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Health Care Reform: Approaching Deadlines for Employer-Sponsored Group Health Plans

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The Patient Protection and Affordable Care Act of 2010 ("Health Care Reform"), signed into law in March 2010, created broad changes which affect employer sponsored health plans. For employers and other calendar year plan sponsors these changes have resulted in several approaching deadlines and tasks that must be completed in the coming weeks and months. This publication highlights some of the upcoming deadlines and recent changes that may impact an employer or plan sponsor's welfare plans. For further information on the recent Health Care Reform please visit our past publications here and here.

Change in Medicare Part D Notification Deadline

Starting this year, employers and other plan sponsors must provide Medicare Part D notices prior to October 15th due to changes made as part of the Health Care Reform. The Centers for Medicare and Medicaid Services require that each year, employers and other plan sponsors that provide prescription drug coverage are required to provide Medicare-eligible participants with notices of creditable or non-creditable coverage regarding their prescription drug coverage. This annual notice must be provided prior to the annual enrollment period for Medicare Part D.

The Health Care Reform has changed the Medicare Part D enrollment period for 2012 and all future Medicare Part D enrollment periods to October 15th through December 7th. In prior years, the enrollment period has been from November 15th through December 31st. As a result of this change, employers and other plan sponsors will need to update their notices of creditable or non-creditable coverage and must provide the notices by October 15, 2011. Employers should begin planning now for this shortened timetable and rapidly approaching deadline by determining whether coverage for the upcoming year is creditable or non-creditable; and preparing and distributing the notices of creditable and/or non-creditable coverage.

Uniform Summary of Benefits and Coverage

On August 22, 2011, proposed regulations were published by the Department of Labor, Health and Human Services, and the Treasury, that provide standards for group health plans and health insurance providers to supply to participants a summary of benefits and coverage and a uniform glossary of commonly used health insurance and medical terms, as required by the Health Care Reform. The Health Care Reform requires that such summaries:

- Be presented in a uniform format

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- Be a separate document
- Use terminology understandable by the average plan participant
- Not exceed four double-sided pages
- Not include print smaller than 12-point font

The content of the summary must include a variety of topics including the following:

- Uniform definitions of standard insurance terms and medical terms
- Descriptions of coverage
- Exceptions, reductions and limitations of the coverage
- Cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations
- Renewability and continuation of coverage information
- Coverage examples to illustrate common benefits scenarios (including a normal childbirth, breast cancer treatment and diabetes management) and related cost-sharing based on recognized clinical practice guidelines
- A statement that the summary of benefits and coverage is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the contractual provisions of the coverage
- Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate or contract
- For plans that maintain one or more networks of providers, an Internet address (or other similar contact information) so that participants can obtain a list of network providers
- For plans that maintain a prescription drug formulary, an Internet address (or other similar contact information) for obtaining information on prescription drug coverage
- An Internet address for obtaining the uniform glossary
- Premiums or cost of coverage

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The Health Care Reform directs group health plans and health insurance carriers to comply with the requirements to provide a summary of benefits and coverage and a glossary of terms starting on March 23, 2012. A proposed template of the summary of benefits can be found here. The proposed regulations also contemplate that changes to the summary template may be appropriate to accommodate various types of plans, to provide additional information to individuals, or to improve the effectiveness of the recommended disclosures. Failure to comply with the requirements can result in significant penalties.

In order to prepare for these new requirements, plan sponsors of fully-insured group health plans should check with their carriers and prepare to begin distributing the summaries starting March 23, 2012. Sponsors of self-funded group health plans should consult with benefits counsel and their third party administrators to develop a summary of benefits and coverage that meets the content requirements of the proposed regulations.

Annual Benefit Limits

Effective for plan years beginning on or after September 23, 2010, the Health Care Reform requires that group health plans, including grandfathered plans, generally may not establish annual limits on the dollar amount of essential health benefits. However, a phase out is in place for plan years beginning prior to January 1, 2014.

Employers and plan sponsors should note that for plan years beginning on or after September 23, 2011, the annual limit on essential health benefits will increase from $750,000 to $1,250,000. Summary plan descriptions ("SPDs") open enrollment materials, and other participant disclosures must be appropriately updated.

Summary of Upcoming Deadlines

In addition to summarizing some of the most recent changes, the chart below highlights some of the upcoming deadlines that may apply to an employer or plan sponsor's retirement and welfare plans. In the coming weeks we will also send out a publication outlining recent changes concerning retirement plans.

Amendments and Notices	Deadlines	Type Of Plan(s) Affected
Notice of creditable or non-creditable coverage for Medicare Part D.	October 15, 2011	Welfare
Safe harbor 401(k) plan notices.	December 1, 2011	401(k)

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Qualified Default Investment Alternative ("QDIA") notices for participant-directed retirement plans.	December 1, 2011	Participant-Directed Retirement
Automatic 401(k) enrollment notices.	December 1, 2011	401(k)
Employer stock diversification notices for participant-directed retirement plans.	December 1, 2011	Participant-Directed Retirement
For plan years beginning after January 1, 2011, annual disclosure of specified plan information and specified investment-related information.	December 31, 2011	Retirement and Welfare
Amendments to plan documents* reflecting any operational changes made during 2011.	December 31, 2011	Retirement and Welfare
Cycle A determination letter request.	January 31, 2012	Retirement
Summary of benefits and coverage and a glossary of terms for plan participants.	March 23, 2012	Welfare
Fee disclosures to plan fiduciaries of a defined contribution plan.	April 1, 2012	Defined Contribution
Fee disclosure to plan participants in a defined contribution plan.	May 31, 2012	Defined Contribution
Revisions of summary plan descriptions ("SPDs") or summaries of material modifications ("SMMs") must be created to inform participants of substantive changes to the plan.	210 days after the plan year in which the amendment is adopted.**	Retirement and Welfare

* For calendar-year plans.

** Although a plan sponsor has 210 days to unilaterally provide an SMM, provide an SMM within 30 days following a request by a participant.