

Legislative Brief

Select Employee Benefit Compliance Timelines Regarding Disclosure Notices



The following chart is intended to be used as a quick overview of a number of basic reporting and disclosure requirements that group health plans and/or employers must provide to participants, beneficiaries and other individuals under Title I of ERISA and other miscellaneous federal laws. Note that not all reporting and disclosure requirements are reflected in this chart. Users of this chart should refer to the specific federal law at issue for complete information on the necessary reporting and disclosure requirements.

Law	Governs	Notice Requirement	Summary
COBRA	Employers that had 20 or more employees on more than 50% of the typical business days during the previous calendar year. Government and church plans are exempt.	Initial/General COBRA notice – generally within 90 days of when group health plan coverage begins	Notice to covered employees and covered spouses of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.
		Notice to Plan Administrator - Employer must notify plan administrator within 30 days of a) qualifying event or b) the date coverage would be lost as a result of the qualifying event, whichever is later	Notice of qualifying event must be sent to plan administrator when employer is not plan administrator (e.g., employer has contracted with a third party to administer COBRA).
		COBRA election notice – generally within 14 days after being notified by the employer or qualified beneficiary of the qualifying event (or 44 days after qualifying event if employer is also plan administrator)	Notice to qualified beneficiaries of their right to elect COBRA coverage upon occurrence of qualifying event. Qualified beneficiaries may be covered employees, covered spouses and dependent children.
		Notice of unavailability of COBRA – plan administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event (or 44 days after qualifying event if employer is also plan administrator)	Plan administrator must send a notice that an individual is not entitled to COBRA coverage to those individuals who provide notice to the plan administrator of a qualifying event whom the plan administrator determines are not eligible for COBRA coverage.
		Notice of early termination of COBRA coverage – as soon as practicable following the plan administrator's determination that coverage will terminate	Notice to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage, reason for early termination, date of termination and any rights that qualified beneficiary may have to elect alternative group or individual coverage, such as a conversion right. May be sent with HIPAA certificate of creditable coverage.
		Notice of insufficient payment – Plan must provide reasonable period of time to cure deficiency before terminating COBRA (e.g., 30 day grace period)	Notice to qualified beneficiary that payment for COBRA was less than the correct amount (though not "significantly less").
		Premium change notice – at least one month prior to effective date	Notice to COBRA participants of change in premium.

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ERISA	ERISA employee welfare benefit plans, unless exempted	<p>Summary plan descriptions - Automatically to participants within 90 days of becoming covered by the plan and to pension plan beneficiaries within 90 days after first receiving benefits (though plan has 120 days after becoming subject to ERISA to distribute SPD). Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise, must furnish every 10 years.*</p>	<p>SPD is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan. Must accurately reflect the plan's contents as of the date not earlier than 120 days prior to the date the SPD is disclosed.*</p>
		<p>Summary of material modification – automatically to participants and pension plan beneficiaries receiving benefits; not later than 210 days after the end of the plan year in which the change is adopted*; if benefits or services are materially reduced, participants must be provided notice within 60 days from adoption; or, where participants receive such information from the plan administrator at regular intervals of not more than 90 days, notice of materially reduced benefits or services must be provided within 90 days.</p>	<p>Describes material modification to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.*</p>
		<p>Plan documents – copies must be furnished no later than 30 days after a written request. Plan administrator must make copies available at its principal office and certain other locations as specified in regulations.</p>	<p>The plan administrator must furnish copies of certain documents upon written request by a participant and/or beneficiary and must have copies available for examination. The documents include the latest updated SPD, latest Form 5500, trust agreement, and other instruments under which the plan is established or operated.</p>
		<p>Form 5500 – generally must be filed by the last day of the seventh month following the end of the plan year, unless an extension has been granted. For calendar year plans, the deadline is normally July 31st of the following year.</p>	<p>Form 5500 filing requirements vary according to type of filer (i.e., small plans, large plans and direct filing entities). Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options. The DOL Internet site at http://www.dol.gov/EBSA/5500MAIN.HTML and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.</p>
		<p>Summary annual report – automatically to participants and pension plan beneficiaries receiving benefits within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension)*</p>	<p>Narrative summary of the Form 5500 and statement of right to receive annual report. Model notices are found in 29 CFR 2520.104b-10(d).</p>
Family and Medical Leave Act (federal FMLA)	Covered employers (private sector employers with 50	Post notice in a location available to both employees and applicants	All covered employers are required to post a notice explaining the FMLA, including the family military leave amendments, regardless of whether they have eligible employees.

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	or more employees in 20 or more workweeks in current or preceding calendar year, as well as all public agencies and local educational agencies)	<p>Written guidance, if it exists</p> <p>Written guidance, upon employee notice of need for FMLA leave</p>	<p>If written guidance regarding employee benefits or leave rights exists, such as in an employee handbook, then FMLA information regarding entitlements and obligations must be included in it as well.</p> <p>Written guidance must be provided to an employee upon the employee's notice to the employer of the need for FMLA leave (i.e., eligibility notice, and rights and responsibilities notice). The employer must detail the specific expectations and obligations of the employee, and explain the consequences of the failure to meet these obligations. After the employer has sufficient information, it must provide a designation notice informing the employee whether the leave is designated as FMLA leave.</p> <p>The DOL has issued optional forms which may be used to satisfy these notice requirements. They can be accessed at http://www.dol.gov/esa/whd/fmla/finalrule.htm</p>
HIPAA-Wellness Programs	Group Health Plans and Insurers that offer Wellness Programs which condition a reward based on outcome.	Plan years beginning on or after July 1, 2007 - plans must disclose the availability of an alternative standard in all materials describing the wellness program.	<p>Wellness programs which offer a reward conditioned upon an individual's ability to meet a standard that is related to a health factor will violate HIPAA nondiscrimination rules unless the program satisfies a number of conditions:</p> <ul style="list-style-type: none"> • Limit reward to 20% of cost of coverage; • Design to reasonably promote health and prevent disease; • Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard. <p>The regulations provide safe harbor language for this disclosure.</p>
HIPAA-Privacy	Group health plans, health care clearinghouses, health care providers that transmit any health information electronically, and enrolled sponsors of Medicare prescription drug discount card, unless exception applies	Notice of Privacy Practices – the plan administrator of covered entities must comply by April 14, 2003 and every 3 years thereafter for large plans; small plans have until April 14, 2004 and every 3 years thereafter; must also comply at enrollment and within 60 days of a material revision to the notice.	HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.
HIPAA-Portability	Group health plans and issuers of group health plan insurance coverage, unless exception applies	Certificate of Creditable Coverage - Automatically upon losing group health plan coverage, becoming eligible for COBRA coverage, and when COBRA coverage ceases. A certificate may be requested free of charge anytime prior to losing coverage and within 24 months of losing coverage.*	Notice from employee's former group health plan to participants and beneficiaries who lose coverage, documenting prior group health plan creditable coverage and length of time covered.

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		<p>General notice of preexisting condition exclusion – must be provided as part of any written application materials distributed for enrollment. If the plan or issuer does not distribute such materials, by the earliest date following a request for enrollment that a plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.*</p>	<p>Notice to participants describing a group health plan's preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period.</p>
		<p>Individual notice of period of preexisting condition exclusion – as soon as possible following the determination of creditable coverage*</p>	<p>Notice to participants and beneficiaries, who demonstrate creditable coverage that is not enough to completely offset the preexisting condition exclusion, that a specific preexisting condition exclusion period applies to an individual upon consideration of creditable coverage evidence and an explanation of appeal procedures if the individual disputes the plan's determination.</p>
		<p>Notice of special enrollment rights – at or before the time an employee is initially offered the opportunity to enroll in the group health plan*</p>	<p>Notice to employees eligible to enroll in a group health plan describing the group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption.</p>
Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	<p>At a minimum, Disclosure Notices for creditable or non-creditable coverage must be provided by the plan at the following times:</p> <ol style="list-style-type: none"> 1) <u>Prior to</u> the Medicare Part D Annual Coordinated Election Period – beginning November 15th through December 31st of each year; 2) Prior to an individual's Initial Enrollment Period for Part D; 3) Prior to the effective date of coverage for any Medicare eligible individual that joins the plan; 4) Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and 5) Upon a beneficiary's request. 	<p>Group health plans — or entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals — must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.</p>
		<p>Disclosure to CMS made on annual basis (60 days after the beginning of the plan year) and upon any change that affects creditable coverage status (within 30 days of the change)</p>	<p>Employers must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Notice form on the CMS Creditable Coverage Disclosure Web Page at https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.</p>

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Medicare Part D-Retiree Drug Subsidy	Employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so	At least 90 days before the beginning of each plan year, plan sponsors must apply for retiree drug subsidy , unless CMS approves request for extension Medicare beneficiaries must be notified that plan's coverage is creditable	An employer who wishes to sponsor a prescription drug plan with retiree prescription drug coverage that is at least as good as Part D coverage may apply for the retiree drug subsidy, which is exempt from federal income tax. The subsidy is available to employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so. Each Plan Sponsor that seeks the retiree drug subsidy must electronically complete the application through the RDS Center at http://rds.cms.hhs.gov .
Mental Health Parity Act (MHPA)	Group health plans (of employers with over 50 employees) offering mental health benefits	30 days before the exemption becomes effective - group health plans covered under ERISA claiming the increased cost exemption must notify the DOL, plan participants and beneficiaries Upon written request	The mental health parity requirements do not have to be met by any group health plan whose costs increase 1 percent or more due to the application of the MHPA's requirements. The increased cost exemption must be based on actual claims data, not on an increase in insurance premiums. The plan must implement the provisions of the MHPA for at least 6 months and the calculation of the 1 percent cost exemption must be based on at least 6 months of actual claims data with parity in place. Upon written request – A summary of the aggregate data and the computation supporting the increased cost exemption must be made available to plan participants and beneficiaries free of charge upon written request.
Newborns' and Mothers' Health Protection Act	Group health plans that provide maternity or newborn infant coverage	Statement within the SPD (or SMM) timeframe	The plan's SPD must include a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the different areas and the federal or state requirements applicable in each.
Qualified Medical Child Support Orders	Plan administrators of group health plans and state child support enforcement agencies	Medical child support order notice - upon receipt of medical child support order, plan administrator must promptly issue notice , including plan's procedures for determining its qualified status. Within a reasonable time after its receipt, plan administrator must also issue separate notice as to whether the medical child support order is qualified.	This is a notification from the plan administrator regarding receipt and qualification determination on a medical child support order directing the plan to provide health insurance coverage to a participant's noncustodial children.
		National Medical Support notice - Within 20 days after the date of notice or sooner, if reasonable, employer must either send Part A to State agency, or Part B to plan administrator. Plan administrator must promptly notify affected persons of receipt of notice and procedures for determining its qualified status. Plan administrator must within 40-business days after its date or sooner, if reasonable, complete and return Part B to State agency and must also provide required information to affected persons. Under certain circumstances, employer may be required to send Part A to State agency after plan administrator	Notice used by State agency responsible for enforcing health care coverage provisions in a medical child support order. Depending upon certain conditions, employer must complete and return Part A of the National Medical Support notice to the State agency or transfer Part B of the notice to the plan administrator for a determination on whether the notice is a qualified medical child support order.*

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		has processed Part B.*	
Uniformed Services Employment and Reemployment Rights Act (USERRA)	All public and private employers, regardless of size	Provide notice by posting where other employee notices are customarily posted, or provide to employees by alternate means	Employers must provide notice of rights, benefits and obligations of persons entitled to USERRA and of employers.
Women's Health and Cancer Rights Act (WHCRA)	Group health plans that provide coverage for mastectomy benefits	Provide notice upon enrollment in the plan and annually thereafter	<p>The DOL has published sample language for both the enrollment notice and the annual notice.</p> <p>Enrollment notice should include a statement that for participants and beneficiaries who are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. Notice should also include a description of any deductibles and coinsurance limitations applicable to such coverage.</p> <p>Annual notice should include a copy of the WHCRA enrollment notice, or a simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description.</p>

*Source: "Reporting and Disclosure Guide for Employee Benefit Plans," U.S. Dept. of Labor, EBSA, reprinted August 2006.

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