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Employee Benefits | Life Insurance | Retirement Planning

TO: Clients of Sitzmann Morris & Lavis Inc.

RE: Health Care Reform Update: Proposed Regulations for Summary of Benefits and Coverage and Premium Tax Credit Provisions

Summary of Benefits and Coverage

The Departments of Health and Human Services (HHS) and Labor (DOL) and the IRS issued proposed regulations on August 22, 2011.

Background: ERISA's disclosure requirements were expanded under PPACA by the addition of a four-page summary of benefits and coverage (SBC) to be provided to applicants and enrollees prior to enrollment or re-enrollment. *The SBC provision applies to all plans regardless of grandfather status.* For fully-insured plans, the SBC must be produced by the health insurance issuer and in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan must produce the SBC. The responsibility for the actual distribution of the SBC remains with the plan sponsor. The Secretary of HHS was required to issue guidance addressing the SBC requirement by March 23, 2011. So, this guidance is coming late.

Key Provisions: The agencies have interpreted "four pages" to mean four double-sided pages, so it will actually be an eight-page summary.

- SBC Template and Uniform Glossary. The guidance includes proposed SBC standards (in template format http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf) and a uniform glossary of common health coverage terms (http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) The proposed SBC template includes instructions, samples, and a guide for providing coverage examples to illustrate benefits provided under the plan for common benefits scenarios. As proposed, a group health plan with multiple coverage options would provide a separate SBC for each option.

- Content Requirements Expanded. In addition to the statutory SBC-required content, the proposed regulations would require four additional elements—(1) an Internet address (or similar contact information) for obtaining a list of network providers; (2) an Internet address for more information about prescription drug coverage; (3) an Internet address to review and obtain the uniform glossary; and (4) premiums (or cost of coverage for self-insured group health plans). (The premium information required would not reflect any employer subsidy, which the agencies recognize could hamper cost comparisons.)
- Appearance and Language. While the proposed regulations would require that the SBC be a stand-alone document, the agencies recognize the potential overlap between the SBC and certain SPD requirements for ERISA plans. Comments are solicited regarding ways the SBC might be coordinated with the SPD and other materials that group health plans typically provide. The SBC also must be provided in a "culturally and linguistically appropriate" manner, following the rules for providing appeals notices.
- Requirements Relating to Providing the SBC. As noted above, the proposed regulations would not change who must provide or receive the SBC. They would clarify that a group health plan's obligation to provide the SBC is satisfied so long as any entity has provided it—that is, if the insurer provides the SBC to participants, the plan administrator's obligation has been satisfied. For ERISA plans, the SBC may be delivered electronically by satisfying the requirements of the DOL's electronic disclosure safe harbor provisions. (See the July 2011 issue of *SML Insurance Brief* for the electronic disclosure rules).
- Timing. The proposed regulations would require that the SBC be automatically provided to a participant or beneficiary no later than the first day of eligibility to enroll in coverage. If there are changes to the SBC-required information before coverage begins, a new SBC would be required. For subsequent plan years, the participant would automatically receive the SBC for the participant's elected coverage with each year's open enrollment materials, but need not receive the SBC for any other benefit package unless requested. Where re-enrollment is automatic, the new SBC would be required no later than 30 days before the beginning of the new plan year. Upon a participant's request or special enrollment, the proposed regulations would require the SBC to be provided within 7 days of the request. If there is a material modification to a plan feature or coverage that would affect the SBC content, notice of the modification would be required no later than 60 days before the

modification's effective date. *For January 1, 2013 plan years that means a notice of modification is required by November 1, 2012. The SBC would be required by December 2.*

- The agencies have requested comments on the feasibility of implementation under that timeline, noting that the SBC template and related materials will not be finalized until after the comment period ends on October 21, 2011. The agencies have also requested comments on the templates, uniform glossary, and coverage examples, including whether the proposed template would require modifications for certain types of plans and benefits.

Effective: For plans years beginning on or after March 23, 2012.

Premium Tax Credit

The IRS issued proposed regulations for the premium tax credit on August 12, 2011.

Background: Beginning in 2014 taxpayers with household incomes between 100 percent and 400 percent of the federal poverty line will be eligible for premium tax credits for coverage purchased through the Exchanges. These premium tax credits would be paid in advance to the insurer of the qualified health plan, thereby reducing the out-of-pocket premiums required to purchase coverage. Later, the advance payment would be reconciled against the amount of the actual premium tax credit, as calculated on the individual's federal income tax return.

Under the employer pay or play provision which takes effect in 2014, if a large employer (50 full-time equivalent employees) has an employee receiving a premium tax credit and the employer's coverage costs more than 9.5% of that employee's household income, the employer must pay a penalty of the lesser of $3,000 per such employee or $2,000 times the total number of full-time employees, reduced by 30. For this purpose, it is the employee portion of the self-only premium for the employer's lowest-cost plan providing minimum essential coverage that is considered.

Key Provisions:

- An individual is eligible for the credit if the individual is a taxpayer who has purchased coverage on the Exchange and is not eligible for "minimum essential coverage" other than through coverage in the individual market.

- An eligible employer-sponsored plan provides "minimum value" if the plan's share of the total allowed costs of benefits is at least 60 percent. The preamble to the IRS proposed regulations indicates that the agencies are contemplating whether to provide transition relief with respect to the minimum value requirement for employers currently offering health coverage.
- Anticipated "Affordability" Safe Harbor for Employers. As noted above, employers may be subject to an assessable payment if the employee's portion of the plan's premium is deemed unaffordable. The preamble to the IRS proposed regulations indicates that future regulations are expected to provide an affordability safe harbor for employers. Under this anticipated safe harbor, an employer that meets certain requirements, including offering its full-time employees (and their dependents) the opportunity to enroll in eligible employer-sponsored coverage, would be able to consider only the W-2 wages it pays the employee when calculating whether the employee portion of the premium for applicable employer-provided coverage exceeds the 9.5 percent threshold that triggers an assessable payment by the employer. According to the agencies, giving employers the ability to base their affordability calculations on their employees' wages (which employers know) instead of employees' household income (which employers generally do not know) is intended to provide a more workable and predictable method for both employers and employees.
- The premium tax credit amount is the lesser of the premium for the Exchange plan purchased by the taxpayer or the excess of the premium for the "benchmark plan" over a percentage of the taxpayer's household income determined under health care reform rules. The benchmark plan is the second lowest cost plan at the silver level (as determined under the rules relating to the Exchanges) that would cover the taxpayer and any family members enrolled in the Exchange plan. The IRS has issued a Fact Sheet which contains three examples of premium tax credit calculations. http://www.treasury.gov/press-center/Documents/36BFactSheet.PDF

Effective date:

The proposed regulations for the premium tax credit take effect for tax years beginning 1/1/14.

What's Next:

We will provide you with more detail as it becomes available. As always, contact your SML Account team if you have any questions.