HUMAN CAPITAL PRACTICE

Willis

ALERT: HEALTH CARE REFORM BILL

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CHECKLIST: NOTICES TO INCLUDE IN HEALTH PLAN 2012 ANNUAL ENROLLMENT MATERIALS

Although there are just a few legislative and regulatory changes to implement for the 2012 plan year (see our **timeline of health care reform effective dates**), this year's annual enrollment season is sure to bring its share of compliance challenges. As in past years, federal law continues to require health plans to send a variety of notices to participating employees and dependents. Employers generally find that the most convenient way to provide notices is to include them as part of their annual enrollment materials.

For easy reference, here is a list of the notices we cover in this year's annual enrollment toolkit:

- **ANNUAL DISCLOSURE REQUIREMENTS**
  - Notice of Grandfathered Status
  - Patient Protection Disclosures
  - Notice of Waiver of Restrictions on Annual Limits
  - HIPAA Special Enrollment and Preexisting Condition Exclusion Notices
  - WHCRA Notice
  - Medicare Part D Creditable (or Non-Creditable) Coverage Notice
  - Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - CMS Data Collection Requirements to Enforce MSP
  - Michelle's Law
  - Wellness Program Notices
  - Summary Annual Report (SAR)
  - Notice of Opt-Out by Self-Funded, Non-Federal Governmental Plan
- **DISCLOSURE REQUIREMENTS FULFILLED (IN PART) BY ANNUAL NOTICES**
  - Initial COBRA Notice
  - HIPAA Notice of Privacy Practices
  - Summary Plan Description (SPD)/Summary of Material Modifications (SMM)
- **OTHER NOTICES MAY BE NEEDED**

The information below relates to notice requirements for a single-employer health plan, meaning a health plan that an employer maintains for its employees and, if applicable, the employees of companies related to the employer by high levels of common ownership or control. The notice requirements discussed may apply differently to plans that cover the employees of two or more employers, that are collectively bargained or that are sponsored by an entity other than an employer.

It is tempting to think that including these items with annual enrollment materials will fulfill all requirements to provide these notices. Unfortunately, that is not the case. Several of these

notices must be provided whenever materials describing plan benefits are provided, and almost all must be provided to new participants upon or shortly after enrollment. Distribution methods are discussed at the end of this article. An open enrollment checklist is provided in the appendix.

TOOLKIT FOR 2012 BUILDS ON LAST YEAR'S TOOLKIT. Last year's annual enrollment season was particularly hectic because, for most employers, several health care reform provisions became effective with the start of the 2011 plan year (see our **annual enrollment toolkit from last year** for details). In preparing this year's annual enrollment toolkit, we assumed that plans have implemented the health care reform law's provisions that were discussed in last year's annual enrollment toolkit (i.e., those that have notice requirements and effective dates earlier than January 1, 2012 according to our **health care reform effective dates timeline**). Reviewing **last year's annual enrollment toolkit** is one way for an employer to check its compliance with the notice requirement under the health care reform law that had the earliest effective dates.

In addition to complying with notice requirements, as explained in **Appendix II to last year's annual enrollment toolkit**, several changes to a plan's documentation are needed to reflect the pre-2012 changes required by the health care reform law. In preparing this year's toolkit, we assumed that plan documents and summary plan descriptions have been appropriately amended to reflect these changes. Those that have not adopted documentation changes to reflect the changes required by the health care reform law may want to review the following Willis sample documents:

- **ERISA Wrapper Plan Document Amendment for Health Care Reform – 2011**
- **ERISA Summary of Material Modifications to Wrapper Plan for Health Care Reform – 2011**
- **Cafeteria Plan Amendment for Health Care Reform – 2011**
- **Cafeteria Plan Summary of Material Modifications for Health Care Reform – 2011**

ANNUAL DISCLOSURE REQUIREMENTS

Some health plan notices are required annually and employers generally can minimize the cost of sending these notices by including them with the health plan enrollment materials that they distribute each year. We include with the notices that are explicitly required annually several notices that, while not strictly required annually, must be provided annually in order to protect employer interests.

NOTICE OF GRANDFATHERED STATUS

The health care reform law makes certain of its provisions inapplicable to grandfathered plans (e.g., provisions setting standards for internal claim handling and external review of claim denials, requiring 100% coverage of preventive care, and imposing nondiscrimination requirements on insured health plans). Of course, grandfathered status is not relevant to any plan that is exempt from these requirements for another reason. For information on applicability, see **Appendix III to last year's annual enrollment toolkit**. The requirements for a plan to have grandfathered status are summarized in **Appendix IV to last year's annual enrollment toolkit**.

One of the requirements for grandfathered status is providing a written statement, in any plan materials describing benefits, regarding the plan's claim of grandfathered status. While this is not strictly an annual disclosure requirement, as long as the plan claims grandfathered status, it must provide the statement in all plan materials provided to participants, including annual enrollment materials. Federal agencies have issued **model language** which can be incorporated into plan materials. Of course, no notice regarding grandfathered status is required for a non-grandfathered plan (e.g., a plan established after March 23, 2010 or one that has already lost grandfathered status). For additional details on grandfathered status, see our **Federal Health Benefits Mandates Compliance Manual**.

GRANDFATHERED PLANS MAY EXCLUDE CHILDREN DUE TO OTHER COVERAGE. One of the health care reform compliance breaks for grandfathered plans allows them to exclude children eligible for other employment-based health coverage (other than a parent's plan), but only until the 2014 plan year. Non-grandfathered plans that cover employees' children generally cannot condition eligibility on any criteria other than a child's age and relationship to the employee. Grandfathered plans that have chosen to exclude employees' children based on other coverage generally have found that they must rely on their employees to provide information about their children's eligibility for other coverage. **Appendix VI of last year's annual enrollment toolkit** provides a sample certification that plans may adapt for this purpose.

PATIENT PROTECTION DISCLOSURES

The health care reform law requires non-grandfathered health plans that require or allow an enrollee to designate a primary care provider to afford participants certain rights to access health care providers and to provide notice of those rights. Plans subject to this requirement must explain in a notice that each participant may:

- Choose any participating primary care provider who is available to accept the participant as a patient
- Designate a participating provider who specializes in pediatric medicine as a child's primary care provider if designation of a primary care provider for a child is required or allowed and the provider is available to accept the child as a patient
- Obtain obstetrical or gynecological care without a referral or prior authorization

Of course, plans that are exempt from the patient protection requirements need not provide this notice. For information on applicability, see **Appendix III to last year's annual enrollment toolkit**.

This is not explicitly an annual notice requirement. The requirement is to include the notice whenever the plan provides a participant with a summary plan description or other similar description of benefits under the plan. Because "other similar descriptions" might include materials describing plan changes at open enrollment, we believe that the best practice is to include this notice with annual enrollment materials, in addition to providing it along with any other distribution of plan materials. The agencies that issued the regulations implementing this provision have provided **model language** for this notice. Of course, plans that are exempt from these requirements need not provide this notice. For information on applicability, see **Appendix III to last year's annual enrollment toolkit**. For additional information on the patient protections, see Willis Human Capital Practice *Alert*, July 2010, **"Patient's Bill of Rights Guidance Issued."**

INTERSECTION OF GRANDFATHERED STATUS AND PATIENT PROTECTIONS. Grandfathered plans are not required to provide the patient protection disclosures described above, but are required to provide notice of grandfathered status, as explained above. If a plan loses grandfathered status, it will no longer need to provide the notice of grandfathered status, but will need to provide the patient protection disclosures. Employers contemplating plan changes that will cause loss of grandfathered status should keep this notice requirement in mind. For additional details on grandfathered status, see our **Federal Health Benefits Mandates Compliance Manual**.

NOTICE OF WAIVER OF RESTRICTIONS ON ANNUAL LIMITS

One of the coverage reforms included in the health care reform law requires eventual elimination of all annual dollar limits on "essential health benefits," with restrictions on annual dollar limits applying to plan years starting before January 1, 2014. (E.g., for plan years beginning after September 22, 2011 and before September 23, 2012, the phase-in schedule allows annual dollar limits on benefits no lower than $1,250,000. See Willis Human Capital Practice *Alert*, July 2010, **"Patient's Bill of Rights Guidance Issued."**)

Plans in existence before September 23, 2010 may obtain waivers of the restrictions on annual dollar limits through an HHS program for plan years starting before January 1, 2014. Under the waivers, such plans may apply lower annual dollar limits than are otherwise permitted, provided they meet certain conditions, including provision of an annual notice and submission of a request to HHS no later than September 22, 2011 (note that this deadline must be met even if a plan obtained a waiver for an earlier plan year). For details on the most recent changes to the waiver program, see Willis Human Capital Practice *Alert*, June 2011, **"Limited Medical Plan Waiver Guidance Released."**

To fulfill the annual notice requirement, the plan or insurer that obtained the waiver must provide a notice "to eligible participants and subscribers as [part of the] plan or policy materials that describe the terms of coverage (e.g., summary plan descriptions) for each plan year for which the waiver applies." HHS guidance elaborates that the notice must be "prominently displayed in clear, conspicuous, 14-point bold type on the front of the materials." It appears that the notice must be provided whenever materials describing plan coverage are provided. Also, because it is described as an "annual" notice, the notice probably must be provided at least once each year, even if an SPD or other plan materials are not provided that often. The guidance states that the notice must use exactly the **language specified**. Deviations are allowed only with written permission.

An employer that obtains a waiver on behalf of a self-insured plan clearly is responsible for providing this notice as required. Many of the plans receiving waivers under HHS programs are insured, however, and the insurers issuing the policies generally are the recipients of the waiver. As a result, the insurer may distribute the required waiver notice. Alternatively, the insurer may ask each employer purchasing coverage to distribute the notice to eligible employees. Employers should be aware of this notice requirement and, in the case of insured plans, should coordinate with the insurers to make sure that the notice is provided as required.

HIPAA SPECIAL ENROLLMENT AND PREEXISTING CONDITION EXCLUSION NOTICES

HIPAA requires employers to provide notice of special enrollment rights at or before the time health plan enrollment is offered, so most employers include the **special enrollment notice** in their annual enrollment materials. Similarly, HIPAA's requirement that any written application/enrollment materials include notice of a plan's preexisting condition exclusion means that annual enrollment packets should include this **general notice of preexisting condition exclusion** as well. For additional information on special enrollment rights and preexisting condition exclusions, see the **Willis HIPAA Portability Compliance Manual**.

WHCRA NOTICE

The Women's Health and Cancer Rights Act (WHCRA) requires annual distribution of a notice to all participants and beneficiaries in a group medical plan advising them of their rights to post-mastectomy breast reconstruction. The DOL has approved using an **abbreviated notice** to fulfill the annual notice requirement, but most employers do not use it. The more detailed **WHCRA enrollment notice** is required at enrollment and it is easier for most employers to use the same text for both notices. For additional details on WHCRA, see our **Federal Health Benefits Mandates Compliance Manual**.

MEDICARE PART D CREDITABLE (OR NON-CREDITABLE) COVERAGE NOTICE

Under the laws governing Medicare Part D, all employer-sponsored group medical plans covering prescription drugs must provide notices advising whether employer-sponsored prescription drug coverage is creditable (i.e., at least actuarially equivalent to Medicare's standard prescription drug benefit). The notices are required annually and at several other times. Required recipients of these notices are Part D-eligible individuals who are "enrolled or seeking to enroll" in the employer's plan. It is difficult to identify the required recipients, so most employers simply distribute the notices to all plan participants.

Meeting some of the requirements for distribution of the notice translates into a need to provide the notice every year on the same date or earlier, and most employers simply include the notices in annual enrollment materials. (Of course, if there is a change in the creditable/non-creditable status of prescription drug coverage, the notices announcing that change must be distributed at the time of the change.) One of the deadlines for providing the notice is related to the start date of Medicare's Part D Annual Coordinated Election Period (ACEP), and the ACEP start date will be a month earlier this year than in previous years. (For details of the change to the ACEP, see our article in *HR Focus*, July 2011, Issue 49, **"New Medicare Part D Notices And Deadlines."**) The best practice is to send revised notices regarding creditable prescription drug coverage before October 15, 2011. HHS has provided a **model notice of creditable prescription drug coverage** and a **model notice of non-creditable prescription drug coverage**, both revised for use after April 1, 2011. For most employers, this means that last year's notices are out of date. When adopting the new forms, employers will need to transfer any customized information from their current notices onto the new forms.

Beyond the distribution for the October 15, 2011 ACEP, employers should follow the annual distribution schedule they have previously followed for the creditable/non-creditable prescription drug coverage notice. For example, an employer that distributes the notices with open enrollment materials during the first week of November each year may, as a matter of best practices, choose to provide the notices in a separate mailing during September 2011 (before the October 15, 2011 start of the ACEP). That employer should return to its previous schedule and still include the notice in the annual enrollment packet that it sends during the first week of November 2011. Doing this allows the employer to avoid another separate distribution of the notices in September 2012 (as noted above, the notices should be provided no later than 12 months after they were last distributed). Employers can use the same **model notice of creditable prescription drug coverage** and **model notice of non-creditable prescription drug coverage** for the annual distribution as they use for the October 15, 2011 ACEP distribution.

The creditable/non-creditable prescription drug coverage notice may be included with other information, as long as it is "prominent and conspicuous." This means that the notice itself or a reference to the notice must appear on the first page of the information with which the notice is included. If a reference is used, it must be in a separate box, bolded or otherwise offset, and in at least 14-point type, as in this sample:

IF YOU HAVE MEDICARE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS, A FEDERAL LAW GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. PLEASE SEE PAGE XX FOR MORE DETAILS.

For additional details on the Part D creditable/non-creditable prescription drug coverage notice requirements, see the **Willis Medicare Part D Compliance Manual**.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

An employer is required under CHIPRA to provide an annual CHIP notice if it maintains an insured or self-insured group health plan under which it offers benefits in a state that provides a premium assistance subsidy under Medicaid or CHIP. (This notice obligation first became effective in 2010, with most employers becoming obligated to provide the notice no later than January 1, 2011.) An employer must provide the CHIP notice to employees who reside in states that provide premium assistance through Medicaid or CHIP, regardless of the employer's location or principal place of business (or the location or principal place of business of the group health plan, its administrator, its insurer or any other service provider affiliated with the employer or the plan), and regardless of an employee's enrollment status in the employer's group health plan. To ease the administrative burden, however, employers are permitted to send CHIP notices to all employees – including those who reside in states that do not offer a premium assistance program.

As long as the materials are correctly distributed to all employees who are entitled to receive the notice, a CHIP notice is not required to be provided in a separate mailing (so employers may furnish the notice with other plan materials, e.g., annual enrollment packets). However, the DOL has said that the CHIP notice must appear as a "separate and prominent" document. In other words, while the CHIP notice can be delivered alongside other enrollment materials (e.g., in the same envelope or folder), it apparently must be separated from other materials in a manner that makes it prominent among the materials provided. Therefore, this notice should not be included in any booklet or other document that provides other notices or plan information (e.g., if included in a folder of enrollment materials, it should appear on a separate piece of paper).

The DOL has provided a **model CHIP notice** that employers may use to fulfill this requirement. The model notice includes information on all of the states that offer a premium assistance program through Medicaid or CHIP, and was most recently updated in August 2011. For most employers, this means that last year's CHIP notices are out of date. When adopting the new model, employers will need to transfer any customized information from their current notices onto the new form. Even if the model notice includes information for states in which the employer has no operations or employees, an employer need not revise the notice to omit information on those states. For additional information, see the **Willis Federal Health Benefits Mandates Compliance Manual**.

CMS DATA COLLECTION REQUIREMENTS TO ENFORCE MSP

The Medicare Secondary Payer (MSP) reporting requirements do not include an explicit notice obligation, but employers may nonetheless be obligated to provide information and collect a form from health plan enrollees each year.

Under the MSP reporting requirements, insurers and TPAs of employer-sponsored health plans (or the employer in the case of a plan that has neither an insurer nor a TPA) must collect and report certain information to CMS (the agency that administers Medicare). The information allows CMS to identify individuals who are covered by both Medicare and an employer's group health plan and determine whether Medicare is the secondary payer. The required information includes, among other items, identifying information about covered employees and dependents (e.g., name, date of birth, gender, Social Security or, if applicable, Medicare identification number). Most of this information is readily available in health plan records, except that dependents' Social Security or Medicare identification numbers are often omitted. In that case, the entity responsible for reporting the information (the RRE) is obligated to obtain the missing information from the individuals.

Employers are RREs only when a plan has neither an insurer nor a TPA, so employers are rarely responsible for reporting. For most employer plans, therefore, the employer has no obligation to provide information to CMS under this reporting requirement. As often happens when insurers and TPAs have obligations, however, an employer may be contractually required to collect the required information from enrollees and provide it to the insurer or TPA.

Employers, insurers and TPAs all have found that many individuals simply refuse to provide Social Security or Medicare identification numbers when requested to do so. Unfortunately, those refusals carry the potential for RREs to incur penalties due to failure to collect and report required information.

To assist with situations in which an individual refuses to provide a Social Security or Medicare identification number, CMS has provided a **form on which an individual may provide the required information or decline to do so**. An RRE will be deemed compliant with the reporting requirement despite the lack of an individual's Social Security or Medicare identification number if the RRE obtains the individual's dated signature on the form at least once every 12 months and retains the documentation. Employers that are collecting the required information from enrollees end up distributing the CMS form, and attempting to obtain signed copies of it, at least once every 12 months. Employers that are unfamiliar with the process may want to coordinate with their insurer or TPA to determine what, if any, data collection duties apply. For additional information, see the **Willis Medicare Secondary Payer Compliance Manual**.

MICHELLE'S LAW

For plans that have a full-time student requirement for dependent eligibility, Michelle's Law includes a notice requirement that is not strictly annual, but may work out to be a required item for such plans' annual enrollment packets.

NOTE ON APPLICABILITY: The health care reform law's requirement that plans make coverage available to employees' children until age 26 has greatly reduced the number of plans that condition a child's eligibility on full-time student status. A plan that does not condition any dependent child's eligibility on being a full-time student need not comply with Michelle's Law and need not provide the notice discussed here.

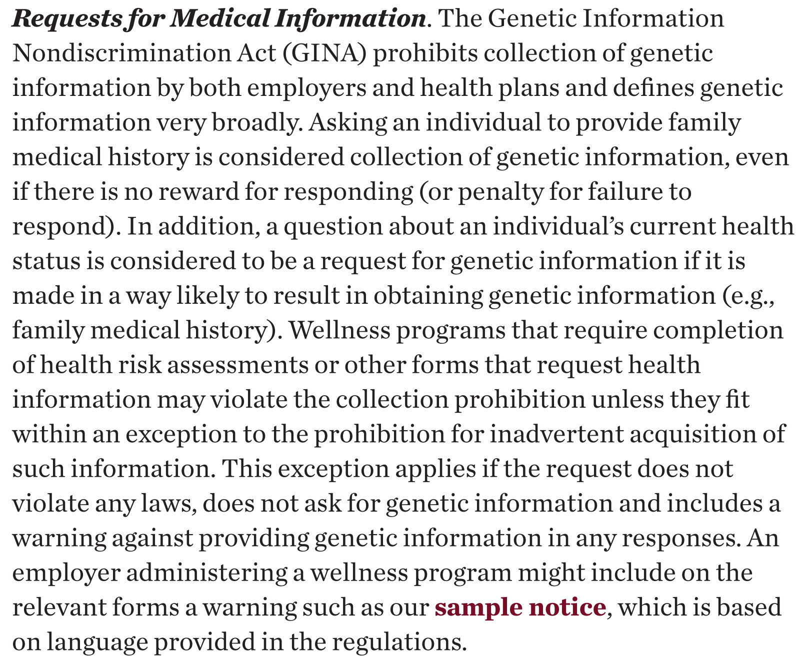
Under Michelle's Law, a group health plan cannot terminate a child's coverage for loss of full-time student status if the change in student status is due to a "medically necessary leave of absence." The plan may be required to allow such a child to remain covered as an employee's dependent for up to a year after the leave of absence begins. For example, a plan that allows a dependent child's coverage to continue after a child's 26th birthday until age 28, so long as the child remains a full-time student, would be obligated to provide extended eligibility to a 27-year-old who took a medically necessary leave of absence from full-time studies.

Whenever an employer whose plan has a full-time student requirement provides a notice that certification of student status is required in order to maintain a dependent's eligibility under the plan, that notice must include a description of the continued coverage that is available under Michelle's Law "in language that is understandable to the typical plan participant." The relevant agencies have not provided a model notice, but employers may want to adapt our **sample Michelle's Law notice** for their plans. For additional information, see our **Federal Health Benefits Mandates Compliance Manual**.

WELLNESS PROGRAM NOTICES

If an employer's health plan includes a wellness program, it may be necessary to include certain notices with materials related to the program, depending on the terms of the program and the information it asks participants to provide. These notices are not required to be provided annually, but most employers administer their wellness programs on an annual cycle making these notices, effectively, annual notices.

Health-Factor-Related Wellness Programs. If a wellness program requires individuals to meet a standard related to a health factor in order to obtain a reward, the HIPAA nondiscrimination rules require the program to comply with five conditions, including a disclosure requirement (see the **wellness programs HIPAA compliance checklist**). Examples of such health-factor-related wellness programs include programs providing premium discounts or richer benefits for those who have positive health factors, such as not smoking, cholesterol below 200, blood pressure within normal range, body mass index below 30, etc. All of the materials describing such programs must disclose that certain individuals may obtain the reward by meeting a reasonable alternative to the health-factor-related standard. The materials need not specify what that reasonable alternative will be – only that some reasonable alternative standard will be made available. The regulations provide **sample language** for this disclosure requirement.



Requests for Medical Information. The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include on the relevant forms a warning such as our **sample notice**, which is based on language provided in the regulations.

For additional information on wellness programs, see the **Willis HIPAA Portability Compliance Manual**.

SUMMARY ANNUAL REPORT (SAR)

Most health plans must file an annual report on Form 5500 with the DOL. In turn, insured health plans that file Form 5500 must provide a summary annual report (SAR) to plan participants. (Self-insured plans that are considered "funded" also must provide an SAR.) The SAR generally must be sent within nine months after the close of each plan year. However, if the plan obtains an extended deadline for filing Form 5500, the SAR deadline is also extended, and the SAR is then due two months after the extended Form 5500 due date. The DOL has provided a **prescribed template** for the SAR. See the **Willis ERISA Reporting and Disclosure Compliance Manual**.

NOTICE OF OPT-OUT BY SELF-FUNDED, NON-FEDERAL GOVERNMENTAL PLAN

Each plan year, a self-funded, non-federal governmental plan can opt out of compliance with the Mental Health Parity and Addiction Equity Act, the Newborns and Mothers Health Protection Act, Michelle's Law and WHCRA. (Previously, such plans could also opt out of compliance with most HIPAA portability, nondiscrimination and renewability requirements, but that option has been eliminated, subject to limited transition relief.) The plan opts out by filing a form with HHS before the beginning of the plan year. For the opt-out to remain in effect, the plan must file a new election before the beginning of each plan year. In addition, a plan that opts out must notify participants annually that it has done so. It is likely (but not entirely clear) that the plan must provide this notice before the beginning of the plan year. CMS has provided a revised **model opt-out form** and **model participant disclosure** which are suitable for all plans using the opt-out. For additional information, see our **Federal Health Benefits Mandates Compliance Manual**.

NEW DISCLOSURE REQUIREMENTS STARTING MARCH 23, 2012. The health care reform law expanded health plans' disclosure obligations, requiring distribution of a uniform four-page "summary of benefits and coverage" (an SBC). Federal agencies were to have provided "standards" for creating and providing SBCs by March 23, 2011, with employers and insurers being required to begin distributing SBCs by March 23, 2012. The agencies have missed their deadline by several months. On August 17, 2011, the agencies issued proposed regulations regarding the SBC requirement, along with a proposed template and other proposed guidance for preparing SBCs. In the proposed regulations and a separate solicitation of comments, the agencies requested public comments on virtually all aspects of the SBCs, including "factors that may affect the feasibility of implementation" starting March 23, 2012.

It is very likely that any final guidance will differ significantly from the August 17 proposal, making the proposal an unreliable source of guidance for employers trying to determine their obligations. Meanwhile, an employer holding an annual enrollment for January 1, 2012 and anticipating a March 23, 2012 effective date for providing SBCs normally would include the SBC in its enrollment packet in order to avoid a separate distribution later in the year. Unfortunately, given the very tentative tone of the proposed guidance and the significant effort involved in producing and distributing the SBCs based on that guidance, it probably is not feasible to provide SBCs with this fall's enrollment packets.

While no promises of a delay have been made, and the agencies have only solicited comments regarding the feasibility of implementation by March 23, 2012, we are hopeful that the agencies will provide an enforcement delay of this requirement. Two factors make us optimistic about a delay:

- The agencies are almost five months late issuing guidance, assuming that the August 17 proposal qualifies as the guidance that was required by March 23, 2011
- It would be very surprising if the agencies finalized the guidance on SBCs before the beginning of 2012, leaving a very short implementation period if the March 23, 2012 deadline holds

Willis' National Legal & Research Group will provide more information on this proposed guidance in a future Willis publication.

A component of the four-page summary requirement is providing advance notice of changes. When this advance notice requirement becomes effective, any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided four-page summary must be announced to enrollees no later than 60 days prior to the date on which the modification will become effective. It is expected that plans will become subject to this requirement at the same time that they become subject to the four-page summary requirement. For additional information, see Willis Human Capital Practice *Alert*, August 2011, **"Looking Ahead – Compliance After 2011."**

DISCLOSURE REQUIREMENTS FULFILLED (IN PART) BY ANNUAL NOTICES

Although yearly distribution is not required for many of the federally mandated health plan notices, employers should consider including some such notices with their annual enrollment materials anyway. Doing so may cure any previous failure to give the notice, and it demonstrates an employer's good faith effort to apprise plan participants of their rights.

INITIAL COBRA NOTICE

COBRA requires that each participant (and his or her covered spouse) be notified of COBRA rights when coverage under a plan begins. Aside from being required, providing this initial COBRA notice can prevent certain COBRA administration problems. For example, COBRA allows a plan to require participants (or others) to provide timely notice of certain events, such as a divorce. DOL regulations stipulate, however, that plans cannot deny COBRA

rights based on failure to provide notice of an event if the participant and his or her covered spouse have not received an explanation of this notice requirement in either the initial COBRA notice or the summary plan description. In many cases, employers do not know (or do not have documentation showing) whether an individual received this explanation as required. To remedy those situations, and to be certain that participants and spouses have the latest information on the conditions they must meet to obtain COBRA coverage, some employers send the initial COBRA notice to all participants (and their covered spouses) every year. The DOL has provided a **model** for the initial COBRA notice. Willis' **sample initial COBRA notice** covers additional items that employers may wish to include in their notices. It is particularly important, for COBRA compliance purposes, that the initial COBRA notice be provided to the employee's enrolled spouse. An initial COBRA notice included in an annual enrollment packet generally will not be considered provided to the spouse unless that enrollment packet is sent by U.S. Mail, properly addressed to both the employee and the spouse at the home address. See the **Willis COBRA Compliance Manual**.

HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA privacy rules require that health plans or their insurers distribute a notice to participants of their privacy rights. HIPAA requires that plans give the notice to new participants and redistribute the notice if it is revised. In addition, HIPAA requires plans to send a reminder to participants every three years that a detailed description of their privacy rights is available and how to get it (see our **sample availability notice**). Sending either the full notice of privacy practices or the reminder notice annually more than fulfills the requirement and might be easier than remembering to send it every three years.

NOTE ON APPLICABILITY: If a plan is fully insured, the insurer is responsible for providing these notices but may delegate its responsibilities for distribution to the employer. For an insured plan, the employer should coordinate with the insurer to make sure that the notice is provided as required. For additional information, see the **Willis HIPAA Privacy Compliance Manual**.

SUMMARY PLAN DESCRIPTION (SPD)/ SUMMARY OF MATERIAL MODIFICATIONS (SMM)

ERISA requires an SPD to be sent to each plan participant within 90 days of enrollment and again every five years (assuming changes have been made to the plan in the interim). The five-year SPD must incorporate all the amendments or changes made to the plan in the intervening years. If there are significant changes in the meantime, an SMM must be sent notifying participants within 210 days after the change becomes effective or within 60 days after the adoption of any change that is a material reduction in covered health benefits or services. Sending a new SPD every year will certainly cover the requirement that the SPD be sent every five years and, depending on the timing, it may also obviate the need to send an SMM. See our **checklist of required information in an SPD** and the **Willis ERISA Reporting and Disclosure Compliance Manual**.

DON'T FORGET ABOUT COBRA, FMLA AND USERRA PARTICIPANTS. Any election and enrollment opportunities provided to active employees must be provided to employees absent on FMLA or USERRA leaves of absence, as well as COBRA qualified beneficiaries (including those previously or currently covered as dependents). Depending on plan terms, similar rights may apply to other enrollees that are not active employees (e.g., retirees). It may be possible to simply send these individuals the same enrollment packet prepared for active employees, but the materials should be reviewed and adjustments made as needed for these individuals (e.g., any materials regarding life, disability or other non-health benefits should not be provided to COBRA qualified beneficiaries).

OTHER NOTICES MAY BE NEEDED

In specific situations, additional notices may be needed and the annual enrollment packet may be the most efficient means of providing those notices. While there are others, such additional notices might include:

- **EARLY RETIREE REINSURANCE PROGRAM (ERRP) NOTICE.** Within a reasonable period after an employer receives reimbursement under the ERRP, notice must be provided to plan participants (including any non-retiree participants) regarding use of the reimbursement. Given that no new applications for the ERRP were accepted after May 5, 2011, most participating employers have already received approval and begun receiving reimbursements.

- **MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) NOTICE OF COST EXEMPTION.** Plans that experience an increase in the cost of coverage of 2% or more due to compliance with the MHPAEA may apply for a one-year cost exemption from the law's requirements, but the conditions for this temporary exemption are difficult to meet, so it is not widely used. Plans that obtain the exemption must provide a notice to participants.

SENDING THE NOTICES

The employer, as plan sponsor and plan administrator of a single-employer health plan, generally is required to provide the notices. Of course, if the employer wishes to hire a third party to perform this function on the employer's behalf, that is permitted. Also, in some – but not all – cases, the insurer providing coverage under an insured plan is concurrently responsible for providing a notice. If, however, the third party or insurer does not provide the notice as required, the employer still may incur penalties or liabilities for the failure.

The notices discussed above have a variety of recipient and delivery requirements. In most cases, however, an employer can fulfill the applicable requirements by sending paper notices (as opposed to electronic) through the U.S. Mail along with enrollment materials to the following individuals, as applicable, at the last known address:

- Enrolled employees and retirees
- COBRA qualified beneficiaries and others receiving similar continuation coverage (including those previously or currently covered as dependents)
- Children covered pursuant to QMCSOs (or their custodial parent)
- Individuals covered as an employee or retiree's survivor

Distribution of a notice to these individuals generally covers any requirement to provide the notice to a covered dependent, unless the employer knows that the dependent does not live with the employee. A notable exception to this general rule is the requirement to provide the COBRA initial notice to an enrolled spouse.

Other means of distribution, such as in-hand distribution or certified mail, may also satisfy the requirements, but we think that regular first class mail with proof of mailing is preferable. This is a bit counter-intuitive for employers accustomed to sending notices by certified mail or getting employees to sign receipts for items distributed at work. After all, those methods of delivery not only show that an item was sent – they may also show that the individual received it. But what happens if someone does not provide the requested acknowledgement? For those individuals, a procedure that relies on acknowledgement of receipt effectively creates a record of non-receipt.

It is usually not necessary to show that an individual received a particular notice. Most notice obligations are fulfilled if the plan makes a good-faith effort to send the notice by reliable means. Courts generally will presume that an individual received an item if there is proof that an item was mailed to the individual's last-known address with adequate postage.

Proof of mailing is important because it shows how, when and to whom the plan sent a particular item. For most employers, a certificate of mailing will be the best proof that an item was mailed. (The certificate is a postmarked form that is obtained from the Post Office when an item is mailed.) Some employers prefer to rely on their internal procedures to supply proof of mailing. In order to do this, an employer will need evidence of consistent business practices for mailing notices coupled with some proof that the process was followed for a particular notice. For many employers, however, it is difficult to prove the required high level of consistency in preparing and mailing notices.

Many employers are also interested in making HR functions more efficient by using electronic delivery. But complex and, in some cases, inconsistent standards must be met for electronic delivery of notices to be considered compliance with the various notice requirements. As a result, most employers will choose to provide required notices on paper, using the U.S. Mail.

Except as noted, each of the notices discussed above may be provided as part of a booklet or other document that includes other notices or plan information. If included in a booklet or other document, the first page of the booklet or document should provide a list of all of the notices included, as well as any required alert about the content such as that required for Medicare Part D creditable/non-creditable prescription drug coverage notices.

APPENDIX I

2012 ANNUAL ENROLLMENT CHECKLIST

TIMELINE

ACTION	COMPLETED
Establish beginning and ending dates for open enrollment.	
Determine which benefits are being changed for the next plan year.	
Establish deadlines for preparation and distribution of open enrollment materials.	
Consult with plan insurers, TPAs and other service providers to confirm operational roles and rules.	
Understand HIPAA special enrollment rules permitting mid-year enrollments for certain individuals losing other coverage or becoming eligible for premium assistance under Medicaid or CHIP, and certain new dependents.	
For benefits options that remained grandfathered for 2011 plan year, determine whether grandfathered status will continue for the 2012 plan year. The requirements for a plan to have grandfathered status are summarized in **Appendix IV to last year's annual enrollment toolkit**, subject to **updates on medical inflation**.	
If, for the 2012 plan year, a benefits option loses its grandfathered status, revise plan documentation as needed for compliance with previously inapplicable requirements. (See **last year's annual enrollment toolkit**.)	
If a benefits option loses its grandfathered status for the 2012 plan year, prepare Summaries of Material Modifications (SMMs) or updated Summary Plan Descriptions (SPDs) or other employee communications regarding changes for 2012 plan year including changes explained in **Appendix II to last year's annual enrollment toolkit**.	
ERISA plans need to communicate any material reduction in benefits within 60 days of the adoption of the anticipated reduction. ■ In 2012, under PPACA, plans will need to send a written summary of any plan changes at least 60 days prior to the effective date of the change (regulations have not yet been provided for this requirement).	

WHO RECEIVES OPEN ENROLLMENT MATERIALS

ACTION	COMPLETED
Identify all potential recipients of enrollment materials, any variations in materials for different recipients, and appropriate means of communication within such group. Recipients generally should include enrolled individuals within the following groups:	
■ Active employees (and other eligible workers)	
■ Employees on leave (FMLA, disability, USERRA)	
■ COBRA qualified beneficiaries	
■ Retired employees (if applicable)	
■ QMCSO alternate recipients (or guardians/legal representatives)	
■ Spouse/dependent of deceased retiree-participants (if applicable)	
■ Guardian/representative of incapacitated persons	
NOTE *Include a statement that receipt of enrollment materials does not imply eligibility or coverage and does not create any rights that are not provided for in the plan documents, including participation rights, and that the plan administrator retains the ultimate authority to determine eligibility.*	

OPEN ENROLLMENT MATERIALS GENERAL FORMAT AND CONTENT

ACTION	COMPLETED
Are summary materials being used? (e.g., brochures, benefits overview)	
Are more detailed existing materials being used? (SPDs)	
Are different materials for different classes of individuals required?	
Ensure materials are accurate, complete and not otherwise misleading. Avoid vagueness or ambiguity. Refer recipients to SPDs for more detailed information.	
Ensure that any summary materials are consistent with other benefits descriptions. (SPDs)	
Clear statement regarding the employer's enrollment process and consequences if employee fails to act. ■ Consequences could include automatic enrollment in basic benefits, continuing enrollment in prior year's benefits or no coverage. ■ Consequences may differ on a benefit-by-benefit basis, or it may be necessary to distinguish between automatic benefits and benefits requiring affirmative enrollment (basic vs. supplemental life insurance benefits, or major medical vs. health FSA). ■ Include a copy of the employee's current elections and amount of required employee contributions to continue.	

CAFETERIA PLAN ELECTION OPTIONS

ACTION	COMPLETED
Clear statement of cafeteria plan election options (distinguish between cafeteria plan benefits and those offered outside cafeteria plan, e.g., voluntary benefits not sponsored by employer).	
Eligibility rules, including special rules and situations where those eligible for underlying benefits are not eligible for pre-tax premium. ■ Addressing special classes of workers (rehired employees) ■ Explaining possible effect of compensation on eligibility ■ Describing actively-at-work clauses (under disability plans) ■ Governing the tax status of dependents (spouses, domestic partners, children)	
Effect of enrolling **ineligible individuals in either the cafeteria plan or the group medical plan** (critical to include warning of plan's rights to recover benefits, premiums paid, or employment termination).	
Benefits descriptions, including exclusion and how benefits have changed from prior year (Summary of Material Modifications).	
If insurers have changed, ensure new coverage is understood and communicate new terms using insurer-prepared language.	
Reminder of maximum contributions capped at $2,500 for health FSAs beginning January 1, 2013.	

ENROLLMENT PROCEDURES AND NECESSARY FORMS

ACTION	COMPLETED
Carrier-required forms for insured benefits.	
Any certifications required by the plan regarding age of dependent or dependent's eligibility for employment-based coverage.	
Any affidavits or registrations for domestic partner or domestic partner's children.	
Any certifications required by the plan regarding a spouse's coverage as it relates to a spousal surcharge.	
Cafeteria plan health FSA, DCAP and adoption assistance election forms complying with applicable tax requirements.	
Qualified transportation plan forms.	
Debit card information and certification from employee that card will be used only for medical expenses under Code § 213.	

NOTICES

ACTION	COMPLETED
If plan is grandfathered, include required notice using **model language**.	
If grandfather status of plan has changed for 2012, remove statement in plan materials of plan's belief of grandfather status.	
Notice to participants in non-grandfathered plans regarding the patient protections using **model language**.	
CHIPRA notice of available premium assistance using **model CHIP notice**.	
Women's Health and Cancer Rights Act (WHCRA) annual notice using either the full **WHCRA enrollment notice** or the **abbreviated version** for those who previously received the enrollment notice.	
Notice of Pre-existing Condition Exclusion (HIPAA general notice at time of initial enrollment or open enrollment). See our **sample notice**.	
HIPAA Special Enrollment Notice (for those waiving coverage during initial or open enrollment). See our **sample notice**.	
Initial COBRA Notice (required at enrollment), using either the DOL's **model**, or an alternative such as Willis' **sample initial COBRA notice**. ■ Compliance considerations for purposes of delivery of Initial Notice to spouse	
HIPAA Notice of Privacy Practices (although not required, some employers provide this every open enrollment). See our **sample notice of privacy practices**.	
HIPAA Notice of Availability of Notice of Privacy Practices (required every three years if it is not provided each year). See our **sample availability notice**.	
Medicare Part D Notice of Creditable or Non-creditable Prescription Drug Coverage using **model notice of creditable prescription drug coverage** and **model notice of non-creditable prescription drug coverage**, as applicable. ■ Compliance considerations if Notice included with other plan materials **NOTE** *Best practice is to make a one-time distribution of this notice by October 15, 2011 to meet the requirement of providing before Medicare open enrollment, and then return to previous distribution schedule (e.g., with open enrollment materials), provided that schedule results in distribution within 12 months.*	
CMS Group SSN Collection Form – when an employee and/or spouse refuses to provide an SSN, using CMS **model form** (collect annually).	
Notice of Michelle's Law – provided when requesting verification of full-time student status of a dependent. See our **sample Michelle's Law notice**. ■ This notice is required every time a full-time student status verification is requested.	
Summary Plan Description – provide to new participants within 90 days of becoming covered under the Group Health Plan.	

NOTICES *(continued)*

ACTION	COMPLETED
Summary of Material Modifications (SMMs) may be used instead of revised SPDs.	
Summary Annual Report – this is required to be distributed within two months following the date Form 5500 was filed.	
Imputed income reminder for Group Term Life in excess of $50,000.	
Imputed income reminder, for both federal and state taxation, for domestic partner coverage or dependent who does not meet requirements of IRC tax dependent or adult child definition.	
Reminder to employees of W-2 reporting of value of employer provided benefits in 2013 (for those employers who file 250 W-2s in 2011).	

KEY CONTACTS

U.S. HUMAN CAPITAL PRACTICE OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Burlington, VT
802 264 9536

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

NORTHEAST

Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
212 915 8802

Norwalk, CT
203 523 0501

Radnor, PA
610 254 7289

Wilmington, DE
302 397 0171

ATLANTIC

Baltimore, MD
410 584 7528

Bethesda, MD
301 581 4261

Knoxville, TN
865 588 8101

Memphis, TN
901 248 3103

Nashville, TN
615 872 3716

Norfolk, VA
757 628 2303

Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

SOUTHEAST

Atlanta, GA
404 224 5000

Birmingham, AL
205 871 3300

Charlotte, NC
704 344 4856

Gainesville, FL
352 378 2511

Greenville, SC
704 344 4856

Jacksonville, FL
904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
407 562 2493

Raleigh, NC
704 344 4856

Savannah, GA
912 239 9047

Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

Appleton, WI
414 259 8837

Chicago, IL
312 288 7700
312 621 4843
312 348 7678

Cleveland, OH
216 861 9100

Columbus, OH
614 326 4722

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI
414 259 8837

Milwaukee, WI
414 203 5248
414 259 8837

Minneapolis, MN
763 302 7131
763 302 7209

Moline, IL
309 764 9666

Pittsburgh, PA
412 645 8506

Schaumburg, IL
847 517 3469

SOUTH CENTRAL

Amarillo, TX
806 376 4761

Austin, TX
512 651 1660

Dallas, TX
972 715 2194
972 715 6272

Denver, CO
303 765 1564
303 773 1373

Houston, TX
713 625 1017
713 625 1082

McAllen, TX
956 682 9423

Mills, WY
307 266 6568

New Orleans, LA
504 581 6151

Oklahoma City, OK
405 232 0651

Overland Park, KS
913 339 0800

San Antonio, TX
210 979 7470

Wichita, KS
316 263 3211

WESTERN

Fresno, CA
559 256 6212

Irvine, CA
949 885 1200

Las Vegas, NV
602 787 6235
602 787 6078

Los Angeles, CA
213 607 6300

Novato, CA
415 493 5210

Phoenix, AZ
602 787 6235
602 787 6078

Portland, OR
503 274 6224

Rancho/Irvine, CA
562 435 2259

San Diego, CA
858 678 2000
858 678 2132

San Francisco, CA
415 291 1567

San Jose, CA
408 436 7000

Seattle, WA
800 456 1415

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