

Model Notices



GENERAL RULES

2.1 TIMETABLE

Applicable Model Notices should go out to employees for the renewal on or after September 23, 2010. (See notes about grandfathered plans.)

2.2 WHICH PLANS

This applies to group health plans of all sizes, fully insured or self-funded, but not dental or vision plans. (This review does not include the issue of notifying employees within 60 days of a material plan change or required language for explaining the plans.)

2.3 GRANDFATHERED PLANS

Grandfathered plans can avoid some of the Model Notice language but care needs to be taken in case the health plan makes across the board changes, regardless of grandfathered status.

2.4 NON-GRANDFATHERED PLANS

The federal Model Notice language presumes that the health plan is not grandfathered.

Updated Model Notices From Those Produced by the Federal Government

“Figuring out what information is required to go out to employees a bit complicated.”

Part of healthcare reform administration is the proper notification of specified changes. This review looks only at those provisions where the federal government has issued a Model Notice. It does not include the communication requirements under the healthcare reform legislation such as the 60-day advance notice requirement or the language on how the medical plans must be described, where no Model Notice or language has been issued and which have different timetables.

The purpose of a Model Notice is to either inform the plan member of [1] an open enrollment period (i.e., eligible dependents under age 26 or those who have previously met their lifetime limit) or [2] a plan change as required under health care reform (i.e., ability to select Primary Care Physicians) or the Plan Sponsor’s decision to elect grandfathered status for the plan. Care must be taken to be sure the health plan’s changes are actually in keeping with

what is explained in the Model Notice.

In the case of the open enrollment option, the member must be informed of his or her option within 30 days to elect coverage. While the Model Notice language gives the member 30 days from the date of the Notice to elect coverage, the health plans will likely be more lenient, perhaps giving the member until the 30th day after the plan renewal to elect coverage.

State and Local Issues

Sometimes federal laws duplicate state and local laws, so the change, if any, is minor. The federal language for the Primary Care Physicians is not clear on how it differs from the general HMO plans in California already, such as the ability for a woman to see an OB-GYN directly without a referral from a Primary Care Physician.

The following language is from the federal government, as modified in red.

Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010. [Note: the model language does not include the provision for grandfathered plans that allows the Plan Sponsor not to accept those under age 26 who are eligible to enroll in employer-sponsored group health coverage. That language has been added in italics.]

The following model language can be used to satisfy the notice requirement:

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]. *Note: for grandfathered plans, dependents under age 26 are not eligible for coverage beyond the prior limits if they are eligible for coverage under another employer-sponsored group health plan.*

Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, 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 or issuer 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. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements 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.

The following model language can be used to satisfy the notice requirement:

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].

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. [Note: this does not apply to grandfathered plans, unless the health plan automatically changes its provisions for all plans.]

The following model language can be used to satisfy the notice requirement:

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 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 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].

Model Language for Grandfathered Plans

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

[ERISA BASED PLANS]

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.

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]. 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.

[NON-ERISA BASED PLANS, SUCH AS GOVERNMENTAL PLANS]

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.

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 [\[insert contact information\]](#). You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Note: the above generally applies to health plans outside of a collective bargaining agreement. Contact us if you have questions on health benefits under a collective bargaining agreement.

Keith McNeil 415-493-2476

