

Key notification and communication requirements in health care reform

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You've likely been focusing mostly on the plan design and administration requirements of health care reform. But, the law has a series of new notification and communication requirements that start this year and extend over the next several years.

You'll need to be thinking not only about the strategic communication needs—how to keep employees engaged in their health and managing costs—but also how to meet these legal requirements in a way that adds the most value. (And, creates the least amount of additional work for you and your team.)

Much is still in flux about the changes in health care, but this article captures the key notification requirements and what to look for as regulations are issued.

Seven health care reform notices

The final regulations detailing the exact disclosure requirements for all regulations are not yet out. But here are seven items that should be on your radar for your benefits communication strategy.

- Notice of key plan design changes effective 1/1/11 (during this fall's enrollment for most companies)
- Summary of material changes (2012)
- Summary of medical coverage (2012)
- Description of all disease management programs (2012)
- Automatic medical enrollment and opt-out actions (TBD—likely 2013)
- Notification of exchanges and “free choice vouchers” (2013)
- Description of claims process (TBD)

1. Notice of key plan design changes—this summer

The DOL has issued some sample language in at least three areas that take effect, for most employers, on Jan. 1, 2011: [Annual and lifetime limit changes](#), [Revised dependent eligibility for older kids](#) and [Primary care physician designation and OB/GYN self referral change](#).

The language is helpful, but companies will need to simplify the DOL's sample language to get the most value from the communications.

Meeting compliance should be easy if companies restate the meaning of the legal text in enrollment campaign materials (print or online) and incorporate legal text in print enrollment notices. But, coordinating the special 30-day enrollment window for dependents and those impacted by lifetime maximums may make for some tricky communication.

What to look for: This sample language, and other resources, is available at <http://www.dol.gov/ebsa/>

Annual and lifetime limit changes: <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>

Revised dependent eligibility for older kids:
<http://www.dol.gov/ebsa/dependentsmodelnotice.doc>

Primary care physician designation and OB/GYN self referral change:

<http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>

2. Summary of material changes (2012)

Companies will need to send a written summary of any plan changes at least 60 days prior to the beginning of their plan year. This shouldn't be a big deal for most employers. But some employers have the tendency to tweak plan design as they write their SPDs. Why? Sometimes certain details don't come up until then. This is something to look out for.

Companies should send out enrollment materials 60 days in advance, describing changes, and not make any changes to the design after that.

What to look for: The Secretary of Health and Human Services (HHS) will develop standards for compliance by March 23, 2011. These notices will be required by March 23, 2012. Here are some questions companies need to ask:

- Will standard language be required?
- Will this requirement replace the Summary of Material Modifications (SMMs) that is mandated under ERISA?

3. Summary of medical coverage (2012)

Companies will need to create a summary of medical plans, sometimes called a "uniform explanation of coverage." The summary must include specific content and definitions, be no longer than 4-pages, and be written in language that is "linguistically" and "culturally" appropriate. And the font can't be smaller than 12-point

What to look for: HHS will issue more complete requirements by next March. Here's what companies should look for:

- Can this requirement be satisfied online through a benefits website?
- Will each plan option need to be a separate summary—including all retiree plans?
- Is there any issue with satisfying this requirement early, in enrollment communication?

This summary can be a companies' opportunity to provide valuable insight through simple, clear communication. It won't be easy. The plan details will likely be complex and mistakes are often made with comparison charts.

HR will also have to keep an eye out for how HHS defines "culturally appropriate" in their requirements. Hopefully most companies already turn legalese into easy-to-understand material for employees, but will HHS now require benefits information to be translated?

4. Summary of your plan's care management programs—2012 (Section 2717)

Participants with self-insured plans, including case management, disease management and wellness and administrative programs to improve patient safety, will need to receive language describing all care management programs. If a company offers fully-insured plans, the administrator will handle this requirement. Companies are required to have this content to employees by March 23, 2012. In practice, you may prefer to merge this requirement with 2013 enrollment communication (for plan years that begin January 1) and to all new hires thereafter.

Companies with a well established wellness and disease management program will likely find this an easy requirement to fulfill. If not, they may want to start introducing these concepts to employees before they read this potentially scary legal language.

What to look for: HHS will develop standards for compliance by March 23, 2011, addressing these key questions:

- Can this language be embedded in enrollment communication?
- Will there be requirements on the way this content is delivered to participants—the language, the length, or the font-size?

5. Notice of automatic enrollment—likely in 2013 (Section 1511)

Employees and new hires must be notified that they are automatically being enrolled in medical coverage and what actions they must take to opt-out.

What to look for: HHS may have more to say about this specific requirement in the future, such as:

- Is this a notice that can be embedded in other communication?
- Can this notice be delivered online?
- Will there be requirements on the way this content is delivered to employees—the language, the length, or the font-size?
- Are there any requirements for retirees currently eligible for an employer-sponsored plan?

6. Notice of eligibility for health insurance exchange—2013 (Section 1512)

Among the key changes in health care reform is an employee's choice, if eligible, to choose a plan from a state-run exchange. Starting March 1, 2013, all employees and new hires must be informed of the new exchanges. Companies will need to provide a print notice with information about the exchanges and an employee's ability to shop for coverage. The notice should also include eligibility rules for premium credits and the differences between an exchange plan and an employer-sponsored plan.

What to look for:

States will probably start establishing their exchanges sometime in 2013 so that Americans can comply with the individual mandate for coverage by January 1, 2014. Some questions that companies should consider when thinking about this as a consumer shopping experience are:

- What consumer educational materials will be available?
- Will the enrollment timeframe be consistent across all states?
- What kind of detail will be required, impacting the required variability of the notices?
- Will there be requirements on the way this content is delivered to employees—the language, the length, or the font-size?

7. Description of claims process—timing uncertain

Companies will need to explain their new claims process—in a culturally and linguistically appropriate way. They'll also need to notify participants of any state health insurance ombudsman.

What to look for: HHS will provide details on an external claims review process required

of self-insured plans, including clarification on:

- Are grandfathered plans impacted by this section of the law?
- When must plan sponsors comply?
- How does this requirement and current SPD language about the claims and appeal process differ?
- Will there be requirements on the way this content is delivered to participants—the length, or the font-size

Use this as opportunity

There are opportunities to communicate in a way that is clear and simple, and maybe even fun, within the parameters of the legal disclosures.

Companies should talk to their in-house or external counsels to explore these areas and make sure meeting the legal requirements is not just checking off a box but adding value to communication efforts. Each requirement provides a new opportunity to draw attention to health and wellness efforts.

You'll serve your organization and your employees best if you view the new requirements as avenues for open and honest communication. Communication that will ideally make employees better health care consumers and more aware of their employers' investment in benefits.

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