New Health Laws Notice Guide

Recently, the Department of Labor's Pension and Welfare Benefits Administration (PWBA) released its *Health Disclosure and Claims Issues: FY 2001 Compliance Project Report*. The report sets forth results from PWBA's FY 2001 Compliance Project, during which 1,267 investigations were conducted of group health plans and their compliance with Part 7 of Title I of the Employee Retirement Income Security Act (ERISA). Part 7 is comprised of provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act of 1996 (MHPA), the Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act), and the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Data from the Project revealed that implementation by group health plans has progressed gradually and that some plans could use additional compliance assistance with respect to the notice requirements of Part 7 of ERISA. This guide includes a chart that summarizes these notice requirements and sample language that may be used by group health plans, issuers, and third party administrators when providing these notices. References to a checklist in this summary are to a self-compliance tool, which is being published simultaneously. Both are available at: **www.dol.gov/pwba.**

For Group Health Plans subject to Part 7 of ERISA, the following disclosures are required:

Type of Disclosure	Applicability	Content Summary	When Provided
HIPAA certificate of creditable coverage (§ 701(e); 29 CFR 2590.701-5) *See Checklist questions 10-15*	All group health plans.	Each certificate must include: ◆ Date issued; ◆ Name of plan; ◆ Individual's name and ID; ◆ Plan administrator name, address, and phone number; ◆ Phone number for further information; and ◆ Individual's creditable coverage information.	◆ When the certificate is provided upon request, as soon as possible. ◆ When the certificate is provided automatically upon loss of coverage and a COBRA qualifying event, not later than the end of the period for providing COBRA notice (generally 44 days). ◆ When the certificate is provided automatically upon loss of coverage and not a COBRA qualifying event, within a reasonable time after coverage ceases (as soon as possible).
General notice of preexisting condition exclusion (29 CFR 2590.701-3(c)) *See Checklist question 8*	Any group health plan that contains a preexisting condition exclusion.	The plan must disclose the existence and terms of any preexisting condition exclusion under the plan and the rights of individuals to demonstrate creditable coverage. This includes a description of the right of the individual to request a certificate from a prior plan or issuer and a statement that the current plan will assist in obtaining a certificate from any prior plan or issuer, if necessary.	Must be provided before a preexisting condition exclusion may be applied to any individual.
Individual notice of preexisting condition exclusion (29 CFR 2590.701-5(d)) *See Checklist question 9*	Group health plans that contain a preexisting condition exclusion, but only after receiving creditable coverage information from an individual that is not enough to offset the preexisting condition exclusion period.	This notice must include: ◆ The plan's determination of the period of creditable coverage (note: the plan must allow the individual a reasonable opportunity to submit additional evidence of creditable coverage); ◆ The remaining preexisting condition exclusion period that will apply to the individual; and ◆ A description of any appeal procedures established by the plan or issuer.	Within a reasonable time of the presentation of creditable coverage by the individual.

For Group Health Plans subject to Part 7 of ERISA, the following disclosures are required:

Type of Disclosure	Applicability	Content Summary	When Provided
Notice of special enrollment rights (29 CFR 2590.701-6(c)) *See Checklist question 18*	All group health plans.	A description of the plan's special enrollment rules.	On or before the time an employee is offered an opportunity to enroll in the plan.
Description of rights with respect to hospital stays in connection with childbirth (§ 711(d); 29 CFR 2520.102-3(u)) *See Checklist question 36*	Group health plans that provide maternity or newborn infant coverage.	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.	In the SPD (or SMM).
WHCRA enrollment notice (§ 713(a)) *See Checklist question 39*	Group health plans that provide coverage for mastectomy benefits.	The benefits that WHCRA requires the group health plan to cover and any deductibles and coinsurance limitations applicable to such coverage. (Under WHCRA, coverage of breast reconstruction benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.)	Upon enrollment in the plan.
WHCRA annual notice (§ 713(a)) *See Checklist question 38*	Group health plans that provide coverage for mastectomy benefits.	Information on the availability of benefits for the treatment of mastectomy-related services, including reconstructive surgery, prosthesis, and lymphedema under the plan; and information on how to obtain a detailed description of the mastectomy-related benefits available under the plan.	Once each year after enrollment in the plan.

Model Certificate

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

* IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:

2. Name of group health plan:

3. Name of participant:

4. Identification number of participant:

5. Name of any dependents to whom this certificate applies:

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

7. For further information, call:

8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ____ and skip lines 9 and 10.

9. Date waiting period or affiliation period (if any) began:

10. Date coverage began:

11. Date coverage ended:_____(or check if coverage is continuing as of the date of this certificate: _____).

*Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Model Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Guidelines for General Notice of Preexisting Condition Exclusion

A group health plan (or issuer) may not impose a preexisting condition exclusion with respect to a participant or dependent before notifying the participant, in writing, of —

- The existence and terms of any preexisting condition exclusion under the plan;
- The rights of individuals to demonstrate creditable coverage (and any applicable waiting periods);
- The right of the individual to request a certificate from a prior plan or issuer, if necessary; and
- That the current plan (or issuer) will assist in obtaining a certificate from any prior plan or issuer, if necessary.

Guidelines for Individual Notice of Preexisting Condition Exclusion

A group health plan (or issuer) seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing —

- Its determination of the period of creditable coverage, including the source and substance of any information on which the plan or issuer relied (note: the plan must allow a reasonable opportunity to submit additional evidence of creditable coverage);
- The remaining preexisting condition exclusion period that will apply to the individual; and
- Any appeal procedures established by the plan or issuer.

Sample Language for the Newborns' Act Disclosure Requirement

The following is sample language that group health plans subject to the Newborns' Act may use in their SPDs to describe the federal requirements relating to hospital lengths of stay in connection with childbirth:

"Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."

Plans subject to State law requirements will need to prepare SPD statements describing any applicable State law.

Sample Language for WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator [insert phone number] for more information.

Sample Language for WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call your Plan Administrator [insert phone number].