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NEW PROPOSED REGULATIONS ON SUMMARY OF BENEFITS AND COVERAGE

On December 22, 2014, The Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) released proposed regulations on changes to the Summary of Benefits and Coverage (SBC).

The effective date of these proposed regulations will be effective for plan years beginning on or after September 1, 2015.

Some highlights are included below.

Streamlined SBC Template

The new format for SBCs is only 2.5 double sided pages, which significantly reduces the format from the original 2 sided, 4 page long document.

In addition, there is a new coverage example included which provides an example of a foot fracture in relation to an emergency room visit. The SBC originally only included two coverage examples regarding maternity and diabetes.

The website where the new SBC templates can be found now has all the information plans need to complete the coverage example, including how to price the maternity claim and diabetic care claim. The SBC website still includes a calculator that could be used for coverage examples but unfortunately still may not provide entirely accurate estimations of cost in the coverage examples.

SBC Must Include Whether Coverage is MEC and Meets MV

The SBC must now specify whether the coverage is considered Minimum Essential Coverage. Also, the SBC must include whether the plan provides Minimum Value (at least 60% Actuarial Value). Previously, a cover memo was sufficient in disclosing this information to individuals, but now it is a requirement for all plan SBCs to contain this information.

Flexibility for Two Vendors that Administer Benefits

The proposed SBC rule allows an employer who uses two separate vendors for health plan administration (e.g. health plan administrator and pharmacy benefit manager) to either provide two SBCs with a note explaining the relationship between the two vendors or provide employees with one merged SBC document.

Health Reimbursement Arrangements (HRAs) are considered self-funded medical plans. An SBC must be provided for an HRA. However, employers could have one SBC for the comprehensive medical plan and include information on the HRA within the scope of the comprehensive plan's SBC.

Uniform Glossary

The proposed regulations maintained the requirement to include the link to the Uniform Glossary in the SBC. The SBC also has to include the statement that a paper copy is available upon request and contact information for a member to make the request. The proposed rules revise the Uniform Glossary. Some definitions have changes and new terms have been added.

NEW PROPOSED REGULATIONS ON SUMMARY OF BENEFITS AND COVERAGE (CONTINUED)

When and How a Plan Administrator Must Provide an SBC

The SBC must be provided to plan members and beneficiaries covered by the plan. For insured plans, the provision of the SBC is a shared responsibility between the employers and the insurance carrier. If one entity provides the SBC, that will meet the other entity's requirement to provide the SBC. The insurance carrier must create the SBC. For self-funded plans, the employer is responsible for creating and distributing the SBC. Some TPAs will create the SBCs for self-funded plans.

SBCs must be provided:

1. **Upon application (when a participant is initially eligible for coverage)**: Must be distributed with the application materials for all plan options for which the participant is eligible. If the plan does not distribute application materials, then the SBC must be delivered no later than the first day the participant is eligible to enroll.

2. **By the first day of coverage (if there are changes)**: Distributed only if there is any change to the information on the SBC provided when the participant was initially eligible. If there is a change, an updated SBC must be provided no later than the first day of coverage.

3. **When an event triggers HIPAA special enrollment rights**: Provided within 90 days of enrollment. Plans may wish to provide the SBC with plan information materials to assist the enrollee in making coverage decisions.

4. **At annual open enrollment**: The regulations refer to this as 'upon renewal.' If a plan requires a positive enrollment, the SBC must be distributed with the annual enrollment materials. If enrollment is passive, the SBC must be provided 30 days prior to the effective date. If renewal decisions are not made within 30 days, the SBC must be provided as soon as practical, but no less than seven business days before the effective date. During annual enrollment, participants need to be provided with an SBC only for the plan option in which they are enrolled.

5. **Upon request**: Within seven business days of the receipt of a request.

The regulations state when the SBC must be provided. *Provided* means the SBC must be sent by the required date. SBCs can be provided in paper format or electronically. A plan can send one paper copy of the SBC to the participant's home address. This will meet the distribution requirements for any plan participants living at that same address. But if the plan is aware of a plan participant living at a different address, a copy of the SBC should be sent to the participant at that address. But if the plan is **aware** of a plan participant living at a different address, a copy of the SBC should be sent to the participant at that address.

The SBC does not need to be provided on a stand-alone basis. It can be provided with other plan materials. If provided with other materials, the SBC information must be intact and displayed prominently at the beginning of such materials. Exercise caution if you include the SBC with the Summary Plan Description (SPD). You must adhere to the timing of the delivery to the SBC requirement rather than the SPD rules.

Providing SBCs Electronically

The regulations have changed regarding the allowable methods to provide SBCs electronically. Two options for electronic delivery include:

1. Determined by status as enrolled or eligible:

    a. For participants who are already covered by the benefit plan, the plan must take necessary measures to ensure the system furnishes the SBC:

        i. Use return receipt or undelivered mail feature or use some other method to check receipt of SBC

        ii. The electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document

        iii. The recipient is notified of the significance of the document and their right to request a paper copy

NEW PROPOSED REGULATIONS ON SUMMARY OF BENEFITS AND COVERAGE (CONTINUED)

iv. The recipient must have either:

- The ability to effectively access documents furnished in electronic form where the participant is reasonably expected to perform his or her duties as an employee and has access to the employer's electronic system
- Provided consent (must include the hardware/software necessary) to receive the documents electronically

b. For participants who are eligible but not yet enrolled in the plan, the employer can provide SBCs electronically if the format is readily accessible and a paper copy is provided free of charge upon request. If the electronic format is an Internet posting, the plan must advise the individuals that the information is available either through paper or email, include the internet address, and include notification that a paper copy is available upon request.

2. If the employer uses an online enrollment system, delivery by electronic means may be completed in the following manner (in both situations, the right to paper copy must be communicated):

a. SBCs can be provided through the online enrollment system in connection with initial enrollment or re-enrollment during the plan's open enrollment

b. SBC can be provided electronically to an individual who requests one online

Note: Employers may also need to send an SBC to COBRA qualified beneficiaries. COBRA qualifying events do not prompt the SBC requirements. Any qualified beneficiaries on your plan at open enrollment will need an SBC provided to them at open enrollment.

Action Required

Employers offering fully-insured plans and self-funded plans should begin reviewing their SBC templates to prepare for the new SBC requirements by September 1, 2015. Employers should also review the above delivery methods for electronic delivery of the SBC to ensure they comply with the rules to allow for electronic delivery to employees.

For the complete details, see:

http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html

PROPOSED RULES RELEASED ON LIMITED WRAPAROUND COVERAGE

Background

Generally, group health plans are subject to the provisions of ERISA, the Public Health Services Act, HIPAA, and the Affordable Care Act (ACA). However, some plans may not be subject to these regulations and are typically referred to as "excepted benefits." Some examples of excepted benefits are stand-alone dental or vision benefits in addition to other benefits that are not health plans. Excepted benefits, therefore, can be offered as part of a group health plan without violating the ACA, ERISA, or HIPAA. Also, if an employee elected into an excepted benefit, they may still qualify for a premium tax credit towards the purchase of coverage in the public Marketplace (i.e. Exchange).

Four categories of excepted benefits exist. These four categories include:

- Benefits that are not considered health coverage (e.g. automobile insurance)
- Limited excepted benefits (e.g. stand-alone vision or dental plans)
- Non-coordinated excepted benefits (e.g. hospital indemnity or fixed indemnity polices)
- Supplemental excepted benefits (e.g. Medicare Supplemental policy)

On December 14, 2013, the Departments of Labor, Health and Human Services, and Treasury (collectively "the Departments") released proposed regulations stating that the Departments planned to develop future rules defining "limited wraparound coverage" as an "excepted benefit."

Limited Wraparound Coverage

On December 23, 2014, the Departments released proposed regulations on a proposed pilot program for limited wraparound coverage. Limited wraparound coverage must be offered no later than December 31, 2017, and the coverage must end three years after it is first offered. Limited wraparound coverage is employer sponsored coverage designed to wrap around an employee's individual health policy (non-employer sponsored coverage). Compliant limited wraparound coverage is considered an excepted benefit, and is not intended to qualify as Minimum Essential Coverage (MEC). Therefore, employers who offer limited wraparound coverage to employees must also offer ACA compliant plans to their full-time employees, and any employees purchasing limited wraparound coverage must purchase an individual ACA compliant plan in order to avoid penalties.

There are five requirements for a limited wraparound benefit to be considered an excepted benefit. The following five requirements are listed below:

1. *Covers only Additional Benefits Outside of an Individual Policy* – The limited wraparound coverage must provide meaningful benefits. This would mean that the coverage cannot merely provide cost-sharing benefits to increase the actuarial value of the individual health insurance. In addition, the coverage cannot be an account-based reimbursement account (e.g. HRA). Some prescribed wraparound coverage that may be considered as providing meaningful benefits may include a benefit that expands an individual health policy's provider network or a benefit plan that provides non-Essential Health Benefit coverage that is not included as part of the individual health policy.
2. *Total Annual Cost of Coverage Limited* – The total annual cost (i.e. employee and employer contribution) of the limited wraparound coverage may be no greater than the maximum annual salary reduction for Health FSAs in that year ($2,550 in 2015).
3. *Non-discriminatory as to Benefits* – The limited wraparound coverage cannot impose pre-existing condition exclusions nor discriminate in eligibility, benefits, or premiums based on a health factor. In addition, the limited wraparound coverage cannot discriminate in favor of highly compensated individuals (HCIs).
4. *Eligibility* – The following eligibility requirements for wraparound coverage must be used if an employer offers limited wraparound coverage:
    a. Eligible individuals for the wraparound coverage may not be enrolled in a Flexible Spending Account (FSA).
    b. The eligible individual must be a part-time employee (averaging less than 30 hours of service per week), a retiree who is eligible for Minimum Essential Coverage (MEC) under the employer plan, or the dependent of a part-time employee or retiree.

PROPOSED RULES RELEASED ON LIMITED WRAPAROUND COVERAGE (CONTINUED)

c. The employer must offer coverage to full-time employees in a manner that avoids penalties under the Employer Mandate under IRC § 4980H(a) and § 4980H(b).

d. If an employer is offering Multi-State Plan (MSP) coverage as the major medical plan, the wraparound coverage must be approved by the Office of Personnel Management (OPM). Also, retroactively, for the plan year beginning in 2014, the employer must have offered a substantial portion of its full-time employees coverage that provided Minimum Value and that was affordable. Finally, for the duration of the pilot program, the total annual employer contributions for both primary and wraparound coverage **after** 2014 would have to be substantially the same as the employer's total contributions for coverage offered to full-time employees in 2014.

5. *Reporting Requirement* – An employer must provide and report enough information to HHS so that HHS can reasonably determine whether such wraparound coverage has met the above requirements for limited wraparound coverage.

Conclusion

Employers should be cautious when offering limited wraparound coverage. It is important that if employers choose to offer wraparound coverage, that they pay close attention to the individuals who are eligible for such coverage. Also, employers offering wraparound coverage must ensure that they are at least offering MEC to full-time employees, which provides Minimum Value and is affordable to avoid penalties under IRC §§ 4980H(a) and (b).

QUALIFIED EXPATRIATE HEALTH PLANS EXEMPT FROM MOST HEALTH CARE REFORM PROVISIONS

On December 16, 2014, the President of the United States signed into law the Consolidated and Further Continuing Appropriations Act, 2015 (The Act). The Act revised and modified provisions related to health care reform which also affect expatriate health plans. The Act modifies existing relief for expatriate health plans set forth in FAQs which were previously released in March of 2013 and January of 2014. These new changes affect expatriate health plans issued or renewed on or after July 1, 2015.

Qualified Expatriate Health Plans

Only qualified expatriate health plans will be provided relief from many of the provisions under Health Care Reform requirements imposed on health plans. An expatriate health plan may be a fully-insured or self-funded employer sponsored plan. The government only considers an expatriate health plan "qualified" so long as it meets all of the following requirements:

- *Enrollees* - Substantially all of the primary enrollees (i.e. not including dependents) in the expatriate plan must fit into one of the following definitions of a "qualified" expatriate:
    - *Workers in the United States* – To qualify as an expatriate employee in the United States, the Individual must have been:
        1) Transferred or assigned to the United States by the employer due to their skills and expertise
        2) Reasonably determined to require access to health insurance in multiple countries; and
        3) Offered other "multinational benefits" (e.g. tax equalization)
    - *Workers outside the United States* – To qualify as an expatriate employee outside of the United States, the Individual must:
        1) Work outside of the United States for at least 180 days in a consecutive 12-month period, which coincides with the plan year
    - *Charitable Workers* – To qualify as a charitable expatriate worker, the Individual must:

QUALIFIED EXPATRIATE HEALTH PLANS EXEMPT FROM MOST HEALTH CARE REFORM PROVISIONS (Continued)

1) Be members or groups formed for traveling or relocating internationally to do certain nonprofit work (and not primarily formed for the sale of insurance), and

2) HHS must determine that this members group requires access to health insurance in multiple countries

- *Standard of Coverage* – To qualify for relief, expatriate coverage must provide the following coverage standards:
  - Provides Minimum Value (at least 60% AV)
  - Covers inpatient hospitalization services, physician services, and emergency services in countries where qualifying expatriates work (for workers transferred to the United States, in the **both** the United States and the transferring country)
  - Satisfies HIPAA portability provisions (e.g. special enrollment rights) that existed prior to ACA
  - If dependent coverage is offered, the offer of dependent coverage must remain until the dependent is age 26
- *Scope of Relief* – If such coverage is considered a qualified expatriate plan, many of the Health Care Reform requirements would not apply to the expatriate coverage. However, coverage under a qualified expatriate plan would count as MEC for both the Individual Mandate and Employer Mandate. In addition, Reporting under IRC §§ 6055 and 6056 are required for these plans.

Action Required

Employers should ensure any expatriate plans they offer meet the requirements of a qualified expatriate health plan. If an employer chooses to offer a non-qualified expatriate plan to satisfy the requirements of an offer of MEC to substantially all of its full-time employees, employers may want to consider offering a qualified MEC plan in addition to the non-qualified expatriate plan.

For the complete details, see:

http://www.gpo.gov/fdsys/pkg/CPRT-113HPRT91668/pdf/CPRT-113HPRT91668.pdf

RETROACTIVE INCREASE TO 2014 QUALIFIED TRANSPORTATION BENEFITS AND TAX REPORTING

On January 8, 2015, the Tax Increase Prevention Act of 2014 (TIPA) retroactively increased the total limit for transit benefits. Qualified transportation plans were forced to reduce transit benefit limits to $130 in 2014, but TIPA retroactively increased this limit to $250. The result is that employers may now correct FICA tax overpayments resulting from the increased 2014 limit if they had originally imputed income for any benefits in excess of $130 a month, and less than or equal to $250 a month. The following is guidance on the special procedure for an employer to correct FICA tax overpayments:

- *Employer Cannot Retroactively Amend Compensation Reductions for Transit Benefits* – An employer who did not previously deduct an employee's transit benefits above the limit may not do so retroactively in 2015 to pay for transit benefits offered in 2014.

- *Administrative Procedures for Amendments* – For employers who have not yet filed their fourth quarter Form 941 in 2014, and who deducted employee's transit benefit deductions in excess of the $130 limit, the employer may either repay or reimburse employees for the over-collected FICA taxes for all four quarters in 2014. An Employer who has already filed their Form 941 will be required to file Form 941-X if they want to make the corrections necessary to account for the over-collected taxes.

- *W-2 Amendments* – If Form W-2s have not yet been furnished to employees, an employer must adjust the W-2 to reflect the increased income exclusion and any over-collected FICA taxes repaid or reimbursed. If W-2s have already been delivered to employees, but have not yet been delivered to the Social Security Administration (SSA), the forms must be corrected and redistributed. Finally, if the forms have already been filed with the SSA, then correction to employees' W-2s must be accomplished using Form W-2c.

Action Required

Employers who treated excess transit benefits as income and wages for 2014 should move quickly to take advantage of the special procedure to retroactively increase the TIPA amount to employees' transit benefits.

For the complete details, see:

http://www.irs.gov/pub/irs-drop/n-15-02.pdf

COMPLIANCE REMINDERS...

Employers in California are obligated to provide notice of the Sick Leave Law, which mandates paid sick leave throughout the state. Employers must display a poster regarding the paid sick leave requirement in a conspicuous place within each workplace. Employers must also provide new employees written notice of their paid sick leave at time of hire.

These notice requirements apply January 1, 2015, even though the requirement to provide paid leave does not become effective until July 1, 2015.

For a model version of the poster, see:
http://www.dir.ca.gov/dlse/Publications/Paid_Sick_Days_Poster_Template_(11_2014).pdf

For a model version of the notice, see:
http://www.dir.ca.gov/dlse/Publications/LC_2810.5_Notice_(Revised-11_2014).pdf

QUESTION OF THE MONTH

Q: Our company's major medical plan covers the pregnancy-related expenses of employees and their spouses. Is our plan also required to cover pregnancy-related expenses of employees' children who are enrolled as dependents?

A: Although health care reform requires group health plans that provide dependent coverage for participants' children to make such coverage available until a child turns age 26, plans do not necessarily have to cover the pregnancy-related expenses of those children. Under the Pregnancy Discrimination Act (PDA), a health plan of an employer with 15 or more employees that covers medical expenses of female employees' spouses must also cover medical expenses of male employees' spouses, including expenses arising from pregnancy-related conditions. But the PDA does not require plans to cover the pregnancy-related expenses of other covered individuals (such as employees' children), so long as pregnancy-related expenses of male and female employees' dependents are treated equally.

Nevertheless, your plan may still have to cover some pregnancy-related expenses of employees' children. If your plan is a small group market insurance plan that is non-grandfathered and not subject to transitional relief (see our article), it will be required to cover maternity care as one of the "essential health benefits" (EHBs). The EHB rules generally apply to the small group market—plans of employers with 50 or fewer employees (starting in 2016, that number will increase to include employers with 100 or fewer employees). While larger employers' plans are not subject to the EHB rules, health care reform's preventive services mandate requires all non-grandfathered group health plans to provide first-dollar coverage of in-network prenatal and post-natal care for all covered individuals under the plan, including an employee's children.

Source: EBIA Thomson Reuters