2015 Enrollment Communications – Notices Checklist

As of June 26, 2014 –

Note:
"This *2015 Enrollment Communications – Notices Checklist* describes notices applicable to group health plans that should be, or could be included for expediency, with enrollment communications. It is not intended to provide a detailed discussion of all of the rules governing the content or the distribution of these notices. As with all matters involving legal interpretation, plan sponsors should rely on their attorneys for legal advice on questions of specific application to their plans."

Major sections in this checklist document (with changes from 2014 enrollment noted):

- ***Required* in Enrollment Communications**
  - Summary of Benefits and Coverage (SBC) template
- ***May Want to Include* in Enrollment Communications**
  - **NEW:** Dependent Social Security Number Solicitation: The ACA will require employers to report SSNs for all individuals covered by their medical plans, including spouses and children. To avoid potential penalties for failing to provide SSNs, the employer must reach out to employees to request this information at least three times. Annual enrollment provides a good opportunity for employers with many missing SSNs to complete one of the "three times."
  - **Discontinued only for Fall enrollment for actives:** Health Insurance Marketplace Coverage notice **–** it was to be provided to all current employees (regardless of benefit eligibility) by October 1, 2013 and after that date, must just be provided to all new hires.
- ***Additional Considerations* for 2015 Open Enrollment (ACA-related and other)**
- **Summary of Benefits and Coverage (SBC) Highlights**

Quick highlights on **electronic delivery requirements:**

- Generally, the same standards apply to the delivery of the "required" notices that apply to the electronic delivery of SPDs. Per DOL e-SPD rules, to provide without prior consent, employees' access to the sponsor's electronic information must be an integral part of their employment duties.
- That means that for employees with the necessary access, **the documents can be posted online (with a paper copy available upon request) as long as they are "furnished" in a manner that ensures receipt**—simply posting them without any other action is not sufficient.

To satisfy DOL requirements (or the requirements of other agencies, such as CMS, that have adopted the DOL standards for their notices), the plan sponsor must provide a notice to employees (either electronically or on paper) *at the time the information is posted*, directing them to the website. The notice should tell participants what has been posted, the significance of the document, and the right to request a paper copy of the document. Recommended steps to ensure receipt include providing a link to the document in an email, or adding a prominent link from the website's home page to the separate section containing the document. In lieu of posting on the Company website, the document could also be attached to the email.

***Required* in Enrollment Communications**		
Notice	**Special Notes**	
Summary of Benefits and Coverage (SBC)	• For open enrollment periods, must provide "at same time as open enrollment materials." • For those enrolling other than during open enrollment (e.g., new hires and HIPAA special enrollees), see S*pecial Notes* on page 8.	
Notice of HIPAA Special Enrollment Rights	Two prototype versions are provided – longer and shorter • Longer version provides additional information (e.g., describes "loss of eligibility"). • Shorter version follows a model notice in the regulations; is legally OK.	
Women's Health and Cancer Rights Act Notice	• A continued annual requirement, so makes sense to include in enrollment materials.	
CHIPRA Notice	• Notice must be provided for the states in which employees reside, so the comprehensive state-by-state listing here isn't required in full and could be reduced to just the applicable states. (But larger employers typically use the full notice.) • The prototype notice provided is current as of **1/31/2014**; it expires as **of 10/31/2016**; **always** check most recent listing at www.**dol**.gov/ebsa/**chipmodelnotice**.doc. • **Note** that in addition to updates to some states' contact information, **the current version has a different title and some different introductory wording** in comparison to last year's model notice. So, if you previously used the 1/31/2014 version, you should visit the website to see the new version and insert the additional language. • **Must be provided as a separate document**, not as part of enrollment guide/newsletter text (but can be distributed *with* other materials, such as part of enrollment packet).	

Notice of Creditable Coverage *(only if plan Rx coverage is creditable)*	***Note:*** Not actually required for NoCCs to be sent ***with*** enrollment materials, but it may be most cost-efficient to do so. • **Notices must be provided prior to October 15** (unless notices were distributed within the 12 months prior to October 15). Note that October 15, 2014 is a Sunday. • Medicare Part D enrollment begins October 15. • If included with other documents, the notice (or a reference to the section of the document with the notice), must be in ***14-pt font in a separate box, bolded or offset on the first page of the document***: **"If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page xx for more details."** • Should add language on what happens if a Medicare-eligible employee drops employer Rx coverage – generally, they can re-enroll in employer plan on the same basis as actives. (For retirees, it's up to the employer's plan provisions.) *Any such language developed should be reviewed by client's counsel.* • If you are providing the Part D Creditable Coverage Notices electronically, include a statement in the accompanying explanatory text advising participants that **they are responsible for providing a copy of the disclosure to Medicare-eligible family members**.	
Notice of Non-Creditable Coverage *(only if plan Rx coverage is non-creditable)*	See special considerations for Creditable Coverage above. Again, not required to be distributed with enrollment materials but it may make sense to do so.	
Notice of Grandfathered Status *(only if plan **is grandfathered** under Health Care Reform)*	Must be included with any description of plan benefits.	
Patient Protection Notice *(only if plan **is not grandfathered** under Health Care Reform)*	This notice is required only when a plan permits or requires a participant to designate a primary care physician/pediatrician, or select an OB/Gyn.	
Wellness Incentives: Notice of Availability of	This notice is required only when materials (including communications other than enrollment materials) describe **the terms** of the wellness program; it is not required if the	

Reasonable Alternative Standard – *only for wellness programs with rewards/penalties based on health standard (e.g., nonsmoker, BMI) or completion of a physical activity such as participating in a walking program*	materials only mention the program. • Must disclose that a reasonable alternative standard is available. • Must include contact information for obtaining a reasonable alternative standard. • Must include a statement that the recommendations of an individual's physician will be accommodated. • Not required to use verbatim; may use substantially similar language. Sample: ***"Model" language:*** "Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If it is unreasonably difficult due to a medical condition for you to meet a standard for a reward under this wellness program, or if it is medically inadvisable for you to attempt to achieve the standards for a reward under this program, contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to develop another way to qualify for the reward."	
***May Want to Include* in Enrollment Communications**		
Notice	**Special Considerations**	
Dependent SSN Request	Please note that each client's circumstances will be different – this sample has nuances to accommodate a specific client's situation, so was not designed as an "all-purpose" letter. Client should obtain a compliance review of any text developed. (See page 7 for more detail.)	
Notice of HIPAA Privacy Practices (or shorter Notice of Availability of HIPAA Privacy Practices)	***Background:*** Usually, plan sponsors are required to provide a short version (notice of availability) to current enrollees at least once every ***three*** years; including it in enrollment materials normally satisfies this requirement. New enrollees would get the long version.	

***Additional Considerations* for 2015 Open Enrollment (ACA-related and other)**	
Topic	**Special Considerations**
Individual coverage mandate	• Employees must maintain Minimum Essential Coverage (MEC) for themselves and dependents, or pay a tax penalty • For lower-paid employees, address subsidies for Health Insurance Marketplace coverage.
Full-time (30 hours scheduled per week) coverage requirement	Note: The delay in the Shared Responsibility requirement (and employer penalty) may have caused some employers to delay changing hours requirements. If they do make changes going forward… • Address any 2015 changes from current eligibility rules; if any current participants will lose coverage (for example, if the employer changes eligibility requirements), address the individual mandate and availability of Marketplace coverage during the 2015 open enrollment period: Nov. 15, 2014 – Feb. 15, 2015. For more information on the marketplace, direct employees to healthcare.gov.
Health Insurance Marketplace Coverage Notices – *now required only for new hires*	These notices about the Marketplace for individual coverage were required to be distributed by October 1, 2013 for then-active employees and since then, at the time of hire. During 2014, a notice provided within 14 days of a new employee's start date is considered "provided at time of hire." • Beginning in 2015, employers must provide a notice to all new employees – regardless of plan enrollment status, full-time or part-time status or benefit eligibility. • Two notices are available —one for use by employers that provide health coverage to some or all employees, and one for employers who do not provide any health coverage. • Notice may be provided by first-class mail OR – if it meets DOL electronic disclosure safe harbor requirements (see page 1) – electronically.
Change in FSA "use it or lose it" rule	Employers whose health care FSAs **do not have grace periods** are permitted (but not required) to allow up to $500 in unused year-end balances to carry over for use in the next plan year. For employers who will offer this new FSA plan feature in 2015, this change needs to be communicated. Along these lines, note that employers whose health care FSAs currently have a grace period may amend their plans to remove the grace period and permit the carryover. **This change also needs to be communicated.** Note that the elimination of the grace period may be considered a material reduction in benefits and possibly should be communicated as an SMM. **Note for employers who also offer HSAs:** They will have a choice in how to handle employees with 2014 year-end FSA balances who enroll in a 2015 HDHP plan with an HSA. Someone cannot contribute to an HSA and have a general purpose FSA in the same year. Employers may: • Give the employee the option to have the 2014 carryover go into a 2015 limited purpose FSA • Automatically roll over the carryover into a 2015 limited purpose FSA, or • At 2015 enrollment, give the employee the option to waive any FSA carryover amounts to 2015. It will be important to determine how the employer will handle these employees.
Tobacco-use cessation coverage as part of preventive care mandate	These group health plans are required to provide benefits, without cost-sharing, for certain preventive services, including tobacco cessation intervention. Plans will be considered in compliance with the requirement if they meet certain guidelines or approaches. The DOL suggests that plans refer to evidence-based clinical practice guidelines, and as example of an

Additional Considerations for 2015 Open Enrollment (ACA-related and other)	
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(non-grandfathered plans)	approach that MAY be used, provides this guideline:
	
	Covering without cost-sharing:
	• Screening for tobacco use, and
	• For those who use tobacco products, at least two tobacco-cessation attempts per year. Coverage for a cessation attempt includes:
	  ○ Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone, group and individual counseling) without prior authorization, and
	  ○ All FDA-approved tobacco cessation medications (including both Rx and OTC medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Change in annual out-of-pocket cost limits and rules (non-grandfathered plans)	• In 2015, these limits will rise to $6,600 for self-only coverage (currently, $6,350) and $13,200 for other levels of coverage (currently, $12,700). • In-network cost-sharing (copays, coinsurance and deductibles) needs to count toward the in-network out-of-pocket maximum.
Health reimbursement accounts (HRAs) for pre-65 retirees	For retiree-only HRAs, include this language: **Retiree-only HRAs and impact on marketplace subsidy eligibility** If you are covered by a retiree-only health reimbursement account (HRA), which is considered employer-provided minimum essential coverage, you are ineligible for Health Insurance Marketplace premium and cost-sharing subsidies, even if you do not use the HRA funds to purchase coverage in the marketplace. If you are given the option to decline HRA coverage, and you do so, you may be eligible for Health Insurance Marketplace subsidies, depending on your income.
Revised COBRA general notices	While COBRA notices are not normally part of annual enrollment communications, it's important to note for future reference that both the COBRA general notice and election notice templates have been revised to reflect the availability of Health Insurance Marketplace coverage (and premium tax credits) as an option to COBRA (even though there are some reasons for employees to prefer COBRA). See Buck's 6/3/2014 FYI, "DOL updates model COBRA notices to highlight marketplace options," for more details. (*COBRA general notice description continues on page 7.)* Employers may want to provide some additional information to employees. **General notices** are to be provided to covered employees and their covered spouses, generally within 90 days of the date

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	on which coverage begins.
Dependent SSN requests	For IRS reporting purposes, employers now must have SSNs for all covered individuals, including spouses and children. To meet ACA requirements **and avoid a penalty**, the employer must reach out to employees to request this information at least three times: • When the dependent is first enrolled in coverage*, • *If the SSN is not provided*, by December 31 of the year of enrollment (or for December enrollments, by January 31 of the following year), and • *If after these steps, the SSN is not provided,* by December 31 of the following year. *need to correlate what 's happening with employees/dependents already enrolled Annual enrollment provides a good opportunity for employers with many missing SSNs to complete one of the "three times." Note that New Hire enrollment materials should already be requiring dependent SSNs.

Summary of Benefits and Coverage (SBC) Highlights	
Special Notes	**Comments**

• SBC must "accurately describe the benefits and coverage under the applicable plan." It must be provided to all "participants and beneficiaries."
• It must be on 8 ½" by 11" paper, in 12-point font, in the template's prescribed format and prescribed language.
• May have to provide in Spanish, Chinese, Navajo or Tagalog upon request to participants who live in county where at least 10% of residents literate only in that language. English version must include a one-sentence statement clearly indicating how to access the language services provided by the plan. (See right.)
• Information for different coverage tiers (self-only, employee-plus-one, family) can be combined on one SBC. If so, then the coverage example should be for self-only coverage and clearly indicate the applicable tier.
• Different levels of cost-sharing can be combined in a single SBC.
• The impact of HRAs, HSAs, FSAs and wellness programs can be reflected in a single SBC.
• Examples of permitted minor SBC format adjustments (the full SBC for each benefit option still must be provided as required):
  ○ Expansion of columns to accommodate an electronic display method,
  ○ Placing the SBC on a single webpage so viewers can scroll through the information,
  ○ May display SBCs, or parts of an SBC, in a way that makes it easier to compare various benefit options, such as allowing viewers to compare only deductibles, out-of-pocket limits, or other features.
• Electronic distribution rules:
  ○ For individuals who are ***eligible for a plan but not yet enrolled***, SBCs may be provided electronically as long as the SBCs are readily accessible. The plan must also advise the individuals in paper form or by email how to obtain the SBC.
  ○ For individuals ***already covered under a plan***, SBCs may be distributed electronically only to employees whose *access to the sponsor's electronic information system is an integral part of their employment duties* (consistent with DOL rules for e-SPDs); otherwise, prior consent to electronic distribution would have to be obtained.
• The SBCs must be provided to participants and beneficiaries at the following times:
  ○ ***Initial enrollment:*** An SBC for ***each*** benefit package option for which the participant is newly eligible must be included in any distribution of enrollment materials. If written materials are not provided, the SBC must be furnished no later than the first date the individual is eligible to enroll in coverage. An updated SBC must be provided by the first day of coverage if any information in the SBC changes.
	CMS maintains a website listing all U.S. counties which met or exceeded the 10% threshold for providing notices in a culturally and linguistically appropriate manner, for 2013*: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2013-clas-data.pdf
	
	*This is the latest CMS data available as of June 26, 2014; DOL states that until further guidance is issued, current SBC templates and documents are to be used. (If this listing is updated, an updated checklist will be distributed.)
	Written translations (in Spanish, Chinese, Navajo and Tagalog) of the current SBC template and uniform glossary are available on the HHS website. SBC template: http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html , scroll down to "Summary of Benefits and Coverage and Uniform Glossary." For SBCs, click on the file name that includes "second year of applicability" in parentheses.

Summary of Benefits and Coverage (SBC) Highlights	
Special Notes	**Comments**
○ ***Open enrollment:*** An SBC for the benefit package option in which the participant is enrolled must be provided. If the participant must make an active election for coverage for the next plan year, or is provided an opportunity to change coverage options during open enrollment, the SBC must be provided at the same time as open enrollment materials. See "on request" below. ○ ***Automatic enrollment:*** If the participant does not have to enroll and *has no opportunity* to change coverage, the SBC must be provided no later than 30 days prior to the first day of the new plan year. ○ ***HIPAA special enrollment:*** An SBC for the benefit package option in which a special enrollee selects must be provided no later than 90 days after enrollment. However, individuals who have not yet enrolled may request an SBC for any benefit package option at any time. These SBCs must be furnished as described below. ○ ***On request:*** An SBC must be provided as soon as practical, but no more than seven business days after the request. In this context, "provided" means when the SBC was sent and not when it is received by the participant. This includes SBCs for options in which the participant is not enrolled, if requested during open enrollment.	**Language Access Services** (sample translations of "To obtain assistance in [language]") • Español: Para obtener asistencia en Español, llame al xxx-xxx-xxxx. • Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa xxx-xxx-xxxx. • 中文: 如果需要中文的帮助, 请拨打这个号码 xxx-xxx-xxxx • Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' xxx-xxx-xxxx.
Uniform Glossary	
• This document is a companion to the SBC. A paper copy must be available on request. • Must be provided to participants and beneficiaries within seven business days *of request.* • May provide the website where participant or beneficiary may review and obtain it (may provide the plan sponsor, HHS or DOL Internet address). • Employers are advised to use it "as is" without any changes. • In addition to the English version of the glossary available at the link at right, versions also are available in Chinese, Navajo, Spanish and Tagalog. See the link toward the bottom of page 8.	The uniform glossary: http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf