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INSURANCE BRIEF

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Health Care Reform Updates

Summary of Benefits and Coverage In a notice published on November 17, 2011, the Department of Labor (DOL) announced that these new reporting requirements would not go into effect until after final rules are published. It is anticipated that the final regulations will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply. This is a relief for employers and insurers alike as the original March 23, 2012 deadline was fast approaching.

Medical Loss Ratio (MLR) Rebates The HHS issued final regulations on December 7, 2011 following the DOL issuing Technical Release No. 2011-04. Included are revised rules on who receives the rebates related to employer sponsored plans and how such amounts may be applied.

Under the final regulations, insurers must provide the rebates for individuals covered by group health plans subject to ERISA or the PHSA to the policyholder—typically the employer sponsoring the plan. According to HHS, requiring insurers to apportion and pay rebates directly to policyholders and each of their subscribers (who are generally employees) in the group health plan context had unintended administrative consequences as well as potential tax consequences for insurers, employers, and individuals.

The DOL Technical Release, which applies to ERISA plans, explains that existing fiduciary duty and plan asset rules govern treatment of insurer rebates. Applying those rules to MLR rebates, the DOL notes that they may qualify as ERISA plan assets (in whole or part) depending on various factors, including the terms of governing documents, whether the insurance policy is issued to the plan itself (or a related trust), and whether insurance premiums are paid from trust assets. Other considerations also apply, including the relative proportion of premiums paid by plan participants (e.g., through employee salary reductions under a cafeteria plan) and the amount of plan administrative expenses paid by the plan sponsor. Any portion of a rebate that constitutes plan assets must be used for the exclusive benefit of plan participants and beneficiaries, and ERISA fiduciary principles must be followed in choosing how to use that portion of the rebate. Examples of allocation methods mentioned in the guidance include refunds to participants or reductions in future participant contributions or benefit enhancements. In addition, this Technical Release provides that prior DOL Technical Release 92-01 (which generally excuses insured group health plans from the obligation to hold participant contributions in trust and from the obligation to file Form 5500 as a funded plan) will be treated as applying to MLR rebates, provided they are used within three months of receipt to pay premiums or refunds.

An equal allocation of the rebate among current participants to decrease their premium share seems the simplest method. Employers will want to be sure they have used all the

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Health Care Reform Updates *cont'd*

rebates within the three month deadline to avoid triggering the need to create a trust to hold the rebate monies and to do a 5500 filing for that trust.

Although the "rebates" currently being given by Blue Shield of California are not subject to the MLR regulations, we continue to advise clients to look to these regulations for guidance on how they should treat these rebates.

There is one additional clarification our clients with international policies may find of interest. The final rules amended the definition of "expatriate policies" issued by non-U.S. issuers for services rendered outside the U.S. which are not subject to the MLR regulation. The definition now reads: group policies that provide coverage to employees, substantially all of whom are: working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country.

Essential Health Benefits (EHB) As background, the Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside the Exchanges, offer a comprehensive package of items and services known as "essential health benefits." EHB must include items and services within at least the following ten categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

The U.S. Department of Health and Human Services (HHS) announced on December 16, 2011, through a press release that state exchanges will now determine their benchmark for EHB based upon use of the most popular plans in their region and the 10 benefit categories. With this new approach, a state exchange will select an existing plan to serve as the benchmark for the items and services that will be included in the EHB package. States would choose one of the following as a benchmark:

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Transit Benefit Increase Expires

Congress did not pass a bill to extend the increased transit benefit under Sec. 132 plans. Under the American Recovery and Reinvestment Act of 2009 the monthly transit benefit had been temporarily increased to match the parking benefit. This increase was extended for 2011 but expired on 12/31/11. As a result, the limit for monthly transit benefits effective January 1, 2012 is $125 while the limit for monthly parking benefits effective January 1, 2012 is $240.

Health Care Reform Updates *cont'd*

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state's commercial market.

If states choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state.

This change to move the responsibility of essential benefits to the state level will give states the flexibility to match their exchange plans to those offered by a typical employer in the state. Further, states that have a more broad based health care coverage mandate will not be penalized for incorporating their states' mandates into their definition of essential benefits. It is HHS' position that these proposed policies will ensure that each state will now be able to properly meet the needs of the residents of their state through the selections of health care coverage that they offer through their exchange.

HHS indicated that future bulletins will address cost sharing features such as deductibles, coinsurance and copayments.

W-2 Reporting The IRS issued Notice 2012-9 on January 4, 2012, incorporating comments received in response to Notice 2011-28. There are many modifications of Notice 2011-28 and additional guidance in the new notice. However, this requirement is still only mandatory in 2012 for employers who file 250 or more W-2's in 2011. It is optional for all other employers until future guidance. Here are some highlights of the changes:

Modifies Q&A-20 to clarify that the standard for determining whether coverage under a dental plan or vision plan is subject to the reporting requirement is based upon the same standard for determining whether the coverage is subject to the rules set forth in the regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (*Generally, a stand alone policy or a benefit that is not bundled with medical is an excepted benefit).*

Adds a new example to Q&A-19 that demonstrates that the reporting requirement does not apply to coverage under a health flexible spending arrangement (FSA) if contributions occur only through employee salary reduction elections.

Provides that employers are not required to include the cost of coverage under an employee assistance program (EAP), wellness program, or on-site medical clinic in the reportable amount if the employer does not charge a premium with respect to that type of coverage provided under COBRA to a qualifying beneficiary (Q&A-32).

Clarifies that employers may include the cost of coverage under programs not required to be included under applicable interim relief, such as the cost of coverage under a Health Reimbursement Arrangement (HRA) (Q&A-33).

Clarifies how to calculate the reportable amount where coverage extends over the payroll period including December 31 (Q&A-36).

Clarifies the application of the exception for certain hospital indemnity or other fixed indemnity insurance offered by an employer on an after-tax basis (Q&A-37 and Q&A-38).

What's Next Contact your SML Account Team if you have any questions about these changes.