

ALERT: HEALTH CARE REFORM BILL

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PROPOSED REGULATIONS FOR SUMMARY OF BENEFITS AND COVERAGE RELEASED

On August 17, 2011, the federal agencies responsible for implementation of the health care reform law (Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury) released proposed regulations on the summary of benefits and coverage (SBC) that group health plans and health insurance issuers are required to distribute to participants. In addition, the agencies have provided a proposed template for an SBC, as well as proposed instructions, sample language and guidance for coverage example calculations to be used in completing the templates. Also included is a proposed uniform glossary of commonly used health insurance and medical terms that group health plans must provide to participants. Along with all of this, the agencies issued a "Solicitation of Comments" in which they asked for public comments on many issues in connection with the SBC. Unfortunately, nothing in these regulations provides for a delay of the March 23, 2012 implementation date, although the agencies did ask for comments on the feasibility of meeting that deadline (which could indicate a willingness to postpone the effective date).

Please note that these are only proposed regulations. Final regulations, which may not be available before the end of the year, could look quite different. This is particularly true given the number of issues on which the agencies have requested comments. The proposed regulations can be found [here](#). The proposed template for the SBC can be found [here](#). Additional guidance, including the uniform glossary, can be found [here](#).

BACKGROUND

The health care reform law expanded health plans' disclosure obligations, requiring distribution of a uniform four-page "summary of benefits and coverage" – an SBC. Employers and insurers are required to begin distributing the SBC on March 23, 2012. The health care reform law required the agencies responsible for implementing the health care reform law to provide "standards" for creating and providing the summaries by March 23, 2011. The agencies did not meet this deadline.

PROPOSED REGULATION

The package of proposed guidance covers a multitude of details regarding SBCs and asks for public comments on many of them. Highlights of the proposed regulations are summarized below.

APPEARANCE

While the health care reform law called for a four-page summary, the proposed regulations interpret the four-page limitation as four *double-sided* pages. This will give employers additional flexibility in providing the required information (the proposed SBC template is currently six single-sided pages long).

In addition, the SBC must be provided as a stand-alone document. It also must be presented in a uniform format, use terminology understandable by the average plan enrollee and not include print smaller than 12-point font.

The SBC must be presented in a culturally and linguistically appropriate manner. The proposed guidance references rules set forth in the guidance issued for claims and appeals. Additional information about this requirement can be found in Willis' Human Capital Practice *Alert*, August 2011, **“Internal and External Review/Appeals Process Updated.”**

CONTENT

The SBC must contain the following information:

- Uniform definitions of standard insurance and medical terms so that consumers may understand and compare health insurance coverage and exceptions to coverage
- Description of the coverage, including the cost sharing, for each category of essential health benefits and other benefits identified by HHS
- Exceptions, reductions and limitations on coverage
- Cost sharing, including deductibles, coinsurance and copayments
- Renewability and continuation of coverage provisions
- Coverage examples that illustrate benefits provided under the plan for pregnancy, for serious and chronic medical conditions and for other common benefit scenarios (the examples in the proposed regulations include a normal childbirth, treatment for breast cancer and diabetes management) and related cost-sharing based on recognized clinical practice guidelines
- For coverage beginning on or after January 1, 2014, statements of whether the coverage is minimum essential coverage and has at least 60% actuarial value (see the text box below)
- Statement that the four-page summary is a summary and that other documents should be consulted to determine the coverage terms
- Contact information (e.g., phone number, internet web address, etc.) for questions and obtaining a copy of the plan document or insurance policy
- 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
- Information on premiums for insured coverage or the cost of coverage for self-insured coverage

COMMENTS REQUESTED REGARDING AFFORDABILITY SAFE HARBOR

On September 13, 2011, the IRS posted **Notice 2011-73**, which solicits public input and comment on a safe harbor that the IRS is considering to help employers determine whether they might incur the “pay or play” excise tax when it becomes effective in 2014. The safe harbor would make it easier for employers to know whether the health coverage they offer to employees is “affordable.”

Where a “large employer” (50 or more employees) offers “unaffordable” coverage, it may incur the pay or play excise tax. In particular, if any of the employer’s full-time employees are “applicable taxpayers” who receive federal assistance to purchase coverage through a health insurance exchange, the employer must pay a \$250 per-month excise tax for each such employee (this penalty is capped at an overall limitation that is equal to the tax that would apply if the employer did not provide minimum essential coverage). Employer-sponsored coverage is considered affordable if a full-time employee’s required contributions for self-only coverage are no greater than 9.5% of household income. (The affordability standard also requires that the employer-sponsored coverage have an actuarial value of 60% or greater.)

Under the anticipated IRS safe harbor, an employer that might otherwise incur this \$250 per month excise tax will not incur it with respect to any employee if a full-time employee's required contributions for self-only coverage under the employer's lowest cost plan that provides minimum value does not exceed 9.5% of the employee's W-2 wages from the employer. Not having to base the affordability calculations on the employee's household income (a number that most employers would not know) will make this process much less burdensome for employers.

Please note that this contemplated safe harbor would only apply for purposes of the employer "pay or play" mandate and would not affect employees' eligibility for health insurance premium tax credits. The IRS first noted the possibility of an affordability safe harbor for employers in the preamble to proposed regulations that address how health insurance exchanges determine who is eligible for premium tax credits.

For additional information on the employer pay or play mandate, please see Willis Human Capital Practice *Alert*, July 2011, "**Looking Ahead - Compliance After 2011.**"

DELIVERY

The group health plan or, if applicable, the health insurer is required to provide an SBC to plan participants and beneficiaries (as defined by the Employee Retirement Income Security Act (ERISA), this would include eligible or enrolled employees, dependents, COBRA participants and children covered pursuant to qualified medical child support orders). If the group health plan is self-insured, the plan administrator (employer) has the obligation to provide the SBC to participants and beneficiaries. If the plan is fully insured, both the plan and insurer have the obligation. In order to prevent them from duplicating efforts, the regulations provide that a responsible party can satisfy the SBC requirement if a complete SBC is provided by another party on a timely basis.

The SBC may be provided to participants and beneficiaries in paper form. If both the participant and beneficiary are known to reside at the same address, providing one SBC to that address will comply with the requirements. For group health plans subject to ERISA or the Internal Revenue Code, electronic distribution is also permitted if the requirements of the DOL's electronic

disclosure safe harbor are met (a non-federal governmental plan can deliver the SBC electronically if it meets either the DOL's electronic disclosure rule or the provisions governing electronic disclosure in the individual health insurance market). Many employers may find it difficult to comply with the DOL's electronic disclosure requirements, particularly with respect to individuals other than employees with work-related computer access.

A group health plan or health insurer must provide plan participants (and beneficiaries) with an SBC for each benefits package offered by the plan or health insurer for which the participant or beneficiary is eligible. For those plans that offer multiple benefits package options, the plan is required to provide a new SBC automatically upon renewal only with respect to the benefits package option in which the participant or beneficiary is enrolled. SBCs are not required to be automatically provided with respect to benefits package options in which the participant or beneficiary are not enrolled. However, if the participant or beneficiary requests an SBC with respect to another benefits package option(s) for which the participant or beneficiary is eligible, the

SBC(s) must be provided upon request. In certain situations, discussed in more detail below, health insurers offering group health insurance must provide an SBC to the group health plan (or its plan sponsor). The SBC may be provided to the plan in paper form. The insurer can also provide it in electronic form if:

- The format is readily accessible by the plan
- The SBC is provided in paper form free of charge upon request

If the electronic form is an internet posting, the insurer must notify the plan by paper or via email on a timely basis that documents are available on the internet and provide the web address.

TIMING

The SBC must be distributed from the health insurer to the group health plan at the following times:

- **UPON APPLICATION.** The SBC must be provided upon application or request for information about the health coverage as soon as practicable following the request but in no event later than seven days following the request. If the insurer provides an SBC upon request for information about health coverage and the group health plan subsequently applies for health coverage, a second SBC is only required if the information in the SBC has changed.
 - If there is any change in the information required to be in an SBC before the coverage is offered, or before the first day of coverage, the insurer must update and provide a current SBC to the plan no later than the date of the offer (or no later than the first day of coverage, if applicable).
- **AT RENEWAL.** If the insurer renews or reissues the policy, certificate or contract of insurance, the insurer must provide a new SBC when the policy, certificate or contract is renewed or reissued. If written application is required for renewal the SBC must be provided no

later than the date the materials are distributed. If renewal is automatic the SBC must be provided no later than 30 days prior to the first of the new policy year.

- **UPON REQUEST.** If the group health plan requests an SBC from the insurer it must be provided as soon as practicable, but in no event later than seven days following the request.

The SBC must be distributed from the group health plan (or health insurer) to plan participants and beneficiaries at the following times:

- **AT ENROLLMENT.** The SBC must be provided as part of any written application materials that are distributed by the plan or health insurer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage.
 - If there is any change to the information required to be in the SBC before the first day of coverage, the plan or insurer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.
- **AT SPECIAL ENROLLMENT.** The plan or insurer must provide the SBC to special enrollees within seven days of a request for enrollment pursuant to a HIPAA special enrollment right.
- **AT RENEWAL.** If the plan or insurer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or insurer must provide a new SBC when the coverage is renewed. If written application is required for renewal, the SBC must be provided no later than the date the materials are distributed. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of coverage under the new plan year.
- **UPON REQUEST.** The plan or health insurer must provide the SBC to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request.

While group health plans and insurers will be required to distribute the SBC upon request and to new enrollees on or after March 23, 2012 (although agencies have requested comments on the feasibility of implementing the SBC requirement by this date), it does not appear that employers will be required to distribute it to all participants by this date. However, mass distribution clearly would be required at the next enrollment opportunity.

MID-YEAR PLAN DESIGN CHANGES

If the insurer or group health plan makes a mid-year material modification to coverage that affects the information in the SBC, the insurer or group health plan must provide notice of the modification to enrollees no later than 60 days prior to the date the modification becomes effective. The 60-day notice requirement does not apply to modifications made at renewal. A material modification is one that affects the information contained in the SBC, including enhancements or reductions of covered services or benefits.

The notice can be sent as a separate notice which describes the material modification or as an updated SBC.

UNIFORM GLOSSARY

Group health plans and insurers must make a glossary available to participants and beneficiaries with uniform definitions on certain health coverage and medical terms. The purpose of the glossary is to help participants to understand the terms of coverage. The glossary cannot be modified by the group health plan or the insurer. The group health plan and insurer must make the glossary available upon request, in either paper or electronic form (as requested) within seven days of the request. The SBC must disclose the right of an individual to request a copy of the uniform glossary.

PENALTIES

An insurer or group health plan that willfully fails to provide an SBC or glossary will be subject to a fine of up to \$1,000 for each failure (a failure with respect to each participant and beneficiary constitutes a separate offense). The DOL, which has enforcement authority over those plans governed by ERISA, has indicated that it will issue separate penalty regulations. According to the preamble of the proposed regulations, a failure to distribute the required materials is also subject to the excise tax reporting requirements for group health plans. Additional information about the excise tax can be found in Willis Human Capital Practice *Alert*, Vol. 2, No. 11, **“Stricter Penalties for Group Health Plan Violations.”**

CONCLUSION

While the SBC regulations are only proposed and the final regulations could set forth differing requirements, it is not known whether the deadline for distributing the SBC will be extended (although the request for comments on this would indicate a willingness to delay the effective date). As such, employers may wish to begin taking steps to comply with the requirements as they are currently set out.

KEY CONTACTS

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