

# Summary of HC Reform Employer Notice & Reporting



# Dependent to Age 26

**When:** Health Plan years beginning on or after 9/23/2010.

**Key Details:** Health Plans and issuers that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. Grandfathered plans do not have to offer this coverage until 2014 to children with other employer coverage available to them.

Communication Action	Responsibility	Exception
Provide children who qualify an opportunity to enroll that continues for at least 30 days. This enrollment opportunity must be provided no later than the first day of the first plan or policy year beginning on or after September 23, 2010.	Employer	
Provide written notice of the enrollment opportunity mentioned above no later than the first day of the first plan or policy year beginning on or after September 23, 2010. A model notice and wording can be found at the following link - <a href="#">Click Here</a>	eXude has updated all Open Enrollment benefit packets and information accordingly. Employer must ensure that all employees receive a copy of the Open Enrollment benefits packets or some other written notice including this information.	Grandfathered plans may also include wording requiring disclosure of other coverage available through the child's employer.
Incorporate notification language in all benefits communication materials that mention the age limit.	eXude has updated all Open Enrollment benefit packets and information accordingly. Employer must update all other plan related communications that they create or distribute. Carrier updates vary – see appendix.	

### When:

Lifetime limits on the dollar value of essential benefits are prohibited for plan years beginning September 23, 2010. This applies to all plans both new and grandfathered.

### Key Details:

Require plan sponsors to give a special enrollment notice to individuals who have reached the lifetime limit under the plan and are otherwise still eligible for coverage.

Plans may apply lifetime per-beneficiary limits on any non-essential health benefits. In addition, benefits may be entirely excluded for a condition without being subject to lifetime limit rules. The regulations create special reinstatement rights for people who have reached a lifetime limit. Special enrollees must be offered all benefit packages available to similarly situated people without higher premium or cost share.

Communication Action	Responsibility	Exception
Develop core language based on DOL's sample notice: <a href="#">Click Here</a>	Employer	
Incorporate language into all benefit communications that mention the limits	eXude has updated Open enrollment benefit summaries accordingly. Employer must update all other plan related communications. *Updates by Carrier vary- see appendix.	
Send lifetime notice to people who are eligible for plan benefits again, and offer 30 day enrollment window. The model notice issued by HHS can be found by <a href="#">clicking here</a> .	Employer	

# Grandfather Status

## When:

A “grandfathered plan” is a group health plan that was in existence on the date of enactment of Health Care Reform, March 23, 2010.

## Key Details:

Plan sponsors required to include a statement in any plan materials provided to participants, describing the benefits provided under the plan that are considered grandfathered.  
Plans can lose their grandfather status for several reasons outlined by HHS (see link below)  
Grandfathering rule applies separately to each benefit option.  
Special rules apply to collectively bargained plans. (see link below)

Communication Action	Responsibility	Exception
The HHS has issued model language which can be incorporated into already existing SPDs and other plan documents. To review this model, please <a href="#">Click Here</a>	Employer	
If the plan has lost its grandfathered status or was never grandfathered, disclosure that the plan is <u>not</u> a grandfathered plan is optional. HHS issued interim guidance on what qualifies a plan as Grandfathered, what disqualifies a plan and how collectively bargained plans are affected. For more information please <a href="http://www.healthcare.gov">www.healthcare.gov</a> by <a href="#">clicking here</a>	Employer	



# Patient Protections

### When:

Whenever the plan or issuer provides a participant with a summary plan description or similar description of benefits under the plan or health insurance coverage. It also must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

### Key Details:

Requires plan sponsors and issuers to provide notice to participants of their rights regarding (1) having their choice of a primary care provider (or pediatrician for children) for plans requiring a PCP designation (still must be in network for in network level of benefits) ; (2) the right to obtain obstetrical and gynecological care without prior authorization; (3) the right to emergency services without pre-authorization and without regard to network provider status.

Communication Action	Responsibility	Exception
Develop core language based on DOL's sample notice: <a href="#">Click Here</a>	Employer	This does not apply to grandfathered plans.
Incorporate language into medical benefit communications including summary plan descriptions or similar description of benefits.	eXude has updated Open enrollment benefit summaries accordingly. Employer must update all other plan related communications. *Updates by Carrier vary- see appendix.	

# Update on HRA MSP Reporting

## Who must report?.....

“A Group Health Plan (GHP) organization that must report under Section 111 is defined as ‘an entity serving as an insurer or third party administrator for a group health plan....and, in the case of a group health plan that is self-insured and self administered, a plan administrator or fiduciary.” – these organizations are called Responsible Reporting Entities (RREs)

HRA Plans Included	HRA Plans Excluded
<ul style="list-style-type: none"> <li>• Employer groups with 20 or more lives</li> <li>• Annual Benefit - \$1,000</li> <li>• Single, employee plus spouse or family coverage</li> <li>• Rollover and Carry-over Options</li> </ul>	<ul style="list-style-type: none"> <li>• Employer groups with fewer than 20 lives</li> <li>• Annual Benefit less than \$1,000</li> <li>• Stand-alone HRAs</li> <li>• Limited purpose HRAs</li> </ul>

## WHAT ARE THE NEXT STEPS?

[Click Here](#)

- Employers need to review who is the RRE for each group health plan.
- Employers should ensure that this data is being sent to CMS.
- Register by June 30th
- Begin reporting by October 1st at the earliest



# OTC Limits

## When:

January 1, 2011, regardless of plan year

## Key Details:

- Over the Counter Medicines cannot be reimbursed by Healthcare accounts except with a prescription
  - Applies to FSA, HRA, MSA and HSA Distributions
- OTC medications will not be processed with Debit Cards after 1/1/11, requires Paper Claim
  - Items like Bandages and Thermometers are still reimbursable without rx.
    - More info: [Click Here](#)

Communication Action	Responsibility	Exception
Develop core language & Update SPD's	Employer	
Incorporate language into all benefit communications that mention the limits	eXude has updated Open Enrollment benefit summaries accordingly. Employer must update all other plan related communications.	

- Requires employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. However, to provide employers the time they need to make changes to their payroll systems or procedures in preparation for compliance with this requirement, the IRS will defer the reporting requirement for 2011, making that reporting by employers optional in 2011.
- The revised Form W-2 for 2011 is now available in draft for viewing. This is the W-2 that most employees will receive in early 2012. The draft form includes the codes that employers may use to report the cost of coverage under an employer-sponsored group health plan.

This reporting is for informational purposes only, to show employees the value of their health care benefits so they can be more informed consumers. The amount reported does not affect tax liability, as the value of the employer contribution to health coverage continues to be excludible from an employee's income, and it is not taxable.

- For information, see this [news release](#), [draft form](#) and [guidance](#).



- You must now electronically complete and submit your Forms 5500/5500-SF. For a limited exception for filing 2008 plan year returns/reports prior to October 15, 2010, [see EFAST2 FAQ 4](#). Under the all-electronic EFAST2 system, filers choose between using [EFAST2-approved vendor software](#) or this website (iFile) to prepare and submit the Form 5500 or Form 5500-SF. Completed forms are submitted via the Internet to EFAST2 for processing.
- You may need to [register](#) for an EFAST2 account if you are preparing, signing, or submitting completed Form 5500/5500-SF.
- If you are already registered, [login](#) and go to User Profile to view your PIN and other registration information.



## Summary of Health Care Reform Notices By Carrier



- **Aetna**
- **Small Group (2-50)** – All of the information for these notices will be included in the renewal packet
- **Large Group (50+)**
  - ***Dependent Age Notices and Lifetime Maximum Notices*** – Employer action is required by communicating to the employees during open enrollment meetings and amending plan documents accordingly
  - ***Patient Protection Notices*** – Employer action is required if the plan is not grandfathered. Employer is required to communicate to employees during open enrollment and to amend plan documents.
- Aetna has confirmed that they will not be providing reform notifications to members

# Summary of Health Care Reform Notices By Carrier



- **Independence Blue Cross**
- **Dependent Age Notices**
  - They will be adding a notice in Update Magazine, a post card for Oct & Nov renewal months, and a bill stuffer for individual members.
  - Update Magazines are sent to all members on a quarterly basis to their home address. This magazine also addresses the formulary changes and other changes that may impact members.
  - Employer action is required by communicating to the employees during open enrollment meetings and amending plan documents accordingly
- **Lifetime Maximum Notices**
  - A scan is being run to identify these members and a letter will be developed and mailed.
- **Patient Protection Notices**
  - They will be handling these notices through the annual benefit clarification notice that will go out in late November/ early December.
  - This is part of the benefit booklet, you can find it in Chapter 2.3. The language is also part of the new Blue Solutions benefit summaries on line.

# Summary of Health Care Reform Notices By Carrier



- **United Healthcare**
- UHC will not be responsible for sending out notices to groups.
- This includes dependent age, lifetime maximum and patient protection notices.
- **Lifetime Maximums** are listed on [www.myuhc.com](http://www.myuhc.com) for each individual member. Under the “View My Claims” section, a member can see how much of their lifetime maximum they have used.
- **Patient Protection Notices** will 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 insurance coverage.