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Medicare Part D – Notice of Creditable Coverage

Beginning in 2011, the annual election period (AEP) for Medicare Part D will open one month earlier – it will now run from October 15 to December 7. The Centers for Medicare & Medicaid Services (CMS) has updated its model Medicare Part D notices of creditable and non-creditable prescription drug coverage to reflect the new dates of the AEP. Updated model notices may be downloaded here.

This change may affect the timing of a group health plan's Medicare Part D notice.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires a group health plan that provides prescription drug coverage to disclose to Medicare-eligible individuals whether that coverage is "creditable" (i.e., whether the plan's prescription drug coverage is actuarially equivalent to Medicare Part D coverage). These notices must be provided "prior to" the start of the AEP for Medicare Part D, which is now October 15. CMS has previously provided guidance that "prior to" the AEP means "within the past 12 months." Accordingly, if a plan distributed its most recent Medicare Part D notice *after* October 15, 2010, arguably the plan has satisfied its 2011 notice requirement, assuming that the plan's status has not changed from creditable to non-creditable or vice-versa (i.e., the plan has already provided a Medicare Part D notice within 12 months prior to the start of the 2011 AEP on October 15, 2011). If the plan's status has changed, an updated Medicare Part D notice should be distributed prior to October 15, 2011 (and possibly again with open enrollment materials - see next paragraph).

Going forward, a plan may continue to provide the Medicare Part D notice at the time it has traditionally provided it, typically during open enrollment, even if this occurs after October 15. As long as a plan distributes the notice at about the same time each year (e.g., including it with open enrollment materials), it should satisfy the "prior to" standard with respect to the AEP. For example, a notice provided at open enrollment in November 2011 would satisfy the plan's obligation to provide a notice within the past 12 months relative to the start of the 2012 AEP on October 15, 2012 (and a notice provided at open enrollment in November 2012 would satisfy the plan's obligation for 2013, and so on).

A plan's existing Medicare Part D notice will not contain the correct dates for the fall 2011 AEP of October 15-December 7. Therefore, an employer may want to consider, for this year only, distributing the updated Medicare Part D notice prior to October 15, 2011, **in addition to including the updated notice in its open enrollment materials**.

Health Care Reform – Four-page Summary of Benefits and Coverage – Proposed Regulations Issued

On August 22, 2011, the Departments of Health and Human Services, Labor, and Treasury published proposed regulations to implement the requirement, established under the Patient Protection and Affordable Care Act (PPACA), that group health plans provide participants and beneficiaries with a four-page (front and back) uniform Summary of Benefits and Coverage (SBC). Below is a brief discussion of the proposed regulations,

including important dates for plans to note.

When Does the Requirement Become Effective?

The requirement to provide SBCs is scheduled to take effect on March 23, 2012. That date is subject to change, however, as the Departments have asked for comments on its feasibility.

Who Must Provide the SBC?

Under the proposed regulations, the plan administrator of a self-insured plan is responsible for providing the SBC. For insured plans, the SBC may be provided by either the plan or the insurer – but note that only one SBC must be provided.

When Must the SBC be Provided?

A group health plan must deliver an SBC at three different times:

- *At enrollment* – The plan must provide an SBC **for all options** for which an individual is eligible with any written application materials distributed by the plan. If no such materials are distributed, the SBC must be distributed no later than the first day the individual is eligible to enroll. The plan must provide an SBC to HIPAA special enrollees within 7 days of a request for enrollment.
- *At renewal* – The plan must provide an SBC for the option in which the individual is enrolled (and must provide SBCs for other options upon request). If a written application is required for renewal, the SBC must be provided no later than the date the application materials are distributed. If benefits renew automatically, the SBC must be provided at least 30 days prior to the start of the new plan year.
- *Upon request* – Upon request by a participant or beneficiary, the plan must provide an SBC as soon as practicable, but no later than 7 days after the request.

Likewise, for insured plans, the SBC must be provided to the plan by the health insurance issuer upon application, at renewal, and upon request.

What Must be Included in the SBC?

Following are some of the items that must be included in the SBC:

- A description of the coverage;
- The exceptions, reductions, and limitations of the coverage;
- The cost-sharing provisions, including deductible, coinsurance, and copayment obligations;
- The renewability and continuation-of-coverage provisions;
- Contact information for questions and for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copies of documents);
- For plans that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;
- For plans that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage;
- An Internet address for obtaining the uniform glossary (see below);
- Premiums, or cost of coverage for self-insured plans.

The SBC must also include "coverage examples" that illustrate benefits provided under the plan for common benefits scenarios (including pregnancy and serious or chronic medical

conditions). HHS has already developed three examples – for pregnancy, breast cancer, and diabetes – and is permitted to adopt up to six.

Included with the proposed regulations is a sample SBC and instructions for completing it. The sample SBC and instructions may be downloaded here and here. Please note that the sample SBC is primarily intended for use by a health insurer, and may require modification for use by a self-insured plan.

What are the Formatting, Language, and Delivery Requirements for the SBC?

The proposed regulations require that the SBC be provided free of charge as a stand-alone document. However, comments are being solicited as to whether a plan should be permitted to provide the SBC in the summary plan description or other materials. The SBC may be no longer than four pages (front and back), must be in 12-point font, and may be printed in color or black and white.

The proposed regulations require that the SBC be provided in a "culturally and linguistically appropriate manner." This means that in certain counties that have been identified by the US Census Bureau as having a concentration of non-English speakers, translation services must be available and a written translation of the SBC must be provided upon request. The current list of such counties is available here (Table 2, p. 14). In future years, an updated list will be maintained by the Department of Labor and will be available on its website.

What is the Uniform Glossary?

The proposed regulations require that a group health plan make available to participants a "uniform glossary" which provides uniform definitions for selected health-coverage-related and medical terms. The uniform glossary must be provided upon request, either in paper or electronic form as requested, within 7 days.

Must the SBC be Reissued if the Plan is Modified?

If a plan makes a mid-year "material modification" to its coverage which would affect the contents of the SBC, the plan must provide a new SBC or a notice of the modification to all participants and beneficiaries no later than 60 days prior to the date the modification takes effect. This requirement does not apply to modifications at renewal.

For purposes of the proposed regulations, a "material modification" includes any change that independently or in conjunction with other contemporaneous changes, would be considered by the average participant to be important.

What is the Penalty for Failing to Provide an SBC?

Under the proposed regulations, a plan that willfully fails to provide an SBC is subject to a fine of up to $1,000 per failure. For these purposes, each participant or beneficiary who does not receive the appropriate SBC is considered a separate failure.

Department of Labor Delays Application of Fee Disclosure Rules

The Department of Labor has again delayed the effective date of its regulation requiring certain service providers to ERISA retirement plans to disclose comprehensive information about their fees to those plans. The new effective date is April 1, 2012. By that date, covered service providers must have provided written disclosures complying with the rule to the retirement plans they serve. While much of the burden of compliance will fall on the service provider, plan fiduciaries should be certain they receive the required disclosures from each covered provider. The failure to provide the disclosure causes the arrangement with the service provider to be a "prohibited transaction" under ERISA.

Along with the delay affecting the service provider disclosures, the Department has delayed the effective date of its regulation requiring plan administrators to disclose information about plan and investment costs to participants who direct their investments in ERISA

401(k) and other individual account plans. This rule will be effective 60 days after the effective date of service provider disclosure regulation. This delay ensures that plan administrators will have the required fee information from their covered service providers so that they can disclose accurate information about plan and investment costs to participants.

ERISA – Fiduciary Definition – Proposed Regulations Withdrawn

On September 19, 2011, the Department of Labor announced that it would withdraw and re-propose regulations affecting the definition of "fiduciary" under ERISA, citing the need to conduct further economic analysis of the regulations' impact. The Department's initial proposal would have expanded the definition to include anyone providing investment advice to plan participants or IRA account holders, eliminating the current requirement that the advice be provided on a regular basis pursuant to an understanding that it will be the primary basis for the investment decisions. Updated regulations are not expected until early in 2012.

If you have questions on the content of this alert or on any Employee Benefits issue you may contact your Thompson Coburn attorney or one of the Employee Benefits attorneys listed below:

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