Health Care Reform

Notice Requirement	Summary
Statement of grandfathered status - Plan administrator or issuer should provide first statement before the first plan year beginning on or after Sept. 23, 2010. Must continue to be provided on a periodic basis with any participant materials describing plan benefits.	Grandfathered plans are group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, (the enactment date for health care reform) that satisfy certain requirements. Grandfathered plans can avoid many of the new health care reform provisions. To maintain grandfathered plan status, a plan administrator or health issuer must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the summary plan description (SPD) and open enrollment materials). The DOL's model notice is available at: www.dol.gov/ebsa/healthreform/.
Special enrollment notice of dependent coverage up to age 26 – Plan administrator or issuer must provide the notice no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This rule applies regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. One-time notice	Group health plans and health insurance issuers that provide dependent coverage of children must make coverage available for adult children up to age 26. However, for plan years beginning before Jan. 1, 2014, grandfathered plans are not required to extend coverage to children under age 26 if they are eligible for their own employer's coverage. Before the coverage requirement was effective, a child under age 26 who was covered under a group health plan or health insurance coverage as a dependent may have lost coverage due to age. Also, a child may not have been eligible for coverage if his or her parent first became covered under the plan when the child was under age 26 but older than the plan's eligible age. Plans must provide these dependents with an opportunity to enroll which continues for at least 30 days, along with written notice of the opportunity to enroll. The coverage for dependents that enroll through a special enrollment opportunity must take effect no later than the first day of the first plan year beginning on or after Sept. 23, 2010. Also, these dependents must be treated as HIPAA special enrollees. The DOL's model notice is available at: www.dol.gov/ebsa/healthreform/.
Special enrollment notice of no lifetime maximum benefit - Plan administrator or issuer must provide the notice no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This rule applies regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. One-time notice	Group health plans and health insurance issuers may not establish lifetime limits on the dollar value of benefits for any participant. Before this restriction was effective, an individual who was covered under the group health plan or health insurance coverage as an employee or dependent may have lost eligibility because he or she reached the lifetime maximum benefit. Plans must provide these individuals with an opportunity to enroll which continues for at least 30 days, along with written notice of the opportunity to enroll. The coverage for individuals who enroll through a special enrollment opportunity must take effect no later than the first day of the first plan year beginning on or after Sept. 23, 2010. Also, these dependents must be treated as HIPAA special enrollees. The DOL's model notice is available at: www.gov/ebsa/healthreform/.

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Notice of rescission – Plan administrator or issuer must provide notice of rescission to affected participants at least 30 days before the rescission occurs.	Group health plans and health insurance issuers may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be rescinded without prior notice to the enrollee.
Notice of patient protections and selections of providers – Plan administrator or issuer must provide notice of new patient protections whenever the SPD or similar description of benefits is provided to a participant. The first notice should be provided no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This requirement does not apply to grandfathered plans.	Group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care. The DOL's model notice is available at: www.dol.gov/ebsa/healthreform/.
Uniform summary of benefits and coverage – Plan administrator or issuer must provide to applicants and enrollees before enrollment and re-enrollment. The Department of Health and Human Services (HHS) is to develop standards for the summary, and plans and issuers will have to start using it after final regulations are issued.	Group health plans will be required to provide a uniform summary of the plan's benefits and coverage to applicants and enrollees. The summary will have to be written in easily understood language and will be limited to 4 pages.
Waiver of Annual Limit Requirement – For applications for waivers covering plan years beginning on or after Feb. 1, 2011, the plan administrator or issuer must provide an annual notice to eligible participants as part of any plan or policy documents regarding coverage that are provided to enrollees (such as SPDs).	Effective in 2014, health plans will be prohibited from imposing annual limits on essential health benefits. For plan years beginning before Jan. 1, 2014, health plans may impose "restricted annual limits" on essential health benefits. The restrictions on annual limits may be waived by HHS if compliance with the restrictions would result in a significant decrease in access to benefits or a significant increase in premiums. Any plans that receive a waiver approval must provide a notice informing participants that the plan does not meet the annual limits and has received a waiver for the requirements. The notice must include: • The dollar amount of the annual limit; • A description of the plan benefits to which the limit applies; and • An explanation that the plan has received a waiver of the restricted annual limit requirement. Plans must use HHS's model language to satisfy the waiver notice requirement, or they must receive HHS's written permission to use different language. HHS's model notice is available at: http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf.

Notice Requirement	Summary
Early Retiree Reinsurance Program (ERRP) Notice – Plan sponsors must provide the notice to all plan participants, not just early retirees. The notice must be provided within a reasonable period of time after the sponsor receives its first ERRP reimbursement. Alternatively, the plan sponsor may provide the notice before receiving its first reimbursement.	Health care reform established a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (age 55 and older, but not yet eligible for Medicare), and their spouses, surviving spouses and dependents. The ERRP was designed to expire on Jan. 1, 2014, or earlier if the program's funding was depleted. (The ERRP received $5 billion in funding.) Note: Because program funds have been exhausted, on Dec. 9, 2011, HHS announced that it will not accept reimbursement requests for claims incurred after Dec. 31, 2011. Plan sponsors participating in the ERRP must provide a notice to participants explaining the sponsor's participation in the ERRP and noting that the sponsor may decide to use the reimbursements to reduce plan participants' premium contributions, copayments, deductibles or other out-of-pocket costs. More information on the ERRP, including a model participant notice is available at: www.errp.gov/.
IRS Form W-2 – Aggregate cost of applicable employer-sponsored coverage must be included. This requirement was originally effective for tax years beginning after Dec. 31, 2010. However, the IRS made reporting optional for all employees for the 2011 tax year, so the effective date is delayed and employers are not required to include this information on W-2 forms issued for 2011. Small employers (those filing fewer than 250 W-2-Forms) and employers contributing only to certain plans, such as multiemployer plans or HSAs, are exempt at least until further guidance is issued.	Employers must disclose the aggregate cost of applicable employer-sponsored coverage provided to employees on the employees' W-2 forms. This requirement does not mean that the cost of the coverage will be taxable to employees. The IRS has issued the 2011 Form W-2 with Instructions including a new category for reporting the cost of employer-sponsored coverage. Form W-2 and its Instructions are available at: www.irs.gov/formspubs/index.html. The IRS has provided guidance on the Form W-2 reporting requirement in Notice 2011-28, which is available at: www.irs.gov/pub/irs-drop/n-11-28.pdf.