Health Care Reform Update

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Today's Topics:

- Summary of Benefits and Coverage document
- Form W-2 reporting requirements
- Supreme Court oral arguments

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Supreme Court Oral Arguments:

- Individual Mandate: Does the federal government have the authority to force individuals to purchase health insurance coverage?
- Anti-Injunction Act: Is the penalty for not purchasing health insurance coverage considered a "tax"? If so, is it too early for the Court to rule on this case?

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Supreme Court Oral Arguments:

- Severability: If the Individual Mandate is unconstitutional, can it be severed from the rest of the health care reform law, leaving the rest of the reform law in place, or will the entire law be struck down?
- Medicaid: The reform law amended the Medicaid program to require states to make Medicaid benefits available to individuals with incomes of up to 133% of the FPL. If a state refuses, then all of that state's federal Medicaid funding can be withheld. Is this unconstitutionally coercive?

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Supreme Court Oral Arguments:

- The Justices seemed to question the government's case.
- If the Individual Mandate is deemed unconstitutional, some other provisions of the health care reform law may be struck down as well, but most experts believe that those provisions that are already in place will remain.

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Summary of Benefits and Coverage:

- The health care reform law requires that certain group health plans and health insurance companies (health insurance issuers) develop and distribute to employees a Summary of Benefits and Coverage ("SBC") document that accurately describes the benefits and coverage under the applicable health plan or policy.
- This must be produced in addition to the SPD. It does not take the place of the SPD.

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Summary of Benefits and Coverage:

- The Department of Labor produced a template at: www.dol.gov/ebsa/healthreform/
- Instructions on how to complete the template are also available at that address.

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Summary of Benefits and Coverage:

- An SBC must be prepared for most group health plans, such as for a major medical plan or health reimbursement arrangement.
- An SBC is not required for "excepted benefits" such as stand-alone dental or vision plans. Also exempt are <u>most</u> FSAs, HSAs, accident-only plans, disability income coverage, and workers' compensation policies.
- Rule of thumb: A flexible spending account funded solely by employee contributions will almost always be an excepted benefit.

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Summary of Benefits and Coverage:

- Appearance: The SBC cannot be longer than 4 double-sided pages. It cannot use print that is smaller than 12-point font.
- The SBC's terminology must be understandable by the average plan enrollee.

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SBC: Contents

- Uniform definitions of standard medical terms and insurance terms
- Exceptions and limitations to coverage
- Cost-sharing provisions
- Renewability and continuation of coverage examples
- Coverage examples
- Contact information for questions or to obtain copies of plan documents or insurance policies
- Internet address to obtain provider directory and uniform glossary
- Internet address for obtaining information about the prescription drug coverage

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SBC: Distribution to employer's plan

- A health insurance company or HMO that offers group health coverage to employers must provide the employer with the SBC as soon as practicable following receipt of the employer's application for health benefits, but in no event later than 7 business days from the date that the company received the employer's application.
- If there is any change in the information contained in the SBC that was provided to the employer upon application but before the first day that coverage actually begins, then the insurance carrier has to provide an updated SBC to the employer before the first day of coverage.

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SBC: Distribution to employer's plan

- If the employer renews existing coverage with an insurance carrier, then the insurance carrier has to give the employer a new SBC either as part of the renewal application packet, or if a renewal application is not required and renewal is automatic, at least 30 days prior to the first day of the next plan year.
- As soon as practicable upon request, but in no event later than 7 business days following receipt of the request.
- No charge.

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SBC: Distribution to employer's plan

- Can be provided in paper or electronic form. If the insurance company chooses to provide the document in electronic form: (1) the format must be readily accessible by the employer; (2) a paper copy must be provided free of charge upon request; and (3) if the electronic form is an internet posting, the insurance company must notify the employer in paper form or via email that the documents are available on the internet.

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SBC: Distribution to participants

- General rule: A participant is entitled to an SBC for each benefit package for which he or she is eligible.
- The SBC must be provided as part of any written application materials that are distributed to participants by the employer or the health insurance company for enrollment.
- If an SBC is provided during open enrollment but there is a change made to the information required to be in the SBC before the first day that coverage begins, then an updated SBC must be provided before the first day of coverage.

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SBC: Distribution to participants

- Mid-year enrollees: Provide the SBC no later than the date by which a summary plan description must be provided.
- Upon renewal. If an application is required for renewal, include the SBC with the renewal application materials. If renewal is automatic and without an application, provide the SBC no later than 30 days prior to the first day of the new plan year.

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SBC: Distribution to participants

- Upon request. Provide a copy to participants or beneficiaries upon request as soon as practicable, but in no event later than 7 days following receipt of the request.
- No charge.

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SBC: Distribution to participants

- Paper or electronic distribution is acceptable. If choosing electronic, the distribution requirements to those employees who are eligible but not enrolled are easier to comply with than the distribution requirements for employees who are already enrolled.

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SBC: Distribution to participants

- Eligible but not enrolled: (1) the format must be readily accessible; (2) the SBC must be provided in paper form upon request and free of charge; and (3) if the electronic form chosen is an internet posting, then the plan or insurance company must notify the individual in paper form (such as a postcard) or email that the documents are available on the internet, provide the internet address, and notify the individual that documents are available in paper form upon request.
- Enrolled: The SBC may be provided electronically if the complicated electronic distribution rules under ERISA are complied with.

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SBC: Avoiding duplication

- An employer group health plan that is required to provide an SBC satisfies its requirement if another party provides the SBC, but only if the other party provides an SBC that contains all of the required language and it is provided on a timely basis.
- If the last known address that you have for a participant is also the last known address that you have for the participant's dependents, then you are only required to provide the SBC to the participant. You do not also have to provide a copy to dependents. But if a dependent's last known address is different than the participant's address, then you must provide the dependent with his or her own copy of the SBC at his or her last known address.

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Uniform Glossary

- Health insurance companies and employer group health plans must also make available to participants and beneficiaries a uniform glossary that provides definitions of certain health-coverage-related terms and medical terms.
- The glossary must be provided to participants and beneficiaries <u>upon request only</u>, in either paper or electronic form (as requested by the individual), within 7 business days of receipt of the request.

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Penalties for noncompliance:

- An employer group health plan that willfully fails to provide the SBC or Uniform Glossary to a participant or beneficiary is subject to a fine of up to $1,000 for each such failure.
- During the first year that these rules are in effect, no fines will be issued on plans and insurance companies that are working diligently and in good faith to provide the required SBC materials.

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Effective dates:

- For those participants enrolling in a plan through an open enrollment period, the SBC must be provided no later than the first day of the first open enrollment period that begins on or after September 23, 2012.
- For those participants enrolling through something other than open enrollment (such as mid-year enrollment for special enrollees), the requirement to provide the SBC begins on the first day of the first plan year that begins on or after September 23, 2012.
- Health insurance companies must provide the SBC to employers starting on September 23, 2012.

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Notice of modification:

- If there is a material modification made to the health benefits that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal of coverage, then the employer group health plan or insurance company must provide notice of the modification to enrollees at least 60 days prior to the date in which the modification will become effective.

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FAQs

- Q: Are plans and issuers required to provide a separate SBC for each coverage tier (e.g., self-only coverage, employee-plus-one coverage, family coverage) within a benefit package?
- A: No, plans and issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable. In such circumstances, the coverage examples should be completed using the cost sharing (e.g., deductible and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption.

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FAQs

- Q: If the participant is able to select the levels of deductible, copayments, and co-insurance for a particular benefit package, are plans and issuers required to provide a separate SBC for every possible combination that a participant may select under that benefit package?
- A: No, plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the Department's sample completed SBC.

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FAQs

- Q: The final regulations require the SBC to be provided in certain circumstances within 7 business days. Does that mean the plan or issuer has 7 business days to send the SBC, or that the SBC must be received within 7 business days?
- A: In the context of the final regulations, the term "provided" means sent. Accordingly, the SBC is timely if sent out within 7 business days, even if it is not received until after that period.

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FAQs

- Q: Are plans and issuers required to provide SBCs to individuals who are COBRA qualified beneficiaries?
- A: Yes. While a qualifying event does not, itself, trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary. There are also limited situations in which a COBRA qualified beneficiary may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event and this may trigger the right to an SBC.

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FAQs

Q: Can a plan or issuer add premium information to the SBC form voluntarily?

A: Yes. If a plan or issuer chooses to add premium information to the SBC, the information should be added at the end of the SBC form.

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FAQs

Q: Can issuers and plans make minor adjustments to the SBC format, such as changing row and column sizes? What about changes such as rolling over information from one page to another, which was not permitted by the instructions?

A: Minor adjustments are permitted to the row or column size in order to accommodate the plan's information, as long as the information is understandable. The deletion of columns or rows is not permitted.

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Form W-2:

- Certain employers must begin including the aggregate cost of employer-sponsored health coverage onto employees' W-2s, in Box 12, Code DD.
- This is for informational purposes only and will not make the benefits taxable to employees.
- Effective: 2012 tax year (or, by 1-31-13).

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Form W-2: Small employer exception

- Employers that issued fewer than 250 Form W-2s in the preceding calendar year are exempt from this reporting requirement.

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Form W-2: Exclusions

- The following benefits should not be included in the reporting:
  - Long-term care plans
  - Accident or disability income
  - Auto insurance, including auto medical insurance
  - Workers' compensation benefits

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Form W-2: Exclusions

- Specified disease coverage (like a cancer policy) or hospital-only coverage if two requirements are met: (1) the employer does not make any tax-free contributions to the coverage (most employers do not contribute to these) and (2) the employee does not pay the premium on a pre-tax basis through a cafeteria plan
- Archer medical savings account programs regardless of whether the employer or employee makes the contribution
- Health savings account regardless of whether the employer or employee makes the contribution

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Form W-2: Exclusions

- Health FSAs that only include employee contributions
- Health reimbursement arrangements
- Dental or vision coverage if the dental/vision coverage is considered an excepted benefit. To be considered an excepted benefit, it must either be: (1) offered pursuant to a separate insurance policy (which means not offered under the same policy as the major medical benefits) or (2) participants must have the right not to elect the dental or vision benefits and if they do elect the dental or vision benefits, they must pay an additional premium or contribution for that coverage.

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Form W-2: Exclusions

Certain group health plan benefits if the employer does not charge COBRA beneficiaries a COBRA premium for them: wellness programs, on-site medical clinics, employee assistance programs.

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Form W-2: Included benefits

- Major medical
- Integrated dental
- Integrated vision
- Employer contributions to a health FSA
- Wellness programs, on-site medical clinics, and employee assistance programs if they provide medical benefits and if the employer charges a COBRA premium for these benefits.
- Specified disease coverage (like a cancer policy) or hospital-only coverage if: (1) the employer contributes to the cost of coverage on a tax-free basis to the employee (most employers do not contribute to these) or (2) the employee pays premium on a pre-tax basis through a cafeteria plan

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Form W-2:

- You are not required to provide a W-2 to an individual to report health costs if the individual would not otherwise receive one. Examples: retirees or COBRA beneficiaries with no reportable wages for the tax year.
- Report the aggregate cost of the includable benefits, regardless of who paid the premiums.

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FAQs

- Q-1: What rules apply in the case of coverage provided by the employer to an employee for a period during a calendar year after that employee has terminated employment?
- A-1: An employer may apply any reasonable method of reporting the cost of coverage provided under a group health plan for an employee who terminated employment during the calendar year, provided that the method is used consistently for all employees receiving coverage under that plan who terminate employment during the plan year and continue or otherwise receive coverage after the termination of employment. However, regardless of the method of reporting used by the employer for other terminated employees, an employer is not required to report any amount in box 12 using Code DD for an employee who has requested to receive a Form W-2 before the end of the calendar year during which the employee terminated employment.

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FAQs

- Example 1. Employee is an employee of Employer on January 1, and continues in employment through April 25. During that entire period and through April 30, Employee had individual coverage for himself under a group health plan with a cost of coverage of $350 per month. Employee elects continuation coverage for the six months following termination of employment, covering the period May 1 through October 31, for which the Employee pays $350 per month. Employer reports $1,400 as the reportable cost under the plan for the calendar year, covering the four months during which Employee performed services and had coverage as an active employee. Employer applies this method consistently for all employees terminating during the calendar year who have coverage under that group health plan. Employer has applied a reasonable method of reporting Employee's reportable cost under the plan.

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FAQs

- Example 2. Same facts as Example 1, except that Employer reports $3,500 as the reportable cost under the plan for the calendar year, covering both the monthly periods during which Employee performed services and had coverage as an active employee, and the monthly periods during which Employee retained continuation coverage under the plan. Employer applies this method consistently for all employees terminating during the calendar year who retained coverage under that group health plan. Employer has applied a reasonable method of reporting Employee's reportable cost under the plan.

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FAQs

- Q-2: Must an employer issue a Form W-2 including the aggregate reportable cost to an individual to whom the employer is not otherwise required to issue a Form W-2, such as a retiree or other former employee receiving no compensation required to be reported on a Form W-2?
- A-2: No. An employer is not required to issue a Form W-2 reporting the aggregate reportable cost to an individual to whom the employer is not otherwise required to issue a Form W-2.

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FAQs

- Q-3: Is the total of the aggregate reportable costs attributable to an employer's employees required to be reported on Form W-3, Transmittal of Wage and Tax Statements?
- A-3: No. The total of the aggregate reportable costs attributable to an employer's employees is not required to be reported on Form W-3, Transmittal of Wage and Tax Statements.

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FAQs

- Q-4: How is the reportable cost under a plan calculated if an employee commences, changes or terminates coverage during the year?
- A-4: If an employee changes coverage during the year, the reportable cost under the plan for the employee for the year must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods for which such coverage is elected. If the change in coverage occurs during a period (for example, in the middle of a month where costs are determined on a monthly basis), an employer may use any reasonable method to determine the reportable cost for such period, such as using the reportable cost at the beginning of the period or at the end of the period, or averaging or prorating the reportable costs, provided that the same method is used for all employees with coverage under that plan. Similarly, if an employee commences coverage or terminates coverage during a period, an employer may use any reasonable method to calculate the reportable cost for that period, provided that the same method is used for all employees with coverage under the plan.

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FAQs

- Example 1: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is $500. Employee is employed by employer for the entire calendar year 2012, and had self-only coverage under the group health plan for the entire year. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as $6,000 ($500 x 12).

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FAQs

- Example 2: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is $500, and that the monthly reportable cost under the same group health plan for self-plus-spouse coverage for the calendar year 2012 is $1,000. Employee is employed by Employer for the entire calendar year 2012. Employee had self-only coverage under the group health plan from January 1, 2012 through June 30, 2012, and then had self-plus-spouse coverage from July 1, 2012 through December 31, 2012. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as $9,000 (($500 x 6) + ($1,000 x 6)).

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FAQs

- Example 3: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is $500. Employee commences employment and self-only coverage under the group health plan on March 14, 2012, and continues employment and self-only coverage through the remainder of the calendar year. For purposes of reporting for the 2012 calendar year, Employer treats the cost of coverage under the plan for Employee for March 2012 as $250 ($500 x ½). Because Employer's method of calculating the reportable cost of under the plan for March 2012 by prorating the reportable cost for March 2012 to reflect Employee's date of commencement of coverage is reasonable, Employer must treat the 2012 reportable cost under the plan for Employee as $4,750 (($500 x ½) + ($500 x 9)).

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FAQs

- Q-5: Is the cost of coverage provided under an employee assistance program (EAP), wellness program, or on-site medical clinic required to be included in the aggregate reportable cost reported on Form W-2?
- A-5: Coverage provided under an EAP, wellness program, or on-site medical clinic is only includible in the aggregate reportable cost to the extent that the coverage is provided under a program that is a group health plan for purposes of § 5000(b)(1). An employer is not required to include the cost of coverage provided under an EAP, wellness program, or on-site medical clinic that otherwise would be required to be included in the aggregate reportable cost reported on Form W-2 because it constitutes applicable employer-sponsored coverage, if that employer does not charge a premium with respect to that type of coverage provided to a beneficiary qualifying for coverage in accordance with any applicable federal continuation coverage requirements. If an employer charges a premium with respect to that type of coverage provided to a beneficiary qualifying for coverage in accordance with any applicable federal continuation coverage requirements, that employer is required to include the cost of that type of coverage provided.

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Disclaimer

This presentation highlights specific areas of law. This communication is not legal advice. The reader should consult an attorney to determine how the information applies to any specific situation. The original air date of this webinar was June 12, 2012, and the law is subject to change after that date.

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Questions?

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