

New Benefit Disclosures and Employee Notification Requirements

With the enactment of the *Patient Protection and Affordable Care Act* (PPACA) and the *Health Care and Education Reconciliation Act of 2010* (a.k.a. health care reform) comes additional obligations for employers who offer health care benefits to their employees. Beginning in 2010 and continuing at least through 2014, employers will need to enhance their existing employee benefit communication strategy to incorporate a series of new employee notification requirements. Final regulatory guidance regarding the new notification requirements has not yet been issued for most of the new notices, but it is expected by spring 2011.

To ensure compliance with the new laws, employers should work with their benefits consultants to understand the new notice requirements, their timing, and their impact on existing employee communication materials and strategies. Here are some highlights of what will be expected of employers offering health benefits.

Key employee notice requirements

- **Notice of grandfathered health plan status**—[Grandfathered plans](#) (those health plans in existence on March 23, 2010) must notify their participants that their plan is a grandfathered health plan, as provided under the PPACA. In addition, these plans must include a statement describing the health plan benefits and contact information for questions or complaints, as part of any plan materials provided to participants. [Model language](#) has been provided in the regulations.
- **Notice of key plan design changes**—Employees must be notified of benefit changes that take effect January 1, 2011, including changes to: annual and lifetime benefit limits, revised eligibility for dependent coverage of adult children, the primary care physician designation, and OB/GYN self referral. The Department of Labor (DOL) has issued model notices to assist employers with developing their employee communications pertaining to these changes. The model notices are located on the DOL's website at www.dol.gov/ebsa as follows:
 - [Annual and lifetime limit changes](#)
 - [Revised eligibility for dependent coverage of adult children](#)
 - [Primary care physician designation and OB/GYN self-referral change](#)
- **Summary of medical benefits**—Starting March 23, 2012, employers, including those offering grandfathered plans, must provide employees with a four-page, user-friendly summary of medical benefits and coverage. This summary must identify the core terms and conditions of coverage written in language the Department of Health and Human Services (HHS) defines to be “linguistically” and “culturally” appropriate. HHS is expected to issue more guidance on the specific requirements in March 2011. Employers should plan to follow up with their insurance provider or third party administrator to determine who will be handling the content and distribution of this information.
- **Summary of material changes**—Effective on or before March 23, 2012, employers who make changes to their health plans will need to provide employees a written summary of those changes 60 days prior to the beginning of their plan year. This will impact the annual enrollment process, timing and materials, in addition to the ability to make plan design changes closer to year-end. HHS is expected to provide further guidance by March 2011. It is unclear under current guidance if the summary of material changes will replace the summary of material modification required under the Employee Retirement Income Security Act of 1974 (ERISA).
- **Summary of plan care management programs**—Effective on or before March 23, 2012, employers will need to notify participants of all care management programs available under the employer's self-insured and fully

insured health plans. HHS is expected to issue more guidance in March 2011 regarding the specific requirements.

- ***Notice of eligibility for health insurance exchange***—Beginning on or after March 1, 2013, employers must notify all employees of: the availability of the new state insurance exchanges, the eligibility criteria for subsidies to purchase insurance through the exchange, and the effect of purchasing coverage through an exchange using employer contributions. States will start establishing their exchanges in 2013 in order for everyone to comply with the individual mandate for all Americans to have minimum essential health insurance coverage by January 1, 2014. HHS is expected to issue further guidance and a model notice.
- ***Notice of automatic enrollment***—Beginning sometime after January 1, 2011, pending further regulatory guidance, employers with more than 200 full-time employees will be required to automatically enroll all new full-time employees and continue enrollment for existing employees in the employer-sponsored medical coverage, unless the employee affirmatively elects to waive coverage. Until regulations are issued on this provision, it is unclear what plan an employer must enroll the employee into if the employer offers multiple plan options. Additionally, it is unclear whether the auto-enrollment would also apply to an employee's family. Notice to employees regarding automatic enrollment and their right to opt out will be required.

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