorable cost-sharing for the hospital stay. This second type of plan provision is permissible under the Newborns' Act if the cost-sharing is consistent throughout the 48/96-hour stay.) ◆ An attending provider may, however, decide, in consultation with the mother, to discharge the mother or newborn earlier.	☐	☐	

	YES	NO	N/A
Question 45 – Provider must not be required to obtain authorization from plan **Plans may not require providers to obtain authorization from the plan to prescribe a 48/96-hour stay. Does the plan comply with this rule?** ..... ◆ Plans may not require that a provider (such as a doctor) obtain authorization from the plan to prescribe a 48/96-hour stay. *See ERISA section 711(a)(1)(B); 29 CFR 2590.711(a)(4).* **Tips:** Watch for plan preauthorization requirements that are too broad. For example, a plan may have a provision requiring preauthorization for all hospital stays. Providers cannot be required to obtain preauthorization from the plan in order for the plan to cover a 48-hour (or 96-hour) stay in connection with childbirth. Therefore, in this example, the plan must add clarifying language to indicate that the general preauthorization requirement does not apply to 48/96-hour hospital stays in connection with childbirth. (Conversely, plans generally may require participants or beneficiaries to give notice of a pregnancy or hospital admission in connection with childbirth in order to obtain, for example, more favorable cost-sharing.) Nonetheless, the Newborns' Act does not prevent plans and issuers from requiring providers to obtain authorization for any portion of a hospital stay that exceeds 48 (or 96) hours.	☐	☐	
Question 46 – Incentives/penalties to mothers or providers **Does the plan comply with the Newborns' Act by avoiding impermissible incentives or penalties with respect to mothers or attending providers?** ..... ◆ Penalties to attending providers to discourage 48/96-hour stays violate ERISA section 711(b)(3) and 29 CFR 2590.711(b)(3)(i). ◆ Incentives to attending providers to encourage early discharges violate ERISA section 711(b)(4) and 29 CFR 2590.711(b)(3)(ii). ◆ Penalties imposed on mothers to discourage 48/96-hour stays violate ERISA section 711(b)(1) and 29 CFR 2590.711(b)(1)(i)(A). ◆ Incentives to mothers to encourage early discharges violate ERISA section 711(b)(2) and 29 CFR 2590.711(b)(1)(i)(B). ❖ An example of this would be if the plan waived the mother's copayment or deductible if mother or newborn leaves within 24 hours. ◆ Benefits and cost-sharing may not be less favorable for the latter portion of any 48/96-hour hospital stay. In this case less favorable benefits would violate ERISA section 711(b)(5) and 29 CFR 2590.711(b)(2) and less favorable cost-sharing would violate ERISA section 711(c)(3) and 29 CFR 2590.711(c)(3).	☐	☐	

	YES	NO	N/A
SECTION B – Disclosure Provisions Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures, as follows:			
Question 47 – Disclosure with respect to hospital lengths of stay in connection with childbirth **Does the plan comply with the notice provisions relating to hospital stays in connection with childbirth?** ..... ◆ Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures. Specifically, the group health plan's SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. *See the SPD content regulations at 29 CFR 2520.102-3(u).* **Tips:** Whether the plan is insured or self-insured, and whether the Federal Newborns' Act provisions or State law provisions apply to the coverage, the plan must provide a notice describing any requirements relating to hospital length of stays in connection with childbirth. A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*	☐	☐	

IV. Determining Compliance with the WHCRA Provisions in Part 7 of ERISA			
If you answer "No" to any of the questions below, the group health plan is in violation of the WHCRA provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
WHCRA applies only to plans that offer benefits with respect to a mastectomy. If the plan does not offer these benefits, check "N/A" and go to **Part V** of this self-compliance tool..... If the plan does offer benefits with respect to a mastectomy, answer **Questions 48-51.**			☐
<u>Question 48 – Four required coverages under WHCRA</u> **Does the plan provide the four coverages required by WHCRA?** ..... ◆ In the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, the plan shall provide coverage for the following benefits for individuals who elect them: ❖ All stages of reconstruction of the breast on which the mastectomy has been performed; ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance; ❖ Prostheses; and ❖ Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient. *See ERISA section 713(a).* ◆ These required coverages can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the plan or coverage. **Tip:** Plans that cover benefits for mastectomies cannot categorically exclude benefits for reconstructive surgery or certain post-mastectomy services. In addition, time limits for seeking treatment may run afoul of the general requirement to provide the four required coverages.	☐	☐	
<u>Question 49 – Incentive provisions</u> **Does the plan comply with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers?** ..... ◆ A plan may not deny a patient eligibility to enroll or renew coverage solely to avoid WHCRA's requirements under ERISA section 713(c)(1). ◆ In addition, under ERISA section 713(c)(2), a plan may not penalize or offer incentives to an attending provider to induce the provider to furnish care in a manner inconsistent with WHCRA.	☐	☐	

	YES	NO	N/A
Question 50 – Enrollment notice **Does the plan provide adequate and timely enrollment notices as required by WHCRA?** ..... ◆ Upon enrollment, a plan must provide a notice describing the benefits required under WHCRA. *See ERISA section 713(a).* ◆ The enrollment notice must describe the benefits that WHCRA requires the group health plan to cover, specifically: ❖ All stages of reconstruction of the breast on which the mastectomy was performed, ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance, ❖ Prostheses, and ❖ Physical complications resulting from mastectomy (including lymphedema). ◆ The enrollment notice must describe any deductibles and coinsurance limitations applicable to such coverage. (Note: Under WHCRA, coverage of the required benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other medical/surgical benefits under the plan or coverage.) **Tip:** A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*	☐	☐	
Question 51 – Annual notice **Does the plan provide adequate and timely annual notices as required by WHCRA?** ..... ◆ Plans must provide notices describing the benefits required under WHCRA once each year. *See ERISA section 713(a).* ◆ To satisfy this requirement, the plan may redistribute the WHCRA enrollment notice or the plan may use a simplified disclosure that: ❖ Provides notice of the availability of benefits under the plan for reconstructive surgery, surgery to achieve symmetry between the breasts, prostheses, and physical complications resulting from mastectomy (including lymphedema); and ❖ Contact information (e.g., telephone number) for obtaining a detailed description of WHCRA benefits available under the plan. **Tip**: The WHCRA annual notice can be provided in the SPD if the plan distributes SPDs annually. If not, the plan should break off the annual notice into a separate disclosure. A model notice is provided in the EBSA publication, *Health Benefits Coverage Under Federal Law.*	☐	☐	

V. Determining Compliance with the GINA Provisions in Part 7 of ERISA			
If you answer "No" to any of the questions below, the group health plan is in violation of the GINA provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
Unlike HIPAA, the GINA provisions generally do apply to very small health plans (plans with less than two participants who are current employees), including retiree-only health plans. **Definitions** (for all defined terms under GINA, see 29 CFR 2590.702-1(a)): *Genetic information* means, with respect to an individual, information about the individual's genetic tests, the genetic tests of family members of the individual, the manifestation (see definition below) of a disease or disorder in family members of the individual or any request for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or any family member of the individual. ◆ Genetic information includes, with respect to a pregnant woman or family member of the pregnant woman, genetic information of any fetus carried by the pregnant woman. ◆ Genetic information includes, with respect to an individual who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member. ◆ Genetic information does NOT include information about the sex or age of any individual. *Family member* means, with respect to an individual, a dependent of the individual or any person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or a dependent of the individual. Relatives of affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor). Relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents). Therefore, family members include parents, spouses, siblings, children, grandparents, grandchildren, aunts, uncles, nephews, nieces, great-grandparents, great-grandchildren, great aunts, great uncles, first cousins, great-great grandparents, great-great grandchildren, and children of first cousins. *Manifestation* means, with respect to a disease, disorder, or pathological condition, that an individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved. A disease, disorder, or pathological condition is not manifested if a diagnosis is based principally on genetic information. *Genetic services* means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information) or genetic education. *Genetic test* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes.			

	YES	NO	N/A
A genetic test does **NOT** include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. For example, a test to determine whether an individual has a BRCA1 or BRCA2, genetic variants associated with a significantly increased risk for breast cancer, is a genetic test. An HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.			
Question 52 – Does the plan comply with GINA's prohibition against group-based discrimination based on genetic information? ..... ◆ A group health plan cannot adjust premium or contribution amounts for the plan, or any similarly situated individuals under the plan, on the basis of genetic information. *See 29 CFR 2590.702-1(b)(1).* ◆ Nothing limits a plan from increasing the premium for the group health plan or for a group of similarly situated individuals under the plan based on the manifestation of a disease or disorder of an individual enrolled in the plan. However, the manifestation of the disease in one individual cannot be used as genetic information about other group members to further increase the premium for a group health plan or a group of similarly situated individuals under the plan. *See 29 CFR 2590.702-1(b)(2).*	☐	☐	
Question 53 – Does the plan comply with GINA's limitation on requesting or requiring genetic testing? ..... ◆ A group health plan generally must not request or require an individual or family member of the individual to undergo a genetic test. *See 29 CFR 2590.702-1(c)(1).* ◆ Exceptions: ❖ A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. *See 29 CFR 2590.702-1(c)(2).* ❖ A plan can obtain and use the results of a genetic test for making a determination regarding payment. However, the plan is permitted to request only the minimum amount of information necessary to make the determination. *See 29 CFR 2590.702-1(c)(4).* ❖ Exception for research: a plan or issuer may request, but not require, that a participant or beneficiary undergo a genetic test if the request is pursuant to research and several conditions are met. *See 29 CFR 2590.702-1(c)(5).*	☐	☐	
Question 54 – Does the plan comply with GINA's prohibition on collection of genetic information, *prior to or in connection with enrollment?* ..... ◆ A plan cannot collect genetic information prior to an individual's effective date of coverage under that plan or coverage, nor in connection with the rules for eligibility that apply to that individual. *See 29 CFR 2590.702-1(d)(2)(i).* ◆ Whether or not an individual's information is collected prior to that individual's effective date of coverage is determined at the time of collection. ◆ Exception for incidental collection:	☐	☐	

	YES	NO	N/A
❖ If a plan obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation, as long as the collection is not for underwriting purposes. *See 29 CFR 2590.702-1(d)(2)(ii)(A).* ❖ However, the incidental collection exception does not apply in connection with any collection where it is reasonable to anticipate that health information would be received, unless the collection explicitly states that genetic information should not be provided. *See 29 CFR 2590.702-1(d)(2)(ii)(B).*			
Question 55 – Does the plan comply with GINA's prohibition on collection of genetic information, *for underwriting purposes?* ..... ◆ A plan cannot request, require, or purchase ("collect") genetic information for underwriting purposes. *See 29 CFR 2590.702-1(d)(1)(i).* ◆ *Underwriting purposes* means, with respect to any group health plan: ❖ Rules for determination of eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); ❖ The computation of premium or contribution amounts under the plan or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); ❖ The application of any preexisting condition exclusion under the plan or coverage; and ❖ Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. *See 29 CFR 2590.702-1(d)(1)(ii).* ◆ Exception for medical appropriateness (only if an individual seeks a benefit under the plan): ❖ If an individual seeks a benefit under a plan, the plan may limit or exclude the benefit based on whether the benefit is medically appropriate *and the determination of whether the benefit is medically appropriate is not for underwriting purposes***.** ❖ If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information. A plan or issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness. *See 29 CFR 2590.702-1(d)(1)(iii) and (e).*	☐	☐	
If you answered "Yes" to **ALL** of the above questions, there are no violations of the GINA regulations.			

VI. Compliance with Michelle's Law			
If you answer "No" to any of the questions below, the group health plan is in violation of the Michelle's Law provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
****Note: Under the Affordable Care Act group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle's Law provisions may apply.**			
Question 56 – Does the plan comply with the Michelle's Law requirement not to terminate coverage of dependent students on medically necessary leave of absence?..... *Medically necessary leave of absence means with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with a group health plan, a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.* *A dependent child is a beneficiary who is a dependent child under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage and who was enrolled in the plan or coverage on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.* ◆ A group health plan or issuer shall not terminate coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose student status before the date that is the earlier of: ❖ the date that is one year after the first day of the medically necessary leave of absence; or ❖ the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. *See ERISA section 714(b).* **Tip:** The group health plan or issuer can require receipt of written certification by a treating physician of the dependent child which states that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.	☐	☐	
Question 57 – Does the plan comply with Michelle's Law's notice requirement? ..... ◆ A group health plan or issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the Michelle's law provision for continued coverage during medically necessary leaves of absence. *See ERISA section 714(c).*	☐	☐	

Self-Compliance Tool for Part 7 of ERISA: Affordable Care Act Provisions

INTRODUCTION

While this self-compliance tool does not necessarily cover all the specifics of these laws, it is intended to assist those involved in operating a group health plan to understand the laws and related responsibilities. It provides an informal explanation of the statutes and the most recent regulations and interpretations and includes citations to the underlying legal provisions. The information is presented as general guidance, however, and should not be considered legal advice or a substitute for any regulations or interpretive guidance issued by EBSA. In addition, some of the provisions discussed involve issues for which the rules have not yet been finalized. Proposed rules, interim final rules, and transition periods generally are noted. Periodically check the Department of Labor's Website (www.dol.gov/ebsa) under Laws & Regulations for publication of final rules.

Under the Affordable Care Act, there are various provisions that apply to group health plans and health insurance issuers and various protections and benefits for consumers that are beginning to take effect or that will become effective very soon. The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 1.*

I. Determining Compliance with the Affordable Care Act Provisions in Part 7 of ERISA

The Patient Protection and Affordable Care Act (the Affordable Care Act) was signed into law by the President on March 23, 2010. Amendments to the Affordable Care Act made through the Health Care Education and Reconciliation Act (Reconciliation Act) were signed into law on March 30, 2010. Generally, the Affordable Care Act's market reform provisions amend title XXVII of the Public Health Service Act (PHS Act), which is administered by the Department of Health and Human Services. The Affordable Care Act also creates section 715 of the Employee Retirement Income Security Act (ERISA), administered by the Department of Labor, Employee Benefits Security Administration, and section 9815 of the Internal Revenue Code, administered by the Department of Treasury (the Treasury) and the Internal Revenue Service (IRS), to incorporate the market reform provisions of the PHS Act into ERISA and the Code, and make them applicable to group health plans and health insurance issuers providing group health insurance coverage. Under section 1251 of the Affordable Care Act, grandfathered health plans are required to comply with some, but not all, of the market reform provisions. In addition, these provisions do not apply to retiree-only or excepted benefits plans (See ERISA Section 732). The Departments of Labor, HHS, and the Treasury have been issuing guidance on an ongoing basis since May 2010.

See EBSA's website: http://www.dol.gov/ebsa/healthreform/ for the most up-to-date guidance.

This compliance aid will be updated in the future to further address additional requirements as they become applicable, as enforcement grace periods expire, or as the Departments issue additional guidance.

	YES	NO	N/A
Section A. Determining Grandfather Status Under the Affordable Care Act Provisions in Part 7 of ERISA *Note: The grandfather status of a plan will affect whether a plan must comply with certain provisions of the Affordable Care Act (ACA). There are also special rules for collectively bargained plans. See also the rules at 29 CFR 2590.715-1251(f) and the amendment to the IFR published on November 17, 2010.* Grandfather status is intended to allow people to keep their coverage as it existed on March 23, 2010, while giving plans some flexibility to make "normal" changes while retaining grandfather status. Grandfathered health plan coverage provides individuals' protection from significant reductions in coverage, provides for coverage to include numerous protections implemented through the Affordable Care Act, and allows employers the flexibility to manage costs. The analysis for determining grandfather status applies separately to each benefit package or option. Accordingly, grandfather status might be retained for some benefit packages or options and relinquished for others. By contrast, if an employer relinquished grandfather status for self-only, family, or any other tier within a benefits package, it would relinquish grandfather status for the entire package. *See 29 CFR 2590.715-1251(a)(1)(i).* There are transitional rules regarding grandfather status as related to recent changes to plan terms. ◆ Specifically a plan will not relinquish grandfather status for changes effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010; changes effective after March 23, 2010, pursuant to a filing on or before March 23, 2010, with a State insurance department; or changes effective after March 23, 2010, pursuant to written amendments to a plan that were adopted on or before March 23, 2010. ◆ If after March 23, 2010, a group health plan or issuer made changes to the terms of the plan or coverage and the changes were adopted prior to June 14, 2010, the changes will not cause the plan or coverage to relinquish grandfather status, if the changes were revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to otherwise cease to be a grandfathered health plan. *See 29 CFR 2590.715-1251(g)(2).* **If the plan is not claiming grandfathered status, proceed to Section B.** **If the answer is "yes" to questions 1 and 2 below the group health plan may be a grandfathered health plan.**			
Question 1 – Did the plan exist with at least one individual enrolled on March 23, 2010?..... ◆ A grandfathered group health plan must have been in existence with an enrolled individual on March 23, 2010. Any plan that does not meet this requirement is not in grandfathered status. *See 29 CFR 2590.715-1251(a)(1)(i).*	☐	☐	

	YES	NO	N/A
Question 2 – Has the plan continuously covered someone (not necessarily the same person) since March 23, 2010? ..... ◆ A group health plan will not relinquish its grandfather status merely because one or more (or all) individuals enrolled on March 23, 2010, cease to be covered. However, a grandfathered health plan must continuously cover someone (not necessarily the same person) since March 23, 2010, to maintain its status. *See 29 CFR 2590.715-1251(a)(1)(i).* **If the answers to questions 1 and 2 were "yes", complete questions 3-11. If the answer is "no" to either question 1 or 2, the group health plan cannot claim grandfather status; proceed to Section B.** **TIP:** Provided changes are made without exceeding the other standards that cause a plan to relinquish grandfather status, changes that generally will not cause plans to relinquish grandfather status include changes to: premiums; to comply with Federal or State legal requirements; to voluntarily comply with provisions of the Affordable Care Act; third party administrators; network plan's provider network; and to a prescription drug formulary.	☐	☐	
Question 3 – Has the plan eliminated all or substantially all benefits to diagnose or treat a particular condition? ..... ◆ For the purpose of determining grandfather status, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition. *See 29 CFR 2590.715-1251(g)(1)(i).*	☐	☐	
Question 4 – Has the plan increased a percentage cost-sharing requirement (such as an individual's coinsurance)? ..... ◆ Any increase measured from March 23, 2010, in a percentage cost-sharing requirement causes a plan to relinquish grandfather status. *See 29 CFR 2590.715-1251(g)(1)(ii).*	☐	☐	
Question 5 – Has the plan increased a fixed-amount cost-sharing requirement other than a copayment (such as a deductible or out-of-pocket limit) such that the total percentage increase measured from March 23, 2010 exceeds the maximum percentage increase? ..... ◆ The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. *See 29 CFR 2590.715-1251(g)(3)(ii).* Medical inflation is the increase since March 2010, in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. *See 29 CFR 2590.715-1251(g)(3)(i).*	☐	☐	

	YES	NO	N/A
Question 6 – Has the plan increased a fixed-amount copayment such that the increase measured from March 23, 2010 exceeds the greater of: the maximum percentage increase, or an amount equal to $5 plus medical inflation? ..... ◆ The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. *See 29 CFR 2590.715-1251(g)(3)(ii).* Medical inflation is the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. *See 29 CFR 2590.715-1251(g)(3)(i).*	☐	☐	
Question 7 – Has there been a decrease in the contribution rate by the employer (or employee organization) towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010? ..... ◆ If the contribution rate is based on a formula, was the decrease in the contribution rate based on a formula by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010? *See 29 CFR 2590.715-1251(g)(1)(v)(B).* **TIP:** If a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. If the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). *See DOL FAQs About the Affordable Care Act Implementation Part II, question 3* at *http://www.dol.gov/ebsa/faqs/faq-aca2.html.* In cases of a multiemployer plan that has either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage, if the employer's contribution rate changes, provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage, the change of the employer's contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to relinquish grandfather status. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 4 at http://www.dol.gov/ebsa/faqs/faq-aca.html.*	☐	☐	

	YES	NO	N/A
Question 8 – Has the plan added or decreased an overall annual limit on benefits? ..... ◆ A plan will relinquish its grandfathered status if it: ❖ Adds an overall annual limit on the dollar value of all benefits when it did not previously impose an overall annual limit (*See 29 CFR 2590.715-1251(g)(1)(vi)(A)*); ❖ Previously imposed an overall lifetime limit on the dollar value of benefits (but no overall annual limit) and adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010 (*See 29 CFR 2590.715-1251(g)(1)(vi)(B)*); or ❖ Decreases the dollar value of the overall annual limit that was in place on March 23, 2010 (*See 29 CFR 2590.715-1251(g)(1)(vi)(C)*). **If the answer to any of questions 3-8 was "yes", the plan is NOT a grandfathered plan, proceed to Section B.**	☐	☐	
Question 9 – Did the plan change issuers after March 23, 2010? ..... If the answer to question 9 is "yes", if the group health plan changed issuers after March 23, 2010, and the change in issuer was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes that would relinquish grandfather status are made. *See 29 CFR 2590.715-1251(a)(1)(ii), as amended.* Proceed to question 10. **If a group health plan changed issuers after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan; proceed to Section B.** **TIP:** The operative date is the effective date of the new contract, not the date the new contract was entered into. Special rules apply for collectively bargained plans. *See* 29 CFR 2590.715-1251(f) for collectively bargained plans.	☐	☐	
Question 10 – Did the plan change from self-insured to fully-insured after March 23, 2010? ..... If the group health plan was self-insured and changed to fully insured after March 23, 2010, and the change was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes are made that would relinquish grandfather status. *See 29 CFR 2590.715-1251(a)(1)(ii), as amended.* Proceed to question 11. **If a group health plan was self-insured and changed to fully-insured after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan; proceed to Section B.**	☐	☐	

	YES	NO	N/A
Question 11 – If the group health plan changed issuers (including a plan that was self-insured and changed to fully insured) and has maintained grandfather status did the plan provide documentation to the new issuer of the plan terms under the prior health coverage sufficient to determine whether any other change was made that would relinquish grandfather status? ..... ◆ To maintain status as a grandfathered health plan, the plan must provide to the new issuer (and the new issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any other change is being made that would relinquish grandfathered status. *See 29 CFR 2590.715-1251(a)(3)(ii), as amended.* **For all plans that, based on questions 1 through 11, have not relinquished grandfather status, complete questions 12-13.**	☐	☐	
Question 12 – Does the plan include a statement that it believes it is a grandfathered health plan in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan? ..... ◆ To maintain status as a grandfathered group health plan, the plan must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits under the plan, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act and must provide contact information for questions and complaints. Model language is available. *See 29 CFR 2590.715-1251(a)(2).*	☐	☐	
Question 13 – Is the plan maintaining records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and are these records made available upon request? ..... ◆ To maintain status as a grandfathered group health plan the plan must maintain records documenting the terms of the plan in connection with the coverage that was in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be maintained for as long as the plan takes the position that it is grandfathered, and must be available for examination upon request. *See 29 CFR 2590.715-1251(a)(3)(i)(A) & (i)(B), as amended.*	☐	☐	
Section B. Determining Compliance with the Affordable Care Act Extension of Dependent Coverage of Children to Age 26 Provisions in Part 7 of ERISA *Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans. A special rule for grandfathered plans is noted below.*			

	YES	NO	N/A
Question 1 – Does the plan provide coverage for dependent children?..... If the answer to this question is no, proceed to Section C. These provisions are only applicable to group health plans that provide coverage to dependent children. If the answer is "yes", proceed to question 2.	☐	☐	
Question 2 – Is the plan a grandfathered health plan?..... **If yes, note:** **Special Rule for Grandfathered Plans:** Grandfathered group health plans are not required to cover dependent children to age 26 if the dependent is eligible to enroll in another employer-sponsored group health plan (other than the group health plan of a parent). *See 29 CFR 2590.715-2714(g)(1).* **If the answer to ALL of the questions below is "yes", the plan is in compliance with the rules regarding Dependent Coverage to Age 26.**	☐	☐	
Question 3 – Does the plan make dependent coverage available for children to age 26? ... Plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 other than in terms of a relationship between a child and the participant. Thus, plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 based on the presence or absence of financial dependency upon or residency with the participant or any other person, student status, employment or any combination of these factors. In addition, plans and issuers cannot limit dependent coverage based on whether the child under age 26 is married. The Affordable Care Act and implementing regulations do not require plans to cover children of children. *See 29 CFR 2590.715-2714(b) & (c).* The terms of the plan or coverage cannot vary based on age, except for children who are age 26 or older. *See 29 CFR 2590.715-2714(d).* **TIP:** A plan or issuer does not fail to satisfy the requirements regarding Dependent Coverage to Age 26 because the plan limits health coverage for children until the child turns 26 to only those children who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 14 at http://www.dol.gov/ebsa/faqs/faq-aca.html.*	☐	☐	
Question 4 – Did the plan provide the one-time notice and an opportunity to enroll?..... There is a special transitional rule for children who satisfy two requirements – (a) their coverage ended, or they were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before the attainment of age 26; and (b) by reason of the application of this provision, they become eligible for coverage on the first day of the first plan year beginning on or after September 23, 2010.	☐	☐	

	YES	NO	N/A
With respect to children, plans and issuers must comply with the following transitional rules: *See 29 CFR 2590.715-2714(f).* ◆ An enrollment opportunity (including written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010 and the enrollment period must continue for at least 30 days. *See 29 CFR 2590.715-2714(f)(2)(i).* ◆ The written notice must include a statement that children whose coverage ended, or who were denied (or were not eligible for) coverage because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. The notice may be provided to an employee on behalf of a child and the notice may be included with other enrollment materials, provided the statement is prominent. *See 29 CFR 2590.715-2714(f)(2)(ii).* ◆ Under this enrollment opportunity, a child must be treated as a HIPAA special enrollee. Therefore, the child must be offered all the benefit packages available to similarly situated individuals who did not lose coverage because they ceased to be dependents and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage because they ceased to be dependents. Further, if the participant, through whom the child is eligible, is not enrolled, the plan must provide that participant an enrollment opportunity. *See 29 CFR 2590.715-2714(f)(4), cross-referencing 29 CFR 2590.701-6(d).* ◆ Plans may coordinate this enrollment opportunity with open season, if an open season occurs before the first day of the next plan year. For example, if a calendar year plan has an open season coming up in advance of January 1, 2011, the plan may coordinate this enrollment period with that open season. Under the enrollment opportunity, coverage must take effect not later than the first day of the first plan year on or after September 23, 2010. *See 29 CFR 2590.715-2714(f)(3).*			
Section C. Determining Compliance with the Affordable Care Act Rescission Provisions in Part 7 of ERISA *Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.* A rescission is a cancellation or discontinuance of coverage that has retroactive effect; this includes a cancellation that treats a policy as void from the time of the group's enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect; or the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage. *See 29 CFR 2590.715-2712(a)(2).* **If the answer to the question below is "yes" the plan is in compliance with the rules regarding rescission of coverage.**			

	YES	NO	N/A
Question 1 – Does the plan only rescind coverage for instances where an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact has occurred? ..... ◆ A group health plan, or health insurance issuer offering group health insurance coverage, must not rescind coverage with respect to an individual (including a group to which the individual belongs, or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. *See 29 CFR 2590.715-2712(a)(1).* **TIP:** Some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission. Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.) *See DOL FAQs About the Affordable Care Act Implementation Part II, question 7 at http://www.dol.gov/ebsa/faqs/faq-aca2.html.*	☐	☐	
Section D. Determining Compliance with the Affordable Care Act Prohibitions on Lifetime Limits and Restrictions on Annual Limits in Part 7 of ERISA *Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.* The restrictions on annual limits do not apply to health flexible spending arrangements (FSAs), medical savings accounts (MSAs), or health savings accounts (HSAs). In the case of health reimbursement accounts (HRAs) that are integrated with other group health plan coverage which complies with the prohibitions on lifetime and annual limits, the fact that benefits under the HRA by itself are limited does not violate these rules. Stand-alone HRAs limited to retirees only are not subject to these rules. **1. Lifetime Limits** **If the answer to ALL of the questions below is "yes" the plan is in compliance with the rules regarding prohibitions on lifetime limits.**			

	YES	NO	N/A
Question 1 – Does the plan comply with the Affordable Care Act's prohibition on lifetime limits? ◆ A group health plan or issuer may not establish any lifetime limit on the dollar amount of benefits for any individual. This prohibition applies for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2711(a)(1).* **TIP:** These rules do not prevent a plan or issuer from placing lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). *See 29 CFR 2590.715-2711(b)(1).* ***Note:*** "Essential health benefits" refers to essential benefits under Section 1302(b) of the Affordable Care Act and applicable regulations (issued by HHS). For plan years beginning before the issuance of regulations defining "essential health benefits," for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits." **For this purpose, a plan or issuer must apply the definition of essential health benefits consistently.** ***See Preamble to Interim Final Regulations, at 75 FR 37188, 37191.***	☐	☐	
Question 2 – Does the plan comply with the requirements regarding one-time notice and opportunity to enroll? There are transitional rules for any individual who satisfies two requirements – (a) their coverage or benefits under a group health plan or health insurance coverage ended by reason of reaching a lifetime limit; and (b) by reason of the application of this provision, they become eligible (or are required to become eligible) for benefits not subject to a lifetime limit on the first day of the first plan year on or after September 23, 2010. Such individuals must be provided notice and an enrollment opportunity. *See 29 CFR 2590.715-2711(e)(1).* With respect to these individuals, plans and issuers must comply with the following transitional rules: ◆ An enrollment opportunity (including written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010 and must continue for at least 30 days. *See 29 CFR 2590.715-2711(e)(2)(i).* ◆ The notice may be provided to an employee on behalf of the employee's dependent and the notice may be included with other enrollment materials, provided the statement is prominent. *See 29 CFR 2590.715-2711(e)(2(ii)).* ❖ **Notice to Individuals Still Covered:** The plan and issuer are required to give the individual written notice that the lifetime limit on the dollar value of benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. *See 29 CFR 2590.715-2711(e)(2)(i).* ❖ **Notice and Enrollment Opportunity to Individuals Who Are Not Enrolled**: If an individual is not enrolled (or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or coverage), the plan and issuer must give the individual written notice that the lifetime limit on the dollar value of benefits no longer applies and that the individual is once again eligible for benefits under the plan. *See 29 CFR 2590.715-2711(e)(2)(i).*	☐	☐	

	YES	NO	N/A
◆ For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010. *See 29 CFR 2590.715-2711(e)(3).* ◆ Individuals who enroll under this opportunity must be treated as special enrollees. Therefore, the individual must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit. Further, if the participant, through whom the individual is eligible, is not enrolled, the plan must provide that participant an enrollment opportunity. *See 29 CFR 2590.715-2711(e)(4).*			
2. Annual Limits The interim final regulations provide that for plan years prior to January 1, 2014, the Secretary of HHS may establish a program under which the requirements relating to restricted annual limits may be waived if compliance with the rules would result in a significant decrease in access to benefits or a significant increase in premiums. Limited benefit insurance plans, also known as mini-medical plans, which are often used by employers to provide benefits to part-time workers, are examples of plans that might seek this kind of delay. If a plan has been granted an HHS waiver, the plan is not required to comply with the annual limit requirements during the applicable waiver period. Proceed to Section E. **If the answer to the question below is "yes" the plan is in compliance with the rules regarding prohibitions/restrictions on annual limits.**			
Question 1 – Does the plan comply with the Affordable Care Act's restrictions on annual limits?..... For plan years beginning prior to January 1, 2014, a plan may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, if the limit is no less than: ◆ For a plan year beginning on or after September 23, 2010 but before September 23, 2011, $750,000; ◆ For a plan year beginning on or after September 23, 2011 but before September 23, 2012, $1.25 million; and ◆ For plan years beginning on or after September 23, 2012 but before January 1, 2014, $2 million. *See 29 CFR 2590.715-2711(d)(1).* **TIP:** These rules do not prevent a plan or issuer from placing annual dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). *See 29 CFR 2590.715-2711(b)(1).*	☐	☐	

	YES	NO	N/A
Section E. Determining Compliance with the Affordable Care Act Prohibition on Preexisting Condition Exclusion for Individuals Under 19 in Part 7 of ERISA *Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.* The definition of preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of denial), such as a condition identified as a result of a pre-enrollment questionnaire or a physical examination given to the individual, or a review of medical records relating to the pre-enrollment period. *See 29 CFR 2590.701-2 (as revised – see 75 FR 37229).* **If the answer to the following question is "yes" the plan is in compliance with the prohibition on preexisting condition exclusions for individuals under the age of 19.**			
Question 1 – Does the plan comply with the Affordable Care Act by not imposing a preexisting condition exclusion on individuals under the age of 19?..... ◆ For plan years beginning on or after September 23, 2010, group health plans may not impose any preexisting condition exclusion on enrollees, including applicants for enrollment, under the age of 19. *See 29 CFR 2590.715-2704(a)(1); 29 CFR 2590.715-2704(b)(2)&(3).*	☐	☐	
Section F. Determining Compliance with the Affordable Care Act Provisions Regarding the provision of the Summary of Benefits and Coverage (SBC) and Uniform Glossary *Note: This provision is applicable for participants and beneficiaries who enroll or re-enroll through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll other than through an open enrollment period (such as newly eligible or special enrollees), SBCs must be provided beginning on the first day of the first plan year beginning on or after September 23, 2012. See 29 CFR 2590.715-2715(f). These provisions* ***do apply*** *to grandfathered health plans.* The Affordable Care Act provides for new disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options available to them in both the individual and group health insurance coverage markets. Generally, group health plans and health insurance issuers are required to provide the SBC and Uniform Glossary free of charge. The Departments published a final rule setting forth the requirements for who must provide and who is entitled to receive an SBC and Uniform Glossary, when these documents must be provided, the content required in the documents, and the form and manner of how the documents can be provided. In addition, the Departments published a notice that sets forth the required template for the SBC and Uniform Glossary documents along with instructions and sample language for completing the template. These			

	YES	NO	N/A
documents are available on the EBSA website at: http://www.dol.gov/ebsa/healthreform/. The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner. The rules for determining whether a language other than English must be made available are the same as the rules for Internal Claims and Appeals and External Review, discussed in Section I of this compliance aid. HHS has made available translated versions of the template and glossary available in the potential required languages at: http://cciio.cms.gov/resources/other/index.html. **Transitional Relief Providing Flexibility and Emphasizing Good Faith Progress Towards Compliance** The Department is working together with employers and issuers to assist them in coming into compliance with these requirements. Specifically, in the instructions for completing the SBC, the Department stated that to the extent a plan's terms do not reasonably correspond to the template and instructions, the template should be completed in a manner that is as consistent with the instructions as reasonably as possible, while still accurately reflecting the plan's terms. *See Instructions Guide for Group Coverage, page 1 General Instructions.* In addition, compliance assistance is a high priority for the Departments. Implementation will be marked by an emphasis on assisting (rather than imposing penalties on) plans and issuers that are working diligently and in good faith to understand and come into compliance with the new law. During the first year of applicability,[1] the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to comply. The Departments will continue to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community. *See ACA Implementation FAQ Part VIII, Q2 and Part IX, Q8.* **The questions below focus on provision of the SBC by group health plans to participants and beneficiaries. The final regulations also require health insurance issuers to provide the SBC to group health plan sponsors and participants and beneficiaries. More information on these requirements can be found at www.dol.gov/ebsa.** **The following questions have been developed to assist in determining compliance with the rules regarding the Summary of Benefits and Coverage and Uniform Glossary.**			
Question 1 – Does the plan provide an SBC, as required? ..... **In Connection with Enrollment** ◆ When providing the SBC to participants and beneficiaries, group health plans and issuers must provide the SBC with respect to each benefit package offered for which they are eligible (*See 29 CFR 2590.715-2715(a)(1)(ii)(A)*) as part of any written application materials distributed by the plan or issuer for enrollment. If no written application materials are distributed for enrollment, the SBC must be provided no later than the first date a participant is eligible to enroll in coverage for themselves or any beneficiaries. *See 29 CFR 2590.715-2715(a)(1)(ii)(B).* For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. *See ACA Implementation FAQ Part VIII, Q9.*	☐	☐	

1 The term "first year of applicability" refers to SBCs and uniform glossaries provided with respect to coverage beginning before January 1, 2014.

	YES	NO	N/A
◆ If there is any change to the information required to be in the SBC prior to the first day of coverage, the plan or issuer must provide an updated SBC to the participants and beneficiaries no later than the first day of coverage. *See 29 CFR 2590.715-2715(a)(1)(ii)(C).* ◆ An SBC must also be provided to special enrollees no later than the date by which an SPD is required to be provided under ERISA section 104(b)(1)(A), which is 90 days from enrollment. *See 29 CFR 2590.715-2715(a)(1)(ii)(D).* **In Connection with Renewal** ◆ Group health plans and issuers are required to provide an SBC to participants and beneficiaries upon renewal or reissuance of coverage. *See 29 CFR 2590.715-2715(a)(1)(ii)(E).* If written application materials are required for renewal (paper or electronic), the SBC must be provided no later than the date on which these materials are distributed. *See 29 CFR 2590.715-2715(a)(1)(ii)(E)(1).* If renewal is automatic, the SBC must be provided no later than 30 days before the first day of coverage in the new plan or policy year. For insured coverage, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of, or after receiving confirmation of the policyholder's intent to renew, the policy, certificate, or contract of insurance, whichever is earlier. *See 29 CFR 2590.715-2715(a)(1)(ii)(E)(2).* ◆ With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled. *See 29 CFR 2590.715-2715(a)(1)(iii)(C).* **Upon Request** ◆ SBCs are required to be provided by group health plans and issuers, as applicable, to participants and beneficiaries upon request, as soon as practicable, but no later than seven business days following the receipt of a request. *See 29 CFR 2590.715-2715(a)(1)(ii)(F).* **Guidance Regarding Applicability** ◆ Disclosures (including the SBC and Uniform Glossary) provided to participants and beneficiaries who enroll or re-enroll through an open enrollment period must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll other than through open enrollment (such as newly eligible or special enrollees), these disclosures must be provided beginning on the first day of the first plan year beginning on or after September 23, 2012. *See 29 CFR 2590.715-2715(f).* ◆ Due to additional administrative complexities with respect to providing SBCs for insurance products that are no longer being offered for purchase (sometimes referred to as closed blocks of business), the Departments will not take any enforcement action against a plan or issuer for failing to provide an SBC *before* September 23, 2013 with respect to an insured product that is no longer being actively marketed for purchase. However, the SBC must be provided *no later than* September 23, 2013. *See ACA Implementation FAQ Part IX, Q12.*			

	YES	NO	N/A
◆ With respect to expatriate coverage, the Departments will not take any enforcement action against a group health plan or group health insurance issuer for failing to provide an SBC for such coverage during the first year of applicability. *See ACA Implementation FAQ Part IX, Q13.* **TIPS:** The requirement to provide an SBC by both a health insurance issuer and a group health plan to participants and beneficiaries can be satisfied for both entities as long as one entity provides the required SBC within the required timeframes. *See 29 CFR 2590.715-2715(a)(1)(iii)(A).* If a participant and any beneficiaries are known to reside at the same address, a single SBC provided to that address will satisfy the obligation to provide for all individuals at the address. Under this circumstance, the obligation will also be satisfied if the SBC is furnished to the participant in electronic form. However if a beneficiary's last known address is different than the participant's address, a separate SBC must be mailed to the beneficiary's address. *See 29 CFR 2590.715-2715(a)(1)(iii)(B) and ACA Implementation FAQ Part VIII, Q10.* Group health plans are permitted to integrate the SBC with other summary materials, such as the SPD, as long as the SBC is intact and prominently displayed at the beginning of the materials (for example, immediately after the table of contents in an SPD) and all of the timing requirements are met. *See 77 FR 8707.* The Departments generally allow electronic delivery of the SBC and Uniform Glossary where appropriate. For participants and beneficiaries who are already enrolled in coverage under a group health plan, an SBC may be provided electronically if the requirements of the Department of Labor's electronic safe harbor are met. For participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if the format is readily accessible; the SBC is provided in paper form upon request; and if the electronic form is an Internet posting, the plan or issuer timely notifies the individual that the documents are available in paper form upon request. *See 29 CFR 2590.715-2715(a)(3).* An SBC may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs may also be provided electronically to participants and beneficiaries who request an SBC online. In either instance, a paper copy must be provided upon request. *See ACA Implementation FAQ Part IX, Q1.*			
Question 2 – Does the plan make available the Uniform Glossary, as required? ..... ◆ The Uniform Glossary includes statutorily required terms, as well as multiple additional terms recommended by the NAIC. The Uniform Glossary is available on the DOL website at http://www.dol.gov/ebsa/healthreform/. The Uniform Glossary may not be modified by plans or issuers. *See 29 CFR 2590.715-2715(c)(3); 77 FR 8708.* ◆ The final rule requires group health plans and issuers to make the Uniform Glossary available upon request within seven business days. *See 29 CFR 2590.715-2715(c)(4).* This requirement may be satisfied by providing an internet address where an individual may review and obtain the Uniform Glossary. *See 29 CFR 2590.715-2715(a)(2)(i)(L).*	☐	☐	
If you are completing this section as part of a review of a grandfathered health plan, STOP here. The following sections address provisions that do not apply to grandfathered health plans.			

	YES	NO	N/A
Section G. Determining Compliance with the Patient Protection Provisions of the Affordable Care Act in Part 7 of ERISA *Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision **does not apply** to grandfathered health plans.*			
1. Choice of Healthcare Professional A plan or issuer that requires or provides for a participant or beneficiary to designate a participating primary care provider must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. With respect to a child, the plan or issuer must permit the designation of a physician who specializes in pediatrics as a child's primary care provider, if the provider participates in the network of the plan or issuer and is available to accept the child. *See 29 CFR 2590.715-2719A(a)(1) & (a)(2).* A group health plan or issuer that provides obstetrical or gynecological (OB/GYN) care and requires the designation of an in-network primary care provider, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant or beneficiary who seeks coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics and gynecology. (This includes any individual authorized under State law to provide OB/GYN care, including a person other than a physician). *See 29 CFR 2590.715-2719A(a)(3).*			
Question 1 – Does the plan require or provide for designation of a participating primary care provider by any participant or beneficiary?..... If the answer is 'no', enter 'N/A' for the following questions and proceed to Question 8. **If the answer to ALL of the questions below is "yes" the plan is in compliance with the choice of healthcare professional provisions of the rules regarding patient protections.**	☐	☐	
Question 2 – Does the plan permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary? ..... ◆ If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. *See 29 CFR 2590.715-2719A(a)(1)(i).*	☐	☐	☐

	YES	NO	N/A
Question 3 – Does the plan provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider? ..... ◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that any participating primary care provider who is available to accept the participant or beneficiary can be designated. *See 29 CFR 2590.715-2719A(a)(4)(i)(A).* **TIP:** This notice must be provided anytime the plan provides a participant with an SPD or other similar description of benefits under the plan. *See 29 CFR 2590.715-2719A(a)(4)(ii).*	☐	☐	☐
Question 4 – With respect to a child, does the plan permit the participant or beneficiary to designate a physician who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child? ..... ◆ If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. *See 29 CFR 2590.715-2719A(a)(2)(i).*	☐	☐	☐
Question 5 – With respect to a child, does the plan provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and the right to designate any participating physician who specializes in pediatrics as the primary care provider? ..... ◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider. *See 29 CFR 2590.715-2719A(a)(4)(i)(B).* **TIP:** This notice must be provided anytime the plan provides a participant with an SPD or other similar description on benefits under the plan. *See 29 CFR 2590.715-2719A(a)(4)(ii).*	☐	☐	☐

	YES	NO	N/A
Question 6 – Does the plan provide coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics or gynecology for a female participant or beneficiary without requiring authorization or referral by the plan, issuer, or any person (including a primary care provider)? ..... ◆ For purposes of this provision, a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. *See 29 CFR 2590.715-2719A(a)(3)(i)(A).* ◆ A plan or issuer must treat the provision of OB/GYN care, and the ordering or related OB/GYN items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider. *See 29 CFR 2590.715-2719A(a)(3)(i)(B).*	☐	☐	☐
Question 7 – Does the plan provide a notice informing each participant of the terms of the plan or coverage regarding designation of a primary care provider and that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology? ..... ◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. *See 29 CFR 2590.715-2719A(a)(4)(i)(C).* **TIP:** This notice must be provided anytime the plan provides a participant with an SPD or other similar description on benefits under the plan. *See 29 CFR 2590.715-2719A(a)(4)(ii).*	☐	☐	☐
2. Coverage of Emergency Services **Question 8 – Does the plan provide any benefits with respect to services in an emergency department of a hospital?** ..... If the answer is 'no,' enter 'N/A' for the following questions and proceed to Section H. **If the answer to ALL of the questions below is "yes" the plan is in compliance with the coverage of emergency services provisions of the rules regarding patient protections.**	☐	☐	

	YES	NO	N/A
Question 9 – Does the plan provide coverage of emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis? ◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis. *See 29 CFR 2590.715-2719A(b)(2)(i).*	☐	☐	☐
Question 10 – Does the plan provide coverage of emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services? ◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services. *See 29 CFR 2590.715-2719A(b)(2)(ii).*	☐	☐	☐
Question 11 – Does the plan provide coverage of emergency services provided out of network without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply to emergency services provided in-network? ◆ If the emergency services are provided out-of-network, the plan must provide the emergency services without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers *See 29 CFR 2590.715-2719A(b)(2)(iii).*	☐	☐	☐
Question 12 – When providing emergency services out-of-network, does the plan impose cost-sharing requirements that comply with the requirements of the interim final regulations? ◆ Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this section. *See 29 CFR 2590.715-2719A(b)(3)(i).* A plan or issuer complies with the requirements if it provides benefits with respect to an emergency service in an amount equal to the greatest of the following three amounts (which are adjusted for in-network cost-sharing requirements): (A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed. (See *29*	☐	☐	☐

	YES	NO	N/A
CFR 2590.715-2719A(b)(3)(i)(A) for more detailed information, including how to determine this amount if there is more than one amount negotiated with in-network providers for the emergency service.) (B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed. *See* 29 CFR 2590.715-2719A(b)(3)(i)(B). (C) The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed. *See* 29 CFR 2590.715-2719A(b)(3)(i)(C). **TIP:** Any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits. *See 29 CFR 2590.715-2719A(b)(3)(ii).*			
Question 13 – Does the plan provide coverage of emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, a permissible affiliation or waiting period, or applicable cost-sharing requirements? ..... ◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code, or applicable cost sharing. *See 29 CFR 2590.715-2719A(b)(2)(v).*	☐	☐	☐
Section H. Determining Compliance with the Affordable Care Act Coverage of Preventive Services Provisions in Part 7 of ERISA *Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. Make sure the plan you are examining is required to comply as of the date you are looking at it. This provision* ***does not apply*** *to grandfathered health plans.* Group health plans and health insurance issuers must provide coverage for, and must not impose cost-sharing requirements with respect to, certain recommended preventive services. Nothing prevents plans or issuers from providing coverage for preventive items and services in addition to the recommended preventive services required under these regulations. *See 29 CFR 2590.715-2713(a)(1) & (a)(5).* **If the answer to ALL of the questions below is "yes" the plan is in compliance with the rules regarding preventive services.**			

	YES	NO	N/A
Question 1 – Does the plan provide coverage without imposing any cost-sharing requirements for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force? .... ◆ Plans and issuers must provide coverage for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. *See 29 CFR 2590.715-2713(a)(1)(i).* ◆ ***Note***: Recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. ◆ A complete list of recommendations and guidelines that are required to be covered under these interim final regulations can be found at http://www.Healthcare.Gov/center/regulations/prevention.html. Any changes to or new recommendations and guidelines will be noted at this site. Therefore, by visiting the site once per year, plans and issuers will have straightforward access to all the information necessary to determine any additional items and services that must be covered without cost-sharing and any items or services that are no longer required to be covered.	☐	☐	
Question 2 – Does the plan provide coverage without imposing any cost-sharing requirements for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention?..... ◆ For the purpose of this section, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. *See 29 CFR 2590.715-2713(a)(1)(ii).*	☐	☐	
Question 3 – With respect to infants, children, and adolescents, does the plan provide coverage without imposing any cost-sharing requirements for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration?..... ◆ With respect to infants, children, and adolescents, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. *See 29 CFR 2590.715-2713(a)(1)(iii).*	☐	☐	

	YES	NO	N/A
Question 4 – With respect to women, does the plan provide coverage without imposing any cost-sharing requirements for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration? A complete list of guidelines that are required to be covered can be found at: http://www.hrsa.gov/womensguidelines/. (Note: there is a limited exception for religious employers regarding coverage for certain women's preventive services). ◆ With respect to women, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. *See 29 CFR 2590.715-2713(a)(1)(iv).*	☐	☐	
Question 5 – Does the plan provide coverage for office visits without imposing cost sharing requirements when recommended preventive services are not billed separately from an office visit and is the primary purpose of the office visit? ◆ If a recommended preventive service or item is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such a service or item, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. *See 29 CFR 2590.715-2713(a)(2)(ii).* **TIP**: If a recommended preventive service is billed separately from an office visit, or if the recommended preventive service is not billed separately and the primary purpose of the office visit is not delivery of the recommended preventive service, then a plan or issuer may impose cost-sharing with respect to the office visit. *See 29 CFR 2590.715-2713(a)(2)(i) & (iii).* **Additional tips:** ◆ Plans and issuers that have a network of providers are not required to provide coverage for and may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider. *See 29 CFR 2590.715-2713(a)(3).* ◆ Plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the recommended preventive services to the extent these are not specified in the recommendations or guidelines. *See 29 CFR 2590.715-2713(a)(4).* ◆ Plans and issuers can impose cost-sharing for a treatment that is not a recommended preventive service under these regulations, even if the treatment resulted from a recommended preventive service. *See 29 CFR 2590.715-2713(a)(5).*	☐	☐	

	YES	NO	N/A
Section I. Determining Compliance with the Affordable Care Act Provisions Regarding Internal Claims and Appeals and External Review in Part 7 of ERISA *The internal claims and appeals and external review provisions of Part 7 of ERISA* ***do not apply*** *to grandfathered health plans.* *Note: There have been several phases of guidance issued regarding the internal claims and appeals and external review provisions under the ACA. More information about the requirements regarding internal claims and appeals and external review processes under ERISA is available at www.dol.gov/ebsa.* **1. Internal Claims and Appeals** Under the Affordable Care Act group health plans and health insurance issuers offering group health insurance coverage were required to implement an effective internal claims and appeals process for plan years beginning on or after September 23, 2010. In general, the interim final regulations require plans and issuers to comply with the DOL claims procedure rule under *29 CFR 2560.503-1* and impose specific additional requirements and include some clarifications (referred to as the "additional standards" for internal claims and appeals). In addition to meeting the following requirements, the plan is required to comply with all of the requirements of the DOL claims procedure rule under *29 CFR 2560.503-1.* **The following questions have been developed to assist in determining compliance with the additional standards for internal claims and appeals processes.**			
Question 1 – Does the plan provide internal claims and appeals processes with respect to rescissions of coverage?..... ◆ Under the DOL claims procedure rule, adverse benefit determinations eligible for internal claims and appeals processes generally include denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit (including a denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits). *See 29 CFR 2560.503-1(m)(4).* ◆ The Department's regulations broaden the DOL claims procedure rule's definition of "adverse benefit determination" to include rescissions of coverage. Therefore, rescissions of coverage are also eligible for internal claims and appeals processes, whether or not the rescission has an adverse effect on any particular benefit at the time of an appeal. *See 29 CFR 2590.715-2719(a)(2)(i); 29 CFR 2560.503-1.* ◆ This provision is applicable for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2719(g).*	☐	☐	

	YES	NO	N/A
Question 2 – Does the plan provide claimants with any new or additional evidence or rationale considered in connection with a claim? ◆ The Department's regulations clarify that plans or issuers must provide to claimants, free of charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with a claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. Similarly, before a plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. This rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. *See 29 CFR 2590.715-2719(b)(2)(ii)(C).* ◆ This provision is applicable for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2719(g).*	☐	☐	
Question 3 – Does the plan ensure that claims and appeals are adjudicated in a manner that maintains independence and impartiality of decision making? ◆ The Department's regulations clarify that plans or issuers must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood or perceived likelihood that the individual will support or tend to support a denial of benefits. *See 29 CFR 2590.715-2719(b)(2)(ii)(D).* ◆ This provision is applicable for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2719(g).*	☐	☐	
Question 4 – Complete the following questions to ensure that the plan complies with the additional content requirements for any notice of adverse benefit determination or final internal adverse benefit determination: **4a. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved?** ◆ The Department's regulations provide that plans and issuers must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved including the date of service, the health care provider, and the claim amount (if applicable). *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1).* This provision is applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html*	☐	☐	

	YES	NO	N/A
◆ Plans or issuers must also provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis and treatment codes (and their meanings), associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1), as amended.* This provision is applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.*			
4b. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes an adequate description of the reasons for the adverse benefit determination or final internal adverse benefit determination?	☐	☐	
◆ The Department's regulations provide that plans and issuers must ensure that the reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the standard that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(2).*			
◆ This provision is applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.*			
4c. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes a description of available internal appeals and external review processes?	☐	☐	
◆ The Department's regulations provide that plans and issuers must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(3).*			
◆ This provision is applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.*			
4d. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793?	☐	☐	
◆ The Department's regulations provide that plans and issuers must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(4).*			

	YES	NO	N/A
◆ An updated list of the State Consumer Assistance Programs is available on the Department of Labor website at *http://www.dol.gov/ebsa/capupdatelist.doc* . ◆ These provisions are applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.*			
Question 5 – Does the plan defer to the attending provider as to whether a claim involves urgent care and provide notice regarding such urgent care claim as required?... ◆ As under 29 CFR 2560.503-1(f)(2)(i), plans or issuers must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or issuer. *29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.* ◆ The determination as to whether a claim involves urgent care is determined by the attending provider and the plan or issuer must defer to such determination. *See 29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.* ◆ This provision is applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	
Question 6 – Does the plan comply with the requirements regarding deemed exhaustion of internal claims and appeals processes? ..... ◆ In the case of a plan or issuer that fails to adhere to all the requirements of the Interim Final Rules relating to the Internal Claims and Appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. The internal claims and appeals process will not be deemed exhausted as long as the violation was: *de minimus,* does not cause, and is not likely to cause, prejudice or harm to the claimant, attributable to good cause or due to matters beyond the control of the plan or issuer, in the context of an ongoing, good faith exchange of information between the plan and the claimant, and is not reflective of a pattern or practice of non-compliance. *See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.* ◆ In the event that the claimant requests a written explanation of the violation, the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. *See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.* ◆ In the case that the external review rejects the claimant's immediate review, the plan must provide the claimant notice of the opportunity to resubmit and pursue the internal appeal of the claim. This notice must be sent within a reasonable time after the external reviewer rejects the claim for immediate review, not later than 10 days. *See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.* ◆ These provisions are applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	

	YES	NO	N/A
<u>Question 7 – Does the plan provide notices in a culturally and linguistically appropriate manner with respect to internal claims and appeals processes?</u> ..... ◆ The Department's regulations provide that plans and issuers must provide relevant notices in a culturally and linguistically appropriate manner. To meet this requirement the plan or issuer must: ❖ include a one-sentence statement in the relevant non-English language about the availability of language services on each notice sent to an address in a county that meets the threshold; ❖ provide, upon request, a notice in any applicable non-English language; and ❖ provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. *See 29 CFR 2590.715-2719(e), as amended.* ◆ The Department's regulations establish a single threshold with respect to the percentage of people who are literate only in the same non-English language for both the group and individual markets. With respect to plans and issuers, the threshold percentage is set at 10 percent or more of the population residing in the claimant's county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau. The list of counties determined to meet the threshold is available on the Department of Labor website at *<u>http://www.cciio.cms.gov/resources/factsheets/clas-data.html</u>*. This list will be updated annually. *See 29 CFR 2590.715-2719(e)(3), as amended.* These provisions are applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at <u>http://www.dol.gov/ebsa/newsroom/tr11-01.html</u>.*	☐	☐	
2. External Review *Plans and issuers must comply with either a State external review process or the Federal external review process. The external review provisions of Part 7 of ERISA **<u>do not apply</u>** to grandfathered health plans.* **The following questions have been developed to assist in determining compliance with the rules regarding the external review processes.**			
<u>Question 1 – Is the plan subject to the requirements of a State external review process or the HHS-Administered Federal External Review Process?</u> ..... ◆ Non-grandfathered, self-insured group health plans subject to ERISA and the Code: ❖ Generally follow requirements of the private accredited IRO process (*established by TR 2010-01, modified by TR 2011-02*). ◆ Non-grandfathered, insured coverage: ❖ Generally, issuers must follow the State process if the external review process meets either the NAIC-Similar or NAIC-Parallel process as determined by HHS.	☐	☐	

	YES	NO	N/A
❖ However, issuers in States without a conforming State process and self-insured non-federal governmental plans may either: - Utilize the private accredited IRO process *(established by TR 2010-01, and modified by TR 2011-02)*; or - Utilize the HHS-Administered Federal External Review Process. ***Background information regarding external review processes for insured plans:** ◆ For insured coverage, HHS has determined which State external review processes meet the minimum requirements to apply to issuers in those States. See *http://cciio.cms.gov/resources/files/external_appeals.html*. ◆ As of July 10, 2012, issuers in Alabama, Alaska, Florida, Georgia, Louisiana, Mississippi[2], Montana, Nebraska, Pennsylvania, West Virginia, Wisconsin, US Virgin Islands, Guam, American Samoa, Puerto Rico and Northern Mariana Islands are currently using one of these two federal external review processes. **If you answered "Yes" to Question 1 above, STOP. The plan is not subject to the DOL Private Accredited IRO process. If you answered "No" to Question 1 above, continue to Question 2.**			
Question 2 – DOL Private Accredited IRO process: Does the plan provide external review for the required scope of adverse benefit determinations?..... Under the Department's regulations the scope of the Federal external review process applies to: ◆ An adverse benefit determination, including a final internal adverse benefit determination, by a plan or issuer that involves medical judgment, including but not limited to those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and ◆ A rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time). *See 29 CFR 2590.715-2719(d)(1)(ii), as amended.* ◆ An adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (i.e., worker classification or similar issue) is not within the scope of the Federal external review process. *See 29 CFR 2590.715-2719(d)(1)(i), as amended.*	☐	☐	

2 Issuers in this state are scheduled to transition to a state process on 1/1/13.

	YES	NO	N/A
Question 3 – DOL Private Accredited IRO process: Does the plan provide an effective external review process?	☐	☐	

- Self-insured coverage subject to ERISA and the Code may either comply with the standards of the private accredited IRO process or voluntarily comply with a State external review process if the State allows access.

- If the plan is complying with the private accredited IRO process, ensure the plan complies with all of the standards articulated in TR 2011-02 including:
  - Providing effective written notice of external review
  - Providing limits related to filing fees
  - Providing claimant at least 4 months to file for external review
  - Requiring that IROs must be accredited
  - Requiring that IROs may not have conflicts of interest that influence independence
  - Providing that IRO decisions are binding on the insurer and the claimant
  - Requiring IROs to maintain written records for at least three years

- Department of Labor clarified in TR 2011-02 that to be eligible for a safe harbor from enforcement from the Department of Labor and the IRS (as previously set forth in sub-regulatory guidance issued in ACA FAQs Part 1 on September 20, 2010), self-insured plans will be required to contract with at least two independent review organizations (IROs) by January 1, 2012 and at least three IROs by July 1, 2012.

  See TR 2010-01 at http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf, and TR-2011-02 at http://www.dol.gov/ebsa/newsroom/tr11-02.html.