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SITZMANN • MORRIS • LAVIS

Employee Benefits | Life Insurance | Risk Management

INSURANCE BRIEF

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SBC Proposed Rules

On December 22nd the Departments of Health and Human Services, Labor and Treasury (the Departments) issued proposed regulations for changes to the Summary of Benefits and Coverage (SBC). These regulations would amend the final regulations issued in February 2012. They include revisions to the templates, instruction guides, uniform glossary, and other supporting materials for compliance with the regulations. These amendments are based on questions and feedback the Departments received. The aim of these amendments is to improve consumers' access to important plan information so that they can make informed choices when shopping for and renewing coverage, as well as to provide clarifications that will make it easier for health insurance issuers and group health plans to comply with providing this information.

The Departments have published a Fact Sheet. The updated templates, instructions and related materials are available on this web page.

Effective date: Policy years beginning on or after September 1, 2015. Comments will be accepted until March 2, 2015.

Background:

SBC's are required for group health plans, including medical, health reimbursement arrangements and certain health flexible spending accounts (FSAs). FSAs that are only funded by employees are excepted. Dental and vision coverage that is not bundled with medical is also excepted.

Key Provisions:

SBC Coverage Examples— the current examples of "having a baby (normal delivery)" and "managing diabetes type 2" will be kept and a third example of a foot fracture with ER visit will be added. The pricing data will be updated to more accurately reflect allowed charges.

SBC and Glossary Formatting and Content Changes— The sample SBC for a group health plan has been shortened from four double-sided pages to two and a half. The SBC and Glossary will be updated to remove references to annual limits for essential health benefits and preexisting condition exclusions. The disclosures relating to continuation of coverage, minimum essential coverage and minimum value are also being revised.

As the Departments stated in Affordable Care Act Implementation FAQs Part VIII, question 7, for purposes of providing an SBC in the context of these regulations, the term "provided" means sent. Accordingly, the SBC is timely if it is sent within seven business days, even if not received until after that period.

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SBC Proposed Rules *cont'd*

If a plan sponsor is negotiating coverage terms after an application has been filed and the information in the SBC changes, the insurer is required to provide an updated SBC by the date the coverage becomes effective.

SBCs may continue to be provided electronically to group plan participants in connection with their online enrollment or online renewal of coverage. SBCs may also be provided electronically to participants who request an SBC online. These individuals must also have the option to receive a paper copy upon request.

The Centers for Medicare and Medicaid Services (CMS) has issued its annual update of the list of counties where at least 10% of the population is literate only in the same non-English language (Spanish, Chinese, Tagalog, or Navajo). The SBC must be provided in a "culturally and linguistically appropriate manner". SBCs provided in the counties listed must include a statement in the indicated language regarding availability of language assistance. The statement is included in each of the four languages in the sample SBC. In California, there are many counties with a Spanish language requirement, and San Francisco county has a Chinese language requirement. The list is available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf.

Your SML Account Team is here to answer any ACA questions.

Transit Limits

Starting in 2009, Congress amended the rules for Sec. 132 qualified transportation plans to make the combined monthly limit for transit and vanpooling benefits equal to the monthly limit for parking. This parity for transit with parking was extended by the 2010 Tax Relief Act through 12/31/2011. Lastly, the American Taxpayer Relief Act of 2012 extended the transit parity rule through the end of 2013. This relief came late (January 2013), but at least it was early enough for employers to quickly change their limits for the 2013 plan year.

Now we have the Tax Increase Prevention Act of 2014 (TIPA) which Congress passed on December 19, 2014. This act retroactively increases the 2014 combined limit for transit and vanpooling benefits again providing parity with the parking limit. Prior to TIPA the transit limit was $130. This increases it to $250. This extension is only for 2014. The transit limit for 2015 remains unchanged at $130.

This extension of transit parity only benefits those who actually allowed their employees to make post-tax deductions above the $130 pre-tax limit, or who made employer contributions for transit. There are no transition rules provided in TIPA to guide those employers affected.

In areas where transit costs can exceed the $130 limit, post-tax deductions make sense if the employer purchases the transit passes. When the employee is purchasing their own pass, as most of our clients' employees do, there is no benefit to allowing post-tax deductions.

What's Next: Employers offering Sec. 132 transit benefits may want to consider the odds of Congress again passing legislation in 2015 restoring transit parity. Employers would need to allow post-tax transit deductions for amounts above $130 up to $250 to have the chance to benefit from any future retroactive legislation. An amendment to existing Sec. 132 plans would be required.

Affordable Care Act FAQs

The Departments have been issuing FAQs on the implementation of the Affordable Care Act (ACA). A complete list of issued FAQs can be viewed at http://www.dol.gov/ebsa/healthreform/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html).

The most recent release (FAQ Part XXII) was November 6, 2014, and is available at http://www.dol.gov/ebsa/faqs/faq-aca22.html. The FAQs Part XXII provide guidance on premium reimbursement arrangements. In case anyone had lingering ideas about employers reimbursing employees for their individual health insurance premiums, these FAQ show that the Departments do not approve any such arrangement. This is true for either post-tax or pre-tax arrangements.

Employer reimbursement arrangements are not permissible under health care reform because these arrangements are themselves a group health plan and, therefore, will violate the ACA's prohibition on annual dollar limits for essential health benefits and the requirement to provide first-dollar coverage for preventive services.

The penalty for failure to comply with the annual limit and preventive services provisions is $100 per employee per day.

Disallowed Pay or Play Strategies

Strategy	Compliance Issue
Pre-tax reimbursement of EE's individual policy premiums	This is considered a group health plan subject to the ACA's annual limit on essential health benefits and preventive services provisions. The annual benefit is limited to the cost of the individual premium, therefore failing to meet this requirement.
Post-tax reimbursement of EE's individual policy premiums	This is considered a group health plan subject to the ACA's annual limit on essential health benefits and preventive services provisions. The annual benefit is limited to the cost of the individual premium, therefore failing to meet this requirement.
Code § 105 plan tied to third-party vendor of individual coverage	This is treated the same as the pre-tax arrangement above and fails to comply with the annual limits provision.
Cash offer to high risk claims EEs who opt out of employer health plan	This is considered discrimination based on a health factor and violates both HIPAA and ERISA.
Plans that exclude hospitalization and/or physician services	The IRS and HHS have issued Notice 2014-69 and proposed regulations stating the minimum value calculator was flawed and that MV plans must include hospitalization and physician services.

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2015 IRS Guidelines

Employee Benefits	2014	2015
Health Care Flexible Spending Account Maximum	$2,500	$2,550
Dependent Care Spending Account Maximum	$5,000	$5,000
Health Savings Accounts:		
• Maximum Individual Contribution	$3,300	$3,350
• Maximum Family Contribution	$6,550	$6,650
• Catch-Up Contribution	$1,000	$1,000
High Deductible Health Plans:		
• HDHP Minimum Annual Deductible (Individual)	$1,250	$1,300
• HDHP Minimum Annual Deductible (Family)	$2,500	$2,600
• HDHP Maximum Out-of-Pocket Limit (Individual)	$6,350	$6,450
• HDHP Maximum Out-of-Pocket Limit (Family)	$12,700	$12,900
Parking (Monthly)	$250	$250
Mass Transit Passes (Monthly)	$130	$130
Bicycle Commuting (Monthly)	$20	$20
401(k) Limit	$17,500	$18,000
401(k) Catch-up	$5,500	$6,000

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