



REVISED CLOSE-UP: Notice and Disclosure Requirements – Plus Model Language to Help You Comply

November 14, 2011

The Affordable Care Act (ACA) includes new notification and disclosure requirements effective for plan years beginning on and after in September 2010. Upon the effective date, group plans and insurers were required to notify their employees in writing about the following six ACA provisions:

- Coverage for dependent children to age 26
- Elimination of lifetime maximums
- Rescissions
- Choice of health care professionals
- Grandfather status
- Notice of material modifications (begins March 23, 2012)

The notice requirements and relevant coverage mandates have been described in detail in previous Close-Ups. This updated Close-Up reiterates prior information and adds an explanation of whether the notice requirement is required once or is an ongoing requirement.

Model language, where provided, for the notices above is available at www.dol.gov/ebsa (and is included in this Close-Up for your convenience). You may want to consider incorporating the legal text into printed enrollment notices.

Provision: 30-day enrollment period for a dependent child

Notice due date: No later than the first day of the first plan year beginning on or after September 23, 2010.

The requirement: This one-time notice applied to any child whose coverage ended, who was denied coverage, or who was not eligible for coverage under a group health plan or coverage because dependent

coverage for children up to age 26 was not available. Any child up to age 26 who became eligible (or was required to be eligible) for coverage under a group health plan or coverage on the first day of the first plan year beginning on or after September 23, 2010 must have been given a one-time written notice of the opportunity to enroll during a 30-day enrollment period. The notice could be provided to an employee on behalf of the employee's child.

A group health plan or insurer that was grandfathered last year was exempt from the provision to provide coverage for dependent children. If this same group or insurer chooses to be non-grandfathered this year, they are required to extend coverage to dependent children, and must now provide this notice to their members.

For group plans or coverage, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. If a notice satisfying these requirements is provided to an employee whose child is entitled to an enrollment opportunity, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied for both the plan and the issuer.

Model language: *Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the*

first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

Provision: Opportunity to enroll for at least 30 days for individuals who have reached a lifetime maximum

Notice due date: Beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

The requirement: While the regulations for this provision are not explicit, we presume that this is a one-time notice, rather than an annual notice. Groups that complied with this notice requirement in 2010 – to permit members who had previously met their lifetime maximum to enroll within 30 days – are not required to provide this notice to members again this year.

The provision states that the plan and issuer must provide individuals who reached a lifetime limit under their plan or coverage and are otherwise still eligible under the plan or coverage with a written notice that the lifetime limit on the dollar value of all benefits no longer applies. Individuals no longer enrolled in the plan or coverage must be provided with an enrollment opportunity.

Employers may include the notice with other enrollment materials that a plan distributes to employees, provided the statement is prominent. If a notice satisfying these issues is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer. When an individual enrolls, coverage must begin no later than the first day of the first plan year beginning on their next enrollment date.

Model language: *The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the*

plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

Provision: Advance written notice that coverage is being rescinded

Notice due date: At least 30 calendar days prior to the coverage being rescinded.

The requirement: This notice must be sent every time a plan/issuer believes it has the right to rescind a member's coverage. Plans and insurers must provide members whose coverage the plan or insurer intends to rescind with a 30-day advance written notice before coverage may actually be rescinded. This advance notice gives affected individuals an opportunity to explore their rights to contest the rescission or look for alternative coverage.

The plan, policy, certificate or contract of insurance may only rescind coverage in the case of fraud or intentional misrepresentation of a material fact. In these cases, coverage must be continued during the 30-day notice period and during any appeal period of that decision.

Model language for use in developing the required notice is not provided presumably because individual situations vary.

Provision: Choice of a health care professional

Notice due date: Whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or coverage.

The requirement: For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, plan and issuers must, on an ongoing basis, provide notice of the member's right to:

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- Chose a primary care provider or a pediatrician when a plan or issuer requires designation of a Primary Care Physician (PCP)
- Obtain obstetrical or gynecological care without prior authorization

Highmark will provide this information in our benefit booklets.

Model language: For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries: *[Insert name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].*

For plans and issuers that require or allow for the designation of a primary care provider for a child, add: *For children, you may designate a pediatrician as the primary care provider.*

For plans and issuers that provide coverage for obstetric or gynecological care and require designation by a participant or beneficiary or a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or

procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Provision: Disclosure of grandfather status

Notice due date: When plan materials are provided.

The requirement: To maintain status as a grandfathered health plan, a plan or health insurance coverage must, for as long as the plan or coverage maintains grandfathered status, include a written statement. The statement must:

- Be included in any plan materials provided to a participant or beneficiary that describes the benefits provided under the plan or coverage
- State that the plan or coverage believes it is a grandfathered health plan within the meaning of Section 1251 of the Affordable Care Act, and
- Provide contact information for questions and complaints

The timing of this disclosure obligation would likely be at least annually and whenever a participant or beneficiary has opportunities to enroll in, renew or change coverage.

Model language: *This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.*

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Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

Provision: Advance notice of material modifications

Notice due date: Beginning on March 23, 2012, enrollees must be provided with at least 60 days' notice of material modifications prior to the date on which the modification(s) become effective.

The requirement: If a group plan or issuer makes any material modification in any terms of the plan or coverage* that is not reflected in the most recently provided summary of benefits and coverage the plan or issuer must give notice of the modification at least 60 days prior to the modification becoming effective.

The Secretary of Health and Human Services (HHS) issued proposed guidance on August 22, 2011. Based upon the proposed guidance (which is subject to change), the advance notice of material modification will be required beginning March 23, 2012 for only those modifications that become effective during a plan year.

There is no indication that the departments intend to issue model language.

**As defined for purposes of Section 102 of the Employee Retirement Income Security Act of 1974.*

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Please note that information contained in this Close-Up is based on our understanding of the Patient Protection and Affordable Care Act of 2010, as amended, and guidance as of the date of this publication.