2022

Federal Mandates & Required Distribution Notices

EMPLOYER SPONSORED HEALTH PLANS

This document is not provided or intended as tax or legal advice. Readers must contact a tax professional or attorney for advice on how specific laws will affect their benefit program.

STRATEGIC SERVICES GROUP

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2022

Required Notices & Federal Mandates for Employer-Sponsored Health Plans

This is a list of annual required notices and action items for group health plans. If your health benefits are insured, your providers may have sent some of these notices or included them in open enrollment materials, such as Summary Plan Descriptions (SPD) or Evidence of Coverage documents. These documents contain all the specific provisions of your plans. If the information in this document differs from your Plan Documents, the Plan Documents will prevail. Please confirm with the providers that these actions were taken. Employers do not need to re-send notices if the provider has already sent them to participants.

Most notices can be provided electronically to employees who have work-related access to the employer's Intranet or to the Internet. This applies even if the employee is not able to print out a paper copy at the place where he or she has computer access, and even if the employee does not consent in writing to receive electronic disclosure of the documents. However, prior written consent is required for non-employees and for employees who do not have work-related access. Additionally, a print copy of the notices must be available at no charge on request.

2022 Federal Mandates & Required Notices:

All Plans, Annually and Open Enrollment

The following required notices are not date-specific and should be provided to employees at open enrollment unless otherwise stated.

REQUIRED PARTICIPANT NOTICES		
Requirement	**Description**	**Timing**
Children's Health Insurance Program (CHIP) Notice	Employer must inform employees of possible premium assistance opportunities available. Provide for employees that reside in states with premium assistance programs under Medicaid or CHIP.	Notice must be given annually, by the first day of the plan year.
COBRA Election Notice	Notice must be provided to qualified beneficiaries of their right to elect COBRA coverage when a qualifying event occurs and about other coverage options available, such as through the Marketplace.	The plan administrator must generally provide qualified beneficiaries with this notice within 14 days after being notified of the qualifying event (44 days for events that are employer's responsibility to report if employer is plan administrator). Extended deadline under the DOL and Treasury final rule, clarified by IRS Notice 2021-58. See the EBSA website for the model notice.
COBRA Qualifying Event Notice	The plan administrator must be notified when a qualifying event occurs.	In general, the employer must notify the plan administrator within 30 days after the date of the following qualifying events (that results in coverage loss): ▪ Death of the covered employee ▪ Termination (other than by reason of gross misconduct) or reduction of hours of the covered employee ▪ The covered employee's Medicare entitlement ▪ The commencement of a bankruptcy proceeding of the employer (causing a substantial elimination of retiree coverage) Unless the plan follows the delayed employer notice rule, the "qualifying event" in this context means the date of the triggering event, not the coverage loss date.
Continuation Coverage Rights Under COBRA	Generally, if an employer has 20 or more employees, it is subject to federal COBRA and must provide enrollees with an initial COBRA notice describing the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.	Notice is due to new enrollees, including spouses, within 90 days after coverage begins.
COBRA Notice of Early Termination of Continuation Coverage	Notice must be provided to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage.	Notice must be provided as soon as practicable following the plan administrator's determination that coverage will terminate.

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COBRA Notice of Insufficient Payment of Premium	Notice must be provided to qualified beneficiary that payment for COBRA continuation coverage premium was less than correct amount..	The plan administrator must provide this notice as soon as practicable and provide reasonable period to cure deficiency before termination. A 30-day grace period will be considered reasonable.
COBRA Notice of Unavailability of Continuation Coverage	Notice must be provided to an individual that is not entitled to COBRA coverage or for an extension of continuation coverage.	The plan administrator must provide this notice within 14 days after being notified by the individual of the qualifying event or of the request for extension.
External Review Process Disclosure	Non-grandfathered plans must provide a description of the external review process.	The description of the external review process must be provided in or attached to the summary plan description, policy, certificate, or other evidence of coverage provided to participants, beneficiaries, or enrollees.
Grandfathered Plan Notice	A grandfathered plan must include a notice about grandfathered plan status in any materials describing the plan's benefits.	Annually, when enrollment materials are provided.
HIPAA Breach Notification	Group health plans must report to HHS and notify affected individuals of any breaches of unsecured protected health information.	Affecting 500 or more: Reporting to HHS, affected individuals, and media must be done without unreasonable delay and in no case later than 60 days of the breach's discovery. Affecting fewer than 500: report to HHS within 60 days of the end of the calendar year in which breach was discovered; report to affected individuals without unreasonable delay and in no case later than 60 days of the breach's discovery.
HIPAA Notices of Privacy Practices	Health plan must provide notice to plan participants explaining their rights with respect to their protected health information and the health plan's privacy practices.	Notice must be provided upon enrollment, within 60 days of a material revision, and at least once every three years. Notice must also be provided upon request.
Internal Claims and Appeals and External Review Notices	**Internal Claims and Appeals:** Non-grandfathered plans must provide notice of adverse benefit determination and notice of final internal adverse benefit determination. **External Review:** After an external review, the independent review organization (IRO) will issue a notice of final external review decision.	For internal claims and appeals, timing of the notices varies based on the type of claim. For external review, the timing of the notice may vary based on the type of claims and whether the state or the federal process applies. May be subject to extended deadlines under the DOL and Treasury final rule and EBSA Disaster Relief Notice 2021-01.

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Medical Child Support Order (MCSO) Notice	Plan administrator's receipt of an MCSO directing the plan to provide health coverage to a participant's noncustodial children.	Plan administrator, upon receipt of an MCSO, must promptly issue notice (including plan's procedures for determining its qualified status). Plan administrator must also issue separate notice as to whether the MCSO is qualified within a reasonable time after its receipt.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	For plans subject to ERISA, notice must provide beneficiaries information on medical necessity criteria for both medical/surgical and mental health/substance use benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation.	Notice must be provided within 30 days of a plan participant's request. See the optional model disclosure form that plan participants may use to request information.
MHPAEA Claims Denial Notice	For plans subject to ERISA, notice must provide the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits.	Notice must be provided in the plan's claim denial notice according to DOL claims procedure regulations, and within a reasonable time and in a reasonable manner upon participant request. See the optional model disclosure form that plan participants may use to request information.
MHPAEA Increased Cost Exemption	A group health plan claiming MHPAEA's increased cost exemption must furnish a notice of the plan's exemption from the parity requirements.	Notice must be provided if using the cost exemption. See the Employee Benefits Security Administration (EBSA) website for model notice.
Michelle's Law Enrollment Notice	Must include a description of the Michelle's Law provision for continued coverage for students during medically necessary leaves of absence.	Notice must be included with any notice regarding a requirement for certification of student status for coverage under the plan.
National Medical Support (NMS) Notice	Depending upon certain conditions, employer must complete and return Part A of the NMS 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 (QMCSO).	Employer must either send Part A to the state agency, or Part B to plan administrator, within 20 business days after the date of the notice. Plan administrator must promptly notify affected persons of receipt of the notice and the procedures for determining its qualified status. Plan administrator must, within 40 business days after the date of the notice, complete and return Part B to the state agency and provide required notification to affected persons.

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Newborns' and Mothers' Health Protection Act Notice	Notice must include a statement describing any requirements under federal or state law that relate to a hospital length of stay in connection with childbirth. 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 federal or state requirements applicable to each area.	Notice must be given annually and upon enrollment. Must be included in the SPD.
Notice to Employees of Coverage Options	Notice provides employees information about the Health Insurance Marketplace and premium tax credits.	Notice due to all new employees (including part-time, temporary, or ineligible for the plan) within 14 days after hire date if the employer offers coverage to any employee.
Notification of Benefit Determination (Claims Notices or "Explanation of Benefits")	Information regarding benefit claim determinations. Adverse benefit determinations must include required disclosures (for example, the specific reasons for the claim denial, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Requirements vary depending on type of plan and type of benefit claim involved.
Notice to Enrollees Regarding Opt-out	Group health plans sponsored by state and local governmental employers must generally comply with federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from certain requirements for any part of the plan that is self-funded by the employer.	Notice must be provided annually, when enrollment materials are provided.
Notice of HIPAA Special Enrollment Rights	Group health plans subject to HIPAA must provide special enrollment such as the right to enroll after the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption. Special enrollment is also available for individuals who lose Medicaid or CHIP coverage and for individuals who become eligible for a state premium assistance subsidy from Medicaid or CHIP.	Notice must be provided at or before the time an employee is initially offered the opportunity to enroll in a group health plan.
Patient Protection Notice	A non-grandfathered group health plan that requires a participant or beneficiary to designate a Primary Care Provider (PCP) must provide a notice to each plan participant that describes the plan's requirements regarding designation of a primary care provider and of the participant's or beneficiary's right to designate certain providers.	The notice must be provided whenever a Summary Plan Description or other similar description of benefits under the plan is provided to a participant or beneficiary.

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Plan Documents	The plan administrator must furnish copies of certain documents upon written request 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.	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.
Section 111 Medicare Secondary Payer Mandatory Reporting	On a quarterly basis, responsible reporting entities (RREs) must submit group health plan entitlement information, including drug coverage information, about active covered individuals to the CMS Benefits Coordination and Recovery Center (BCRC). The insurer is the RRE for a fully insured plan. The plan administrator is the RRE for a self-funded plan. See the Section 111 MSP Mandatory Reporting GHP User Guide.	Section 111 RREs must register with the BCRC and fully test the group health plan data reporting exchange before submitting information. CMS will assign the RRE with a timeframe during which the RRE will submit files on a quarterly basis.
Section 1557 Nondiscrimination Notice	Under the 2016 final rule, certain employers must include nondiscrimination notice and language assistance taglines (in at least the top 15 languages spoken by individuals with limited English proficiency) with all significant publications or communications. See the HHS model notice of nondiscrimination, statement of nondiscrimination, and tagline. On June 12, 2020, HHS announced a final rule implementing Section 1557 that revises or repeals many provisions contained in the prior 2016 rule. Practically speaking, the final rule, and therefore Section 1557, does not apply to self-funded plans and many fully insured plans, as health insurers are not principally engaged in the business of providing health care. The final rule would not apply to a fully insured plan unless the plan received federal financial assistance from HHS or unless the plan is operating a program that is principally engaged in the business of providing health care.	Under the 2016 final rule, employers must include notice and taglines with all significant publications and communications. Covered entities must reasonably determine which of their publications and communications are "significant." See Q22–Q26 from the HHS Section 1557: Frequently Asked Questions for information on what publications and communications are significant. Under the 2020 final rule, the notice and taglines requirements were revised to state that covered entities are required to provide a notice of nondiscrimination and taglines whenever necessary to ensure meaningful access to language services for individuals with limited English proficiency. However, parts of the final rule are currently being litigated and HHS has announced it will issue a new notice of proposed rulemaking. Employers should consult with their attorneys when complying with the 2020 final rule.

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Summary of Benefits and Coverage (SBC)	A template that describes the benefits and coverage under the plan, including a uniform glossary defining certain terms. See the DOL SBC template. See the DOL Glossary of Health Coverage and Medical Terms.	Must be provided when enrollment materials are provided, or 30 days prior to start of plan year if no open enrollment. Provide to special enrollees within 90 days. If making a mid-year modification to plan that affects the SBC, must provide updated SBC or Summary of Material Modification no later than 60 days before change is effective. If the change is communicated as part of open enrollment, then it is considered acceptable notice, regardless of whether the SBC or the SPD, or both, are changing. Open enrollment acts a safe harbor for the 60-day prior/60-day post notice requirements.
Summary of Material Modifications (SMM)	When a plan is amended or when other information is required to appear in the plan's Summary Plan Description (SPD) changes, ERISA requires that notice of the amendment or change be provided through an SMM.	Changes that constitute a material reduction in covered services or benefits, within 60 days of adoption of the change. Modifications that are not a material reduction in benefits, distributed within 210 days after the end of the plan year in which modification is adopted (if revised SPD not issued). If the change is communicated as part of open enrollment, then it is considered acceptable notice, regardless of whether the SBC or the SPD, or both, are changing. Open enrollment acts a safe harbor for the 60-day prior/60-day post notice requirements.
Summary Plan Description (SPD)	Summary of plan provisions and certain ERISA-required standard language, written for average participant and sufficiently comprehensive to inform covered persons of their benefits, rights, and obligations under the plan.	Must be furnished to participants within 90 days of becoming covered by the plan. Updated SPD must be furnished every 5 years if changes are made to SPD information or plan is amended. Otherwise, must be furnished every 10 years.
Wellness Program – Notice of Reasonable Alternatives	A notice must be provided to employees who are eligible to participate in a wellness program that involves a medical examination or a disability-related inquiry (such as a health risk assessment or biometric screening). A health-contingent wellness program must disclose the availability of a reasonable alternative in any materials describing the program. For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard.	The notice must be provided annually: a) before the employee provides medical information and sufficiently in advance to allow the employee to make an informed decision about whether to participate, and b) when enrollment materials are provided.
Women's Health and Cancer Rights Act (WCHRA) Notice	Notice describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy.	Notice must be given annually and upon enrollment.