

# Health Care Reform Update

## New Notice Requirements

Health care reform imposes a number of new notices requirements on group health plans.

### **COVERAGE FOR CHILDREN UP TO AGE 26**

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The plan and the carrier must provide written notice of the opportunity to enroll regardless of whether the plan offers an open enrollment period.

The enrollment period must be at least 30 days. The opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. The coverage is effective no later than the first plan year beginning on or after September 23, 2010. *Note: It is unclear whether allowing retroactive coverage poses a cafeteria plan problem. To be safe, if the employer has a cafeteria plan, it should provide the notice and opportunity in advance so that the election will be made prior to the effective date of coverage.*

The written notice must include a statement that children 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 the plan or coverage.

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].**

For plan years beginning before January 1, 2014, a grandfathered plan may exclude an adult child eligible to enroll in another group health plan (other than of his parent). While the government has not issued a separate sample notice for grandfathered plans, it would appear the notice could be revised as follows:

**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] provided they are not eligible to enroll in another group health plan (other than of their parents). 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].**

The notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent.

The notice may be provided to an employee on behalf of the employee's child.

## PROHIBITION ON LIFETIME LIMITATIONS

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If an individual is eligible for benefits under the group health plan, the plan and the carrier are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan, effective not later than the first day of the first plan year beginning on or after September 23, 2010.

Additionally, if the individual is not enrolled in the plan, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and carrier must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

*Note: It is unclear whether allowing retroactive coverage poses a cafeteria plan problem. To be safe, if the employer has a cafeteria plan, it should provide the notice and opportunity in advance so that the election will be made prior to the effective date of coverage.*

Model notice:

**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].**

The notices may be provided to an employee on behalf of the employee's dependent.

The notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent.

## PATIENT PROTECTIONS

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If a non-grandfathered group health plan requires the designation by a participant or beneficiary of a primary care provider, the plan or carrier must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights:

- that any participating primary care provider who is available to accept the participant or beneficiary can be designated;
- with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and
- that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

Model language:

For plans that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

**[Name of group health plan or health insurance carrier] 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 designates a primary care provider automatically, insert:

**Until you make this designation, [name of group health plan or carrier] 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 carrier] at [insert contact information].**

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

**You do not need prior authorization from [name of group health plan or carrier] 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 carrier] at [insert contact information].**

The notice must be included whenever the plan or carrier provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.

## **GRANDFATHERED PLANS**

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To maintain status as a grandfathered health plan, a plan or health insurance coverage (1) must include a statement in any plan materials provided to a participant describing the benefits provided under the plan that the plan believes it is a grandfathered health plan and (2) must provide contact information for questions and complaints.

Model language:

**This [group health plan or health insurance carrier] 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.**

**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](http://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 <http://www.healthcare.gov/>.]**

## **PROHIBITION ON RESCISSIONS**

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A group health plan must not rescind coverage under the plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan.

A rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. A cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective (i.e., future) effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

A group health plan or a carrier must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the coverage is insured or self-insured or whether the rescission applies to an entire group or only to an individual within the group.

## **APPEALS PROCESS**

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A new Federal review process generally applies to non-grandfathered, self-funded plans. Fully insured plans non-grandfathered plans are subject to a State external review process.

The following model notices are available:

- A notice of adverse benefit determination (<http://www.dol.gov/ebsa/IABDModelNotice2.doc>);
- A notice of final internal adverse benefit determination (<http://www.dol.gov/ebsa/IABDModelNotice1.doc>); and
- A notice of final external review decision (<http://www.dol.gov/ebsa/IABDModelNotice3.doc>).

These notices are also available at: <http://www.hhs.gov/ociio/regulations/consumerappeals/>.

Model language for the description of the internal claims and appeals and external review procedures in the summary plan description provided to participants and beneficiaries will be posted on the DOL and HHS websites in the future.

A group health plan and carrier must provide the notices in a culturally and linguistically appropriate manner as follows:

- For a plan that covers 100 or more participants at the beginning of a plan year, the plan and carrier must provide notices upon request in a non-English language in which the lesser of 500 or more participants, or 10 percent or more of all plan participants, are literate only in the same non-English language.
- For a plan that covers fewer than 100 participants at the beginning of a plan year, the plan and carrier must provide notices upon request in a non-English language in which 25 percent or more of all plan participants are literate only in the same non-English language. The plan must also:
  - include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language;
  - once a request has been made by a claimant, provide all subsequent notices to the claimant in the non-English language; and
  - to the extent the plan or carrier maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or carrier must provide such assistance in the non-English language.

## **OTHER REQUIRED NOTICES**

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Employers will need to provide to employees a uniform explanation of coverage (2012) and information on the existence of the Exchange (2013) and provide the IRS and employees with information regarding coverage (2014). Additional information will provided at a later date.

## **ACTION ITEMS**

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- Work with your carriers and third-party administrators to ensure notices are contained in appropriate plan materials; and
- Continue to monitor guidance as it becomes available.



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