BRYAN CAVE
A Broader Perspective

Alert

Employee Benefits & Executive Compensation
Client Service Group

To: Our Clients and Friends

September 7, 2011

Check It Out and Check It Off: 2012 Group Health Plan Checklist

While the Patient Protection and Affordable Care Act, as amended ("PPACA"), required significant design changes for group health plans in 2010 or 2011, some additional requirements must be implemented for 2012. Below is a checklist of these mandates as well as a list of existing enrollment and annual notice requirements that group health plan sponsors should consider during open enrollment.

Requirements That Apply To All Group Health Plans

Beginning with the dates specified below, a group health plan subject to PPACA must comply with the following requirements, regardless of its status as a "grandfathered health plan":

Summary of Benefits

Health care reform expanded ERISA's disclosure requirements to require that a summary of benefits and coverage be provided to applicants and enrollees prior to enrollment or re-enrollment. The summary must be written using at least 12-point font and cannot exceed four double-sided pages.

Pursuant to the proposed rules issued in August, 2011, the summary must include the following information:

- uniform definitions of standard insurance and medical terms so that applicants and enrollees can compare health coverage and understand the terms of coverage, or exceptions to such coverage and an Internet address where an individual may review and obtain the uniform glossary;
- premiums (or cost of coverage for self-insured plans);
- a description of the group health plan's coverage, including cost-sharing, for each category of benefits identified by the Secretary of the Department of Treasury, Labor or Health and Human Services in guidance;

- a description of any exceptions, reductions, and limitations on coverage;
- cost-sharing provisions, including deductible, co-insurance, and co-payment obligations;
- renewability and continuation of coverage provisions;
- a coverage facts label that includes examples illustrating common benefits scenarios (e.g., pregnancy, serious or chronic medical conditions, and related cost-sharing) based on recognized clinical practice guidelines;
- a statement that the outline is a summary of the plan (or policy or certificate) and that the coverage document itself should be consulted to determine the governing contractual provisions;
- the telephone number to call for additional questions and the Internet web address where a copy of the group certificate of coverage (or individual coverage policy) or summary plan description ("SPD") can be reviewed and obtained;
- for plans that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers; and
- for plans that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan.

A summary must be provided to participants and beneficiaries as part of any written enrollment materials and a summary must be included for each benefit package offered for which the participant or beneficiary is eligible. However, upon renewal, only the summary for the benefit package in which the participant is enrolled needs to be furnished, unless the participant or beneficiary requests a summary for another benefit package. The summary must also be furnished to special enrollees within seven days of a request for enrollment pursuant to a special enrollment right.

Although the summary of benefits mandate was effective for plan years beginning on or after September 23, 2010, a special distribution deadline of 24 months after the enactment of PPACA extended the initial distribution date for the summaries to no later than March 23, 2012. If there is a material modification of plan terms or coverage that is not reflected in the most recently provided summary, the plan must issue a summary of material modification ("SMM") to the summary of benefits at least 60 days before the modification becomes effective. Note that the proposed rules are open for comments, which are due no later than October 21, 2011. Accordingly, these rules and the distribution deadline are subject to change.

Instructions and a template of a draft summary of benefits is published in the Federal Register and can be viewed at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21192.pdf.

W-2 Reporting Obligation

Under health care reform, employers must report the aggregate cost of applicable employer-sponsored coverage on an employee's Form W-2. The W-2 reporting requirement is first required for the 2012 tax year. Accordingly, plan sponsors should verify that they have the appropriate systems in place to collect and determine the value that must be reported on the Form W-2 issued in January 2013 for the 2012 tax year. IRS Notice 2011-28, available at http://www.irs.gov/pub/irs-drop/n-11-28.pdf,

provides interim guidance on the reporting requirements (including information on how and what to report).

Additional Requirements That Apply To All Non-Grandfathered Plans

Group health plans that are not grandfathered for PPACA purposes must comply with the following additional requirements:

Expanded Preventive Services

Health care reform requires plans to cover certain preventive services without any cost-sharing when delivered by in-network providers. For 2010, plans were required to provide coverage pursuant to the recommendations in effect on September 23, 2009. With respect to any new recommendations, a plan has up to one year from the effective date to comply.

The following Grade A and B Recommendations of the U.S. Preventive Services Task Force went into effect after September 23, 2009 and must be covered without cost-sharing for plan years that begin on or after the dates specified below:

- screening and counseling for obesity in children (January 31, 2011);
- expanded recommendation on meningococcal vaccine (September 25, 2010);
- expanded recommendation on HPV vaccine (January 8, 2011);
- expanded recommendation on influenza vaccines for all adults age 19 to 49 (March 2, 2011);
- expanded recommendation on the pneumococcal vaccine (March 12, 2011);
- new recommendation related to combination measles, mumps, rubella, and varicella vaccine (May 7, 2011); and
- new recommendations on heritable disorders in newborns and children (May, 21, 2011).

Calendar year plans will need to be in compliance with the coverage items listed above beginning January 1, 2012. Plan sponsors should confirm with their third-party administrators that coverage will be provided without cost-sharing in accordance with the new recommendations. Also, note that coverage for the following preventive care for women must be provided without cost-sharing beginning in the first plan year that begins on or after August 1, 2012 (January 1, 2013 for calendar year plans):

- contraceptive methods and counseling;
- well-women visits;
- screening for gestational diabetes;
- human papillomavirus (HPV) testing;
- counseling for sexually transmitted infections;
- counseling and screening for human immune-deficiency virus (HIV);
- breastfeeding support, supplies and counseling; and

- screening and counseling for interpersonal and domestic violence.

For more information about the preventive items and services that must be covered, visit http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Claims, Appeals and External Reviews

The enforcement grace period for the internal claims and appeals and external review required under health care reform was extended only until plan years beginning on or after January 1, 2012. Therefore, plan sponsors will need to ensure that the appropriate arrangements have been taken for their plan to comply with such requirements, including updating existing summary plan descriptions to describe the new internal claims and appeals and external review procedures. If its summary plan description had been previously updated to reflect the new requirements, the plan sponsor should confirm that it reflects the interim final regulations issued in July 2010, as subsequently amended this past June. Click here to review our earlier Client Alert summarizing the amended regulations.

Note that the amended appeals regulations require that a plan sending a notice to an address in a county in which at least 10% of its population is literate only in the same non-English language (based on data maintained by the U.S. Census Bureau) must:

- include a one-sentence statement in the English versions of all notices prominently displayed in the non-English language clearly indicating how to access the language services provided by the plan (sample language appears in the DOL model notice of adverse benefit determination, which is available at http://www.dol.gov/ebsa/IABDModelNotice2.doc);
- provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language and providing assistance with filing claims and appeals (including external review) in the non-English language; and
- provide, upon request, a notice in any applicable non-English language.

The preamble of the amended appeals regulations (http://www.gpo.gov/fdsys/pkg/FR-2011-06-24/pdf/2011-15890.pdf) includes a chart of 255 counties in the United States and Puerto Rico that currently meet the 10% threshold. This information will be updated annually and posted on the websites of the U.S. Departments of Labor and Health and Human Services.

If your group health plan will be losing its grandfathered status in the upcoming plan year, click here to review our previous Client Alert on the PPACA mandates for non-grandfathered plans.

Existing Notice Requirements

Below is a list of enrollment and annual notices that group health plan sponsors should consider during open enrollment.

Enrollment Notices

- *COBRA Notice.* Plan administrators must provide a written initial COBRA notice to each employee and his or her spouse when group health plan coverage first commences of his or her rights under

the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"). Additionally, plan administrators must provide a COBRA election notice to each qualified beneficiary of his or her right to elect continuing coverage under the plan upon the occurrence of a qualifying event. Each of these notices must contain specific information, and the Department of Labor has issued model notices.

- *HIPAA Privacy Notice.* If the group health plan is required to maintain a notice of privacy practices under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the notice must be distributed upon an individual's enrollment in the plan. Notice of availability to receive another copy must be given every three years. Plan sponsors should confirm that the notices of privacy practices for their group health plans have been revised to reflect the requirements under Subtitle D of the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"). Following a material modification, which includes any change required pursuant to HITECH, the revised notice of privacy practices must be distributed to plan participants within 60 days after the change to the notice.
- *Special Enrollment Rights.* A group health plan must provide each employee who is eligible to enroll with a notice of his or her HIPAA special enrollment rights at or prior to the time of enrollment. Among other things, this notice must describe the recently enacted rights afforded under the Children's Health Insurance Program Reauthorization Act.
- *Pre-existing Condition Exclusion Notice.* If the plan contains pre-existing condition exclusions, subject to the PPACA limitations, a notice describing the exclusions and how prior creditable coverage can reduce the exclusion period must be provided to participants as part of any written enrollment materials. If there are no written enrollment materials, the notice must be provided as soon as possible after a participant's request for enrollment.

Annual Notice Requirements

The following notices must be provided to participants and beneficiaries each year. An employer may choose to include these notices in the plan's annual open enrollment materials.

- *Women's Health and Cancer Rights Act Notice.* The Women's Health and Cancer Rights Act requires that a notice be sent to all participants describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy. This notice must be given to plan participants upon enrollment and then annually thereafter. The Department of Labor has developed model language to fulfill this requirement.
- *Medicare Part D Notice.* Group health plans providing prescription drug coverage must provide a notice to any individual covered by or eligible for the group health plan who is eligible for Medicare (an "eligible individual"). The notice must explain whether the plan's prescription drug coverage is creditable. Coverage is creditable if it is actuarially equivalent to coverage available under the standard Medicare Part D program. In order to satisfy the distribution timing requirements, the notice is generally distributed upon an individual's enrollment in the plan, each year during open enrollment (before the new enrollment commencement date of October 15) and during the plan year if the status of the coverage changes (either for the plan as a whole or for the individual).

Model notices are available from the Centers for Medicare and Medicaid at https://www.cms.gov/CreditableCoverage/Model%20Notice%20Letters.asp#TopOfPage.

- *CHIP Premium Assistance Notice.* Employers must also provide notices annually to employees regarding available State premium assistance programs that can help pay for coverage under the plan and how to apply for it. A model notice from the Department of Labor is available at http://www.dol.gov/ebsa/chipmodelnotice.doc.

ERISA's General Notice Requirement

It is important to keep current with ERISA's general notice requirements, as to both timing and content. For example, changes in plan design must be reflected in SMMs or updated SPDs timely distributed to eligible employees. If a plan change involves a material reduction in covered services or benefits, an SMM or an updated SPD must be furnished within 60 days after adoption of the change. Note that this obligation is independent of the PPACA requirement to issue an SMM at least 60 days before a modification to a summary of benefits becomes effective (see Section I); however, satisfaction of the PPACA requirement will satisfy this requirement with respect to the such changes. Restated SPDs must be furnished every five years if the plan has been amended within five years of publication of the most recent SPD, and every ten years if the information has not been changed. Open enrollment may present the best time to distribute these materials.

* * * * *

If you have any questions regarding anything discussed in this Alert, the attorneys and other professionals of the Employee Benefits and Executive Compensation group of Bryan Cave LLP are available to answer your questions.

Richard (Rick) L. Arenburg	(404) 572-6765	richard.arenburg@bryancave.com
Brian W. Berglund	(314) 259-2445	bwberglund@bryancave.com
Harold G. Blatt	(314) 259-2216	hgblatt@bryancave.com
Armin G. Brecher	(404) 572-6634	armin.brecher@bryancave.com
Bard Brockman	(404) 572-4507	bard.brockman@bryancave.com
Carrie E. Byrnes	(312) 602-5063	carrie.byrnes@bryancave.com
Paul F. Concannon	(404) 572-6856	paul.concannon@bryancave.com
Edmund (Ed) Emerson	(404) 572-6739	edmund.emerson@bryancave.com
Jennifer Faucett	(404) 572-4516	jennifer.faucett@bryancave.com
Kyle P. Flaherty	(212) 541-2134	kpflaherty@bryancave.com
Mark H. Goran	(314) 259-2686	mhgoran@bryancave.com
Carrie E. Herrick	(314) 259-2212	carrie.herrick@bryancave.com
Rebecca Holdredge	(314) 259-2042	rebecca.holdredge@bryancave.com
Jonathan Hull	(314) 259-2359	jthull@bryancave.com
Charles B. Jellinek	(314) 259-2138	cbjellinek@bryancave.com
Michele L. Lux	(314) 259-2519	mllux@bryancave.com
Hal B. Morgan	(314) 259-2511	hbmorgan@bryancave.com
Dan O'Keefe	(314) 259-2179	dmokeefe@bryancave.com
Christian Poland	(312) 602-5085	christian.poland@bryancave.com
Jeffrey S. Russell	(314) 259-2725	jsrussell@bryancave.com
Christopher (Chris) Rylands	(404) 572-6657	chris.rylands@bryancave.com
Steven G. (Steve) Schaffer	(404) 572-6830	steven.schaffer@bryancave.com
Kathleen R. Sherby	(314) 259-2224	krsherby@bryancave.com
Sarah Roe Sise	(314) 259-2741	srsise@bryancave.com
Michael Corey Slagle	(214) 721-8031	corey.slagle@bryancave.com
Alan H. Solarz	(212) 541-2075	ahsolarz@bryancave.com
Jennifer W. Stokes	(314) 259-2671	jennifer.stokes@bryancave.com
Lisa A. Van Fleet	(314) 259-2326	lavanfleet@bryancave.com
Tom Wack	(314) 259-2182	tewack@bryancave.com
Julie A. Wagner	(314) 259-2637	jawagner@bryancave.com
Jay P. Warren	(212) 541-2110	jpwarren@bryancave.com
Carolyn Wolff	(314) 259-2206	carolyn.wolff@bryancave.com
Serena F. Yee	(314) 259-2372	sfyee@bryancave.com

Follow @ERISABryanCave on Twitter.