Mastering the Method for Optimal Delivery

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Enrollment Notices: Mastering the Method for Optimal Delivery

Larry Grudzien

Attorney at Law

About Larry

Larry Grudzien
ERISA Attorney

Lawrence (Larry) Grudzien, JD, LLM is an attorney practicing exclusively in the field of employee benefits. He has experience in dealing with qualified plans, health and welfare, fringe benefits and executive compensation areas. He has more than 35 years' experience in employee benefit law.

Mr. Grudzien was also an adjunct faculty member of John Marshall Law School's LL.M. program in Employee Benefits and at the Valparaiso University's School of Law. Mr. Grudzien has a B.A. degree in history and political science from Indiana University, J.D. degree from Valparaiso University School of Law and LL.M. degree in tax from Boston University School of Law. He is a member of Indiana and Illinois Bars.

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Agenda

- Recommended and Mandated Participants Notice – All Plans
- Required Notice – All Plans, but not Required Annually or at Open Enrollment
- Recommended and Mandated Participant Notices – Plans that Meet Specific Criteria
- Mandated Participant Notices – Plans that Meet Specific Criteria

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Recommended and Mandated Participant Notices

All Medical Plans

Uniform Summary of Benefits & Coverage
Glossary of Terms

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- Summary of covered benefits, and it also provides examples of how plan will pay benefits in specific circumstances
- Glossary is of common health plan terms
- The SBC requirement applies in addition to ERISA's SPD and SMM requirements
- All medical plans

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Provided By / Provided To

- Plan sponsor or carrier - Provides to all participants and eligible employees
- Most carriers *prepare* SBCs but require plan sponsors to actually *provide* them to participants
- Self-insured plans: TPA or employer must prepare

Delivered by Date (Timing)

- With Open Enrollment materials; Also at initial enrollment
- Within 7 business days after requested
- Within 90 days after HIPAA special enrollment, If auto re-enrollment at least 30 days before 1st of Plan Year

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How to Provide?

An SBC provided by a plan or insurer to a participant or beneficiary may be provided in paper or in electronic format.

The FAQ guidance provides important relief relating to distribution requirements by noting that unless the plan or insurer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form.

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Penalties for Not Providing

- A penalty of up to $1,000 per failure (as adjusted for inflation) can be assessed on plan administrators (for self-insured health plans) and both plan administrators and insurers (for insured health plans) that “willfully fail” to timely provide the SBC
- A failure with respect to each participant or beneficiary constitutes a separate offense
- The fine cannot be paid from plan or trust assets

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Updating

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A group health plan or insurer must provide notice of a material modification if it makes a “material modification” in any of the terms of the plan that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal (i.e., mid-plan year).

The notice of the material modification must be provided no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided and occurs mid-plan year.

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Women's Health and Cancer Rights Act

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- The notice must state that, for an individual who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for—— 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
  - treatment of physical complications of the mastectomy, including lymphedemas
- The notice must also describe any deductibles and co-insurance limitations applicable to such coverage, which must be consistent with those established for other benefits under the plan or coverage.
- All medical plans

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Provided By / Provided To

- Plan Administrator (can be delegated to the carrier)
- Send to all plan participants
- The DOL has interpreted this as requiring a separate notice to a beneficiary "where the last known address of the beneficiary is different than the last known address of the covered participant."

Delivered by Date (Timing)

- Annually & upon initial enrollment
- Usually sent at Open Enrollment
- The DOL has provided that notices must be delivered in the same manner required under DOL regulations for providing SPDs.

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HIPAA Notice of Special Enrollment Rights

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- Tells all eligible employees what circumstances give rise to special mid-year enrollment rights (even if they do not enroll)
- Special enrollment is available in the following situations:
  - a loss of eligibility for group health coverage or health insurance coverage
  - becoming eligible for state premium assistance subsidy
  - the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption
- All medical plans

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Provider and Timing

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Provided By / Provided To

- Plan Administrator (Sponsor), can be delegated to carrier
- Send or give to eligible employees

Delivered by Date (Timing)

- Initial Eligibility and also must be in SPD
- The DOL has provided that notices must be delivered in the same manner required under DOL regulations for providing SPDs.

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Medicare Part D

Creditable or Non-Creditable Coverage Notice

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Details

- Indicates whether the plan's prescription drug coverage is *creditable* or *non-creditable* with Medicare prescription drug coverage.
- There are two model notices depending whether the creditable or not.
- All plans
- Provided By / Provided To
  - Plan sponsor is only required to send to all Medicare-eligible participants (including COBRA participants and eligible dependents), but usually just sends to all participants

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Delivered by Date (Timing)

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- Under regulations issued by CMS, disclosure notices must be provided to Part D eligible individuals at the following times:
  - prior to commencement of the annual coordinated election period (ACEP) (October 15) for Part D
  - prior to an individual's initial enrollment period (IEP) for Part D
  - prior to the effective date of coverage for any Part D eligible individual that enrolls in the employer's prescription drug coverage
  - whenever the employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable
  - upon request by the Part D eligible individual
- If included with Open Enrollment materials before Oct 15, need not send again until next year
- It can delivered by paper or electronic means.

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CHIP Notice – Medicaid and Children's Health Insurance Program

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- Informs employees about possible state financial assistance for health insurance coverage
- All plans, if participants reside in a state with CHIP financial assistance
- Provided By / Provided To
  - Plan sponsor
  - Send to all eligible employees in states listed on the CHIP Notice. *Note that California and Illinois are not*

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Delivered by Date (Timing)

- Annually, before beginning of plan year
- Recommend to include with Open Enrollment materials
- And upon initial eligibility
- The DOL may assess a civil penalty of up to $100 per day against an employer, starting on the date of the employer’s failure to meet the notice requirement.

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Newborns' and Mothers' Health Protection Act

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- It provides that group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a vaginal delivery, to less than 48 hours, or following a cesarean section, to less than 96 hours.
- A group health plan may also not require a physician or other health care provider to obtain authorization from the plan for prescribing the minimum hospital stay for the mother or newborn.
- All medical plans

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Details

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Provided By / Provided To

- Must be in SPD
- Often sent by Plan Administrator or carrier
- Send to all plan participants

Delivered by Date (Timing)

- Must include in SPD
- May want to send annually with Open Enrollment materials

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Required Notices – All Medical Plans
Not Required Annually or at Open Enrollment

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HIPAA Privacy Notice

Carrier's Notice/Self-Insured Plan's Notice/Employer's Notice for Plan Overall

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- Tells plan participants about their HIPAA Privacy rights, the plan's Privacy obligations, and the contact information for the Privacy Official if a participant wants to file a complaint
- All medical plans
- Provided By / Provided To
  - Insured plan: Carrier must send to all plan participants if employer does not receive Protected Health Information (PHI).
- Delivered by Date (Timing)
  - General distribution rules:
    - At initial enrollment
    - If relevant information changes
    - Upon request
    - Every 3 years must notify of right to request new Notice.

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Exchange Notice

Notice of Coverage Options

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- Tells employees about Health Insurance Exchanges/Marketplace; that employees might be eligible for federal subsidies; info about employer coverage, if available
- All medical plans
- Provided By / Provided To
  - Employers/ Provide Notice to all employees (full-time & part-time, whether eligible for coverage or not)
  - Can use Model Notices issued by DOL
- Delivered by Date (Timing)
  - Within 14 days of date of hire, must give to all employees
  - Can also include with open enrollment materials and when an employee terminates

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COBRA Initial or General Notice

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- The initial notice communicates to plan participants their COBRA rights and obligations
- DOL provides model initial notice
- Applicable to all plans subject to COBRA
- Provided By / Provided To
  - The initial notice must be furnished by the plan administrator to the covered employee and spouse when plan coverage first begins
- Delivered by Date (Timing)
  - The initial notice is delivered within 90 days after coverage begins

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COBRA Election Notice

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- The election notice gives qualified beneficiaries information regarding their rights and obligations with reference to a specific qualifying event
- DOL provides Model Election Notice
- Applicable to All Plans Subject to COBRA
- Provided By / Provided To
  - When a qualifying event occurs (and after notice of the event is provided to the plan administrator), the plan administrator must furnish an election notice to each qualified beneficiary (including the covered employee, covered spouse, and any covered dependent child) who loses plan coverage in connection with the qualifying event.
- Delivered by Date (Timing)
  - The plan administrator must provide a COBRA election notice to “any qualified beneficiary” with respect to a qualifying event within 14 days after the plan administrator has been notified (by the employer or by a qualified beneficiary) that the qualifying event has occurred.

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Notice of Termination of COBRA Coverage

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- When COBRA coverage terminates before the end of the maximum coverage period, the plan administrator must provide a written notice of termination of COBRA coverage to each affected qualified beneficiary.
- Thus, a notice of termination is required when COBRA coverage ends because—
  - COBRA premiums are not paid in full on a timely basis
  - the employer ceases to provide any group health plan to any employee
  - the qualified beneficiary becomes covered under another group health plan after electing COBRA
  - the qualified beneficiary becomes entitled to Medicare after electing COBRA
  - a disabled qualified beneficiary whose disability caused an extension of the COBRA maximum coverage period is determined not to be disabled
  - the qualified beneficiary's COBRA coverage is terminated for cause

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- Applicable to all plans subject to COBRA
- Provided By / Provided To
  - Plan administrator must provide a notice of termination to each qualified beneficiary whose COBRA coverage terminates before the maximum coverage period ends.
- Delivered by Date (Timing)
  - A notice of termination must be furnished by the plan administrator “as soon as practicable” following its decision to terminate COBRA coverage
  - The notice is not necessarily required to be furnished in advance of a termination of COBRA coverage
  - Separate notices required when qualified beneficiaries live at different addresses

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Notice of Unavailability of COBRA Coverage

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Details

- A notice that COBRA coverage is unavailable to certain individuals who may expect to receive COBRA coverage (or an extension of COBRA coverage).
- When required, the notice of unavailability must explain why COBRA coverage (or an extension of COBRA coverage) is not available.
- Applicable to all plans subject to COBRA

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Provided By / Provided To

- Plan Administrator
- The notice of unavailability is required if the plan administrator:
  - receives one of the following notices:
    - a notice that a qualifying event has occurred
    - a notice that a second qualifying event has occurred
    - a notice that an individual has been determined by the Social Security Administration to be disabled
  - determines that the individual in question is not entitled to COBRA coverage (or an extension of COBRA coverage)

Delivered by Date (Timing)

- The administrator must furnish the notice of unavailability within the time period that would apply for providing the election notice to the individual if he or she were entitled to elect COBRA.
- This deadline is generally is 14 days after the plan administrator has received notice of a qualifying event.

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Qualifying Event Notice to Plan Administrator

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- The plan administrator must be notified when a qualifying event occurs.
- Depending on what kind of qualifying event occurs, this notice must be provided either by the employer or by the covered employee/qualified beneficiary.
- Applicable to all plans subject to COBRA

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Provided By / Provided To

- Employer
- In general, the employer must notify the plan administrator of the following qualifying events:
  - death of the covered employee
  - termination (other than by reason of gross misconduct)4 or reduction of hours of the covered employee
  - the covered employee's becoming entitled to Medicare
  - the commencement of a bankruptcy proceeding of the employer (causing a substantial elimination of retiree coverage)

Delivered by Date (Timing)

- Within 30 days after a qualifying event

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Recommended and Mandated Participant Notices

Plans that Meet Specific Criteria

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Wellness Program HIPAA Disclosures

Applies only for certain types of Wellness Programs

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- Tells eligible individuals they can satisfy an alternate standard if they are medically unable to meet Wellness Program's standard that is related to a health factor.
- Applicable to wellness programs with a reward or penalty that affects employee's cost for coverage under the GHP & requires achievement of performance standards
- Provided By / Provided To
  - Plan administrator
  - Send to all plan participants
- Delivered by Date (Timing)
  - Annually, at open enrollment
  - Prior to or at offering of Wellness Program

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Wellness Program – New EEOC Notice

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- Tells individuals what information will be collected, how it will be used, who will receive it, and how it will be kept confidential.
- Applicable to wellness programs that collect employee health information (e.g., Health Risk Assessments) [or require medical exams or lab tests]
- Provided By / Provided To
  - By first day of 2017 plan year
  - Thereafter, participants must receive it (annually) before providing any health information, and with enough time to decide whether to participate in the program.

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Summary Annual Report

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- An annual statement summarizing the latest annual report (Form 5500) for the plan
- Applicable to Large Plans (100+ - all plans that file form 5500)
- Provided By / Provided To
- Plan administrator
- Send to all participants
- Delivered by Date (Timing)
- Annually, within 60 days after filing of Form 5500 (or 9 months after end of Plan Year)

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Form 1095-C

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Details

- Tells individuals about the health coverage they were offered by their employer, or if they were not offered coverage.
- Applicable to “Applicable Large Employers” (ALES) – ERs who had at least 50 FT EEs or FTEs in the prior calendar year.
- Provided By / Provided To
  - Employer
  - Send to all individuals who were FT EEs in at least one month of the prior calendar year, whether or not ER offered health benefits
- Delivered by Date (Timing)
  - Annually, by January 31 (has information about prior calendar year)

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Mandated Participant Notices

Plans that Meet Specific Criteria

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Patient Protection “Provider Choice” Disclosure

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- Tells participants they can designate a pediatrician as primary care provider (PCP) and that no referral is required to see an OB-Gyn provider
- Applicable to NON-grandfathered plans with PCP selection requirement and/or network providers and facilities
- Provided By / Provided To
  - Carrier or Plan
  - Send or give notice to all participants
- Delivered by Date (Timing)
  - Annually, with carrier’s Certificate of Coverage; and upon initial enrollment, and whenever Plan sponsor provides SPD

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HIPAA/HITECH Breach Notice

If breach involved more than 500 individuals

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- Notifies affected participants and Health and Human Services (HHS) that there was a breach of Protected Health Information (PHI) during the prior 60 days
- Applicable to plans that had a breach of PHI during the past 60 days
- Provided By / Provided To
  - Plan sponsor
  - Must provide notice to Affected Plan participants (directly) and HHS (on HHS website)
- Delivered by Date (Timing)
  - Without unreasonable delay & not more than 60 days after discovery of breach

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HIPAA/HITECH Breach Notice

If breach involved 500 or fewer individuals

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Details

- Notifies affected participants & Health and Human Services (HHS) that there was a breach of Protected Health Information (PHI)
- Applicable to plans that had a breach of PHI
  - During past plan year for notice to HHS
  - During past 60 days for notice to participants
- Provided By / Provided To
  - Plan sponsor
  - Must provide notice to Affected Plan participants (directly)
  - And HHS (on HHS website)
- Delivered by Date (Timing)
  - Within 60 days after end of plan year to HHS
  - Without unreasonable delay and not more than 60 days after discovery of breach to participants

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General Notice of Pre-existing Condition Exclusion

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- Explains the plan's Pre-Ex limit provision and how prior creditable coverage can reduce the limitation period
- Applicable to small insured plans that were allowed to renew as non-PPACA-compliant
- Provided By / Provided To
  - Most plans will no longer provide this notice because will no longer have pre-existing condition exclusions after 2014 PY
- Delivered by Date (Timing)
  - If must provide this Notice, do so at initial enrollment and open enrollment; also must be in SPD

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Grandfathered Notice

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- To maintain grandfathered status, a plan or coverage must provide, in any plan materials describing benefits for participants or beneficiaries,
  - a statement that the plan or coverage is believed to be a grandfathered plan
  - contact information for questions or complaints
- Applicable to plans claiming grandfathered status

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Provided By / Provided To

- Plan administrator
- All plan participants

Delivered by Date (Timing)

- This disclosure requirement applies to any SPD, SMM, or benefit enrollment materials provided to participants or beneficiaries beginning with the first plan year on or after September 23, 2010.
- The agencies have clarified that it is not necessary for a grandfathered plan to provide a disclosure statement regarding its grandfathered status every time it sends out a communication (e.g., an explanation of benefits) to participants and beneficiaries.

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Company Background - Services

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Eligibility
Enrollment
Integration
Self Service
Communications
EE Call Center
Decision Support
Retiree H&W Admin.
COBRA
Direct Billing
Total Rewards
Reimbursements (HSA / FSA)
Commuter Benefits
Dependent Verifications
ACA & Other Compliance Svc.

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We help participants understand and use their benefits wisely so that they can be accountable for their healthcare.

We enable you, as the plan sponsor, to enable and deliver your benefits strategy.

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Company Background – Book of Business

250 employees serving our clients from two services center; Schaumburg, IL and Rancho Cordova, CA.

Clients & Services Supported

Mid/Large Administration clients	**226**
Average client size - participants	**4,100**
Technology Clients	**3,952**
Reimbursement / COBRA clients	**187**
Administration Participants	**1,500,000+**
ACA 1095 Forms Generated	**250,000**

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Some of Our Partners

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Questions?

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Contact Information

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