HealthPlans
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Compliance Bulletin
August 17, 2012

Federal Health Care Reform
Implementation of Regulations
Issue Number 6:
• Summary of Benefits and Coverage
• Benefit Changes • PCORI Fee

With the Supreme Court's June 28, 2012 decision upholding the individual mandate and all parts of the Affordable Care Act (ACA) that apply to group health plans, **Health Plans** continues to move full-steam ahead to help you understand the impact of the law on your plans and to work with you to implement the applicable provisions.

This *Bulletin*, the sixth in our health care reform series, will address the ACA provisions listed below that start taking effect through January 1, 2013* and outline the steps required to implement each.

Summary of Benefits and Coverage (SBC) and Uniform Glossary *(pages 2-8)* required for all medical plan options (plan designs), as of the earlier of the first open enrollment period or plan year that begins on or after September 23, 2012

Benefit Changes *(pages 9-10)*

- **Increased coverage for women's preventive services** for non-grandfathered medical plans, effective plan years starting on and after August 1, 2012
- **Minimum overall annual benefit limit of $2 million** for all medical plans, effective plan years starting on and after September 23, 2012
- **Maximum health flexible spending account elections of $2,500** effective plan years beginning on and after January 1, 2013

Patient Centered Outcomes Research Institute (PCORI) fee *(pages 11-12)* (previously known as the Comparative Effectiveness fee) assessed against all medical plans, effective plan years ***ending*** on or after October 1, 2012, and payable by July 31 of the following calendar year

* Please see our April, 2012 Compliance Alert regarding the Form W-2 reporting requirements that apply to 2012 Forms W-2 which must be issued by January, 2013. We are not further addressing the requirements in this Bulletin.

Please see the last page of this Bulletin for a list of health care reform topics to be addressed in future issues.

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Summary of Benefits and Coverage (SBC) and Uniform Glossary

Our April 2012 *Compliance Alert* provided an overview of the final regulations for the Summary of Benefits and Coverage (SBC) and Uniform Glossary which were issued in February 2012. In this section, we are:

- Expanding the information previously provided
- Incorporating the latest guidance from the Departments of Labor, Treasury and Health and Human Services
- Describing the steps necessary to produce and distribute SBCs and Uniform Glossaries

Here is an index to the topics covered in this section:

Overview

SBCs were mandated under the Affordable Care Act (ACA), and the Departments of Labor, Treasury, and Health and Human Services ("the Departments") were charged with developing rules to specify content and format. The stated goal for the SBCs is to help individuals "better understand their own health coverage as well as other coverage options" by providing a tool that "ensure[s] information is presented in clear language and in a uniform format...".[1] The Departments also developed a Uniform Glossary defining the terms used in the SBC. In other words, SBCs and the Uniform Glossary were conceived to help consumers evaluate and make apples-to-apples comparisons of benefits under different plans without regard to which employer or insurer would be offering the coverage.

To meet their goals for clarity and uniformity, the Departments have issued very specific instructions and guidance. These rules are summarized in the chart that begins on page 3.

[1]Federal Register, Vol. 77, No. 30, page 8668

SBC Rules Summary

The SBC Rules Chart below outlines the current requirements based on the most recent federal guidance. This chart expands on the one included in our April 2012 *Compliance Alert* to include more detail regarding required content.

SBC Rules Chart

Topic	Regulatory Details
Applicability	Required for all individual, group and self-funded group medical plans (including HRAs) that are generally subject to ACA, regardless of size and grandfather status
Format The regulations have very specific layout and language requirements	• Eight pages (four 2-sided sheets) • Specific font size and type for each section • Specific language to describe coverage • May be modified to show additional network coverage tiers • May not delete any row or column on basic template

Content
Each content element in the SBC template must be addressed; specific language must be used to describe plan provisions
	The SBC is divided into the following sections:
	• **Important Questions**, showing:
	  • Deductibles, out-of-pocket limits, network requirements and services not covered
	  • Information about any employer-funded HSA or HRA available to offset out-of-pocket costs (optional)
	• **Common Medical Events**, showing coverage and limits for:
	  • Office visits (Primary care, specialist, other and preventive care)
	  • Testing
	  • Prescription coverage
	  • Outpatient surgery
	  • Emergencies
	  • Inpatient stays
	  • Mental health and substance abuse services
	  • Maternity services
	  • Special health needs such as home health care, rehabilitation services, durable medical equipment and hospice
	  • Children's dental and vision coverage
	• **Excluded Services & Other Covered Services** showing:
	  • 14 specific services as either covered or excluded; information about all other covered services may NOT be included
	  • Any other services listed under Common Medical Events as not covered at any tier
	• **Your Rights to Continue Coverage** addressing possibility of continuing coverage
	• **Your Grievance and Appeals Rights** providing contact information for filing an appeal or complaint
	• **Coverage Examples** showing patient out-of-pocket costs for two scenarios; examples must use the costs determined by Health and Human Services (HHS).

Initial Notice Requirements	Earlier of: • First Open Enrollment period, or • First Plan Year that begins on or after September 23, 2012

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SBC Rules Chart, *cont'd*

Ongoing Notice Requirements	SBCs must be issued: • 30 days in advance of renewal date if employees are **not** required to actively elect to maintain coverage (evergreen elections) • On the first day of open enrollment if employees may actively elect to maintain or change coverage before the start of a new plan year • With enrollment materials for newly eligible employees • On the first day of coverage if coverage provisions changed since the SBC was distributed with the enrollment/open enrollment materials • 60 days in advance of any mid-year increase or reduction in benefits, (a change would be communicated by amendment, but the updated SBC would have to be available to any newly eligible or newly enrolled employee) • Upon request, within 7 business days
Distribution Methods	**Electronically** (email or internet) • For employees enrolled in plan – may be guided by ERISA safe harbor rule: ◊ Employee works at computer, or ◊ Employee agrees in writing to receiving information electronically • For eligible employees/dependents who are not enrolled: ◊ Can post on the Internet, notifying eligible person by mail or email that the documents are available on the Internet or in paper form by request **Paper** • To anyone, anytime
Penalties for Failure to Provide	• Willful failure to provide information required subject to fine of not more than $1,000 for each failure • Failure with respect to each participant or beneficiary constitutes a separate offense
First Year Safe Harbor	• The Departments will not impose penalties on plans working diligently and in good faith to provide the required SBC content in an appearance consistent with final regulations.

To further illustrate just how strict the standards are, here are some excerpts from the instructions:

"The items shown on page 1 must always appear on page 1, and the rows of the chart must always appear in the same order."

"The disclaimer at the top of page 1 should be replicated and the plan or issuer may not vary the font size, graphic, or formatting."

"Minor adjustments are permitted to the row or column size in order to accommodate the plan's information. The deletion of columns or rows is not permitted."

To see a sample SBC developed by the Departments, go to www.dol.gov/ebsa/pdf/**SBCSample**Completed.pdf

A Note about Final Authority on Plan Benefits

If information on the SBC does not reflect all provisions included in the plan document, the plan document (together with any associated amendments) remains the final authority for benefits under the plan.

However, because the SBC has such specific content requirements, a material omission or mistake could trigger enforcement action by the DOL, even if the plan document and/or SPD correctly and completely state the provisions (see *Noncompliance Penalties and Enforcement Actions* below).

Uniform Glossary

In addition to the SBC, the Departments developed a Uniform Glossary to provide consumers with definitions of the terms used in the SBC. All of the terms included in the glossary and their definitions have been prescribed by the Departments.

While the Uniform Glossary must be delivered to eligible employees in paper form or electronically, within 7 business days of a request, there is no requirement to provide it except when requested.

The SBCs will include the web address for the government site where the Uniform Glossary is available to read or download: www.dol.gov/ebsa/pdf/SBC**UniformGlossary**.pdf.

Implementation Guide

Health Plans has dedicated a full team of compliance, communications, technology and project management staff to developing and delivering SBCs by the statutory deadline applicable to each plan (see *SBC Rules Chart, Initial Notice Requirements*). Although the ACA gives self-funded plan sponsors the legal obligation to produce and distribute the SBC, **Health Plans** is committed to helping you meet this requirement.

Initial Rollout

Our current schedule for rolling out the first wave of SBCs is below.

Initial Rollout Schedule

Plan Years Beginning	**Anticipated Delivery Date from Health Plans to Sponsors** (provided final plan design is available three weeks in advance)
October 1, 2012	During the month of September In these cases, delivery of your SBCs would be somewhat in advance of the statutory requirements which provide that if open enrollment begins *before* September 23, 2012, the SBC does not need to be available to employees until the plan year begins. But we understand that you would prefer to supply them to your employees, if possible, before October 1
On and after November 1, 2012	The later of : • 7 days before open enrollment begins • October 1, 2012

Distribution and Delivery Rules

The distribution and delivery rules below apply to the ongoing administration of SBCs, as well as to the initial rollout.

Distribution

Who

In general, distribution to eligible and enrolled employees is required, without separate notice to dependents. However, if the plan has been notified that a dependent should receive plan-related communications at a different address, then the SBC must also be sent to that dependent.

When

Annually, at the earlier of:

- The date open enrollment materials are distributed
- Thirty (30) days before new plan year begins

Also:

- By the first day of the new plan year if the benefits were changed or corrected after open enrollment materials were delivered to employees
- On the date election materials are given to newly eligible employees

What

- If employees are enrolled in an option, the SBC for their current option
- If employees are eligible, but not enrolled, SBCs for all available options
- The Uniform Glossary does not have to be included, but must be available within 7 business days of a request from any eligible employee or dependent.

Delivery

SBCs may be delivered:

- On paper (hard copy) to individual employees via:
  - ◊ Mail
  - ◊ In-hand delivery to specific employees (not, for example, by leaving a stack in a common area for employees to pick up)
- Electronically with notice to all eligible employees about their availability, subject to ERISA and ACA electronic distribution rules as follows:
  - ◊ The ERISA safe harbor rule permits electronic delivery to enrolled employees who work at computers in the regular course of their jobs or who agree in writing to accept electronic delivery.
  - ◊ Even if you do not use electronic delivery for enrolled employees, you may post the SBC for eligible, but not enrolled employees, and notify them by email or postcard that the SBC is available online.
  - ◊ If SBCs are distributed electronically, you must also be able to provide a paper copy of the latest SBC within 7 business days of an employee's or dependent's request.

Health Plans will create PDFs of the SBCs required for each of your plan options at no cost to you, sending it to the person you designate as responsible for SBC distribution. You may then distribute the SBCs using any of the following methods:

- Print and mail to all eligible employees,
- Print and distribute in-hand to all eligible employees,
- Email to all eligible employees*, and/or
- Post electronically on your internet or intranet site*, and notify employees via email or regular mail about the availability of the SBC for review

* See *Delivery* above for information about the ERISA and ACA rules for electronic delivery.

If you would like additional support from **Health Plans** for distribution, please contact your Account Manager. Any associated costs will depend on the estimated print and mailing expenses.

Implementation Action Items

To meet the deadlines and delivery requirements for the initial rollout, here are the actions that **Health Plans** and you, as the plan sponsor of your group health plan, will need to take:

Implementation Action Items

Health Plans Action Items	Plan Sponsor Action Items
• Continue developing and testing SBCs for all plan designs, setting priorities by the statutory deadline for distribution • Contact employers through Account Managers to confirm the email addresses of the individuals responsible for distributing (or authorizing distribution of) the SBCs on employer's behalf • Deliver SBC PDFs to Plan Sponsors as described on Initial Rollout Schedule • Notify employers if additional guidance affecting SBCs is issued	• Provide a final plan design for the new year *three weeks before* the start of your open enrollment period • Determine whether you will include the Uniform Glossary with your SBCs (it is not required, but the Glossary must be delivered within 7 business days upon a request from an eligible employee or dependent) • Determine who in your organization will distribute or authorize distribution of the SBCs and provide a current email address to your Account Manager • Contact your Account Manager if you would like additional support for the initial distribution of SBCs • Establish a process for printing and delivering individual SBCs and Uniform Glossaries upon individual request by employees or dependents

Ongoing SBC Administration

Going forward, **Health Plans** will continue to update and maintain SBCs for your medical plans. However, the ACA has changed the notice requirements associated with amending plans as described below.

Plan Amendment Advance Notice Requirements

The new SBC regulations impose significant new notice requirements when plan amendments affect the content of an SBC in any way.

- **Amendments made between renewals** (or after the beginning of the plan year) regardless of whether there is an improvement or reduction in coverage ***– must be communicated 60 days in advance*** of the change***.***

  New SBCs don't need to be distributed, but an announcement of the plan change (e.g., a copy of the amendment itself) must be distributed to all enrolled employees no less than 60 days before the effective date. In addition, we understand that a new SBC with the updated information should be available to any newly eligible employees by the effective date.

- **Corrections to benefits effective at renewal** (or at the new plan year) not reflected in the open enrollment SBC, must be included in a new SBC, and the new SBC ***must be distributed to all enrolled employees by the first day that the new coverage takes effect***.

Note:

Under the pre-ACA ERISA rules, notices of material modifications (i.e., notices of significant reductions in benefits) had to be distributed within 60 days of the effective date of the amendment. Other changes, such as minor benefit adjustments or benefit enhancements had to be communicated to employees within 60 days of the end of the plan year in which the change took effect. **The new regulations will require you to make decisions on benefit changes well in advance of the effective date of the change. See Plan Sponsor Action Items in the following chart.**

Ongoing SBC Administration cont'd

Ongoing Administration Action Items

Here are the steps that **Health Plans** and Plan Sponsors will need to take for ongoing administration.

Health Plans Action Items	Plan Sponsor Action Items
• Draft amendments as they are requested by plan sponsors • Update the SBC with new information as applicable • Deliver PDF of updated SBC to Plan Sponsor	• Provide details regarding plan amendments 10-12 weeks in advance of mid-year plan change effective dates • Provide any corrections to the open enrollment SBC 2 weeks before the new plan takes effect • Distribute amendments or new SBCs to enrolled employees • Contact your Account Manager if you would like additional support for the distribution of amended SBCs • Distribute updated SBCs and Uniform Glossaries to employees or dependents within 7 business days of a request

Noncompliance Penalties and Enforcement Actions

Recognizing the heavy lift imposed by the aggressive implementation period, the Departments will not be taking enforcement action during the first year against any plan making good faith efforts to provide SBCs which incorporate all the required content.

In future years however (or if the Departments decide there is an absence of good faith efforts in the first year), the penalties for noncompliance are severe:

$1000 for each eligible person (counting both employees and dependents) who did not receive an SBC or whose SBC did not include all the required content in the prescribed format.

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Benefit Changes

There are three types of benefit changes mandated under the ACA that start taking effect in 2012 and 2013:

- Women's Preventive Health Coverage for non-grandfathered medical plans
- Minimum Overall Annual Limits for all medical plans
- Maximum Contributions for Health Flexible Spending Accounts (FSAs)

This section addresses these requirements, and outlines the steps that **Health Plans** and you will need to take to implement these changes.

Women's Preventive Health Coverage – Non-grandfathered medical plans

Our April 2012 *Compliance Alert* introduced the new women's preventive health care requirements which take effect for *non-grandfathered plans* on plan years that begin on and after August 1, 2012.

The services listed below must be covered in-network at 100% under your non-grandfathered medical plan(s). (If your plan has multiple networks or tiers of coverage, the services must be covered at 100% under at least one tier.) Many of the services may already be covered under your plan, and they may currently be covered at 100%.

- Well-woman visits at least annually
- Contraceptive drugs and devices available by prescription*
  - ◊ All FDA-approved contraceptive drugs and devices
  - ◊ May cover generic at 100% and apply copayments to preferred and non-preferred brands when generic is available
- Contraceptive office visits, including costs associated with counseling and providing devices*
- Voluntary sterilization including all recommended procedures for women*
- Breastfeeding support, counseling and supplies for each birth, without limit
- Gestational diabetes screening for women 24-28 weeks pregnant and for high-risk women
- HPV DNA testing every 3 years for women age 30 and older
- Annual counseling on HIV and sexually-transmitted infections (STIs) for sexually-active women
- Domestic violence screening and counseling

* Churches and religious orders have a permanent exemption from provisions regarding contraceptive services. Other non-profit organizations with religious affiliations have a one-year safe harbor (until at least August 2013) to comply with the contraceptive coverage requirements. The form Plan Sponsors must complete for the waiver is available at www.cciio.cms.gov under Regulations and Guidance; Health Market Reforms; Prevention; February 10, 2012.

Minimum Overall Annual Limit – All medical plans

Starting with plan years that begin on and after September 23, 2012, any overall annual limit on benefits must be at least $2 million. This is the third change in the permitted limit since the ACA started taking effect on September 23, 2010. For plan years beginning on and after January 1, 2014, overall annual limits must be completely eliminated.

Maximum Health FSA Elections

Beginning with plans years that start on and after January 1, 2013, employee contributions to health FSAs (medical care reimbursement accounts) must be capped at $2,500 per plan year per participant. Going forward the cap will be indexed to inflation and may be increased.

Note that if each of two spouses is eligible to elect salary reduction contributions to an FSA, each spouse may elect to make salary reduction contributions of up to $2,500 (as indexed for inflation) to his or her health FSA, even if both participate in the same health FSA sponsored by the same employer.

Implementing Benefit Changes

Here are the steps that **Health Plans** and Plan Sponsors will need to take to implement the benefit changes described above.

Benefit Change Action Items

Benefit Change	Health Plans Action Items	Plan Sponsor Action Items
For non-grandfathered medical plans – provide 100% coverage of prescribed women's preventive health services	• Draft applicable amendments for non-grandfathered plans* • Implement coverage changes in claims processing systems	• Distribute amendment to plan participants
For all medical plans – adjust overall annual maximum to be at least $2 million	• Identify plans with limits under $2 million • Work with employers to eliminate or establish a new limit • Draft applicable amendments* • Implement coverage change in claims processing systems	• Decide whether to increase or eliminate limit • Distribute amendment to plan participants
For health flexible spending accounts with limits over $2,500 – reduce annual employee contribution amount to $2,500 or less	• Identify plans with limits over $2,500 • Draft amendments to establish $2,500 limit • Implement coverage change in claims processing systems • Modify election materials	• Distribute amendment to plan participants

*If the women's preventive care and annual limit changes both apply to your medical plan on the same effective date, **Health Plans** will create a consolidated amendment that incorporates both.

PCORI Fee

The ACA created the Patient-Centered Outcomes Research Institute (PCORI). PCORI is charged with promoting research to evaluate and compare health outcomes and clinical effectiveness related to medical treatments, services, procedures and drugs in order to help patients, clinicians, purchasers and policymakers make informed health care decisions.

PCORI will be funded in part by fees assessed on sponsors of self-funded group health plans and on insurers, hence the PCORI fee. (Initially it was called the Comparative Effective fee.) The fee will be assessed annually for a seven year period, based on the average number of covered individuals — employees and dependents ("covered lives") — in a plan for each plan year ***ending*** on or after October 1, 2012 and before October 1, 2019.

The chart below outlines how the PCORI fee will work for self-funded group health plans.

PCORI Fee Summary Chart

Topic	Regulatory Details
Applicable plans	Medical plans covering employees and/or retirees, including HRAs that are not integrated into the medical plan, without regard to whether the plan is grandfathered *But not* excepted benefits, such as limited scope dental and vision plans and most flexible spending accounts; or expatriate plans and stop loss coverage
Applicable plan years	Each plan year ending on or after October 1, 2012, and before October 1 , 2019.
Fee due date	By July 31 of the calendar year immediately following the last day of the plan year, for example: • If plan year ends between 10/1/12 and 12/31/12 – first fee due by July 31, 2013 • If plan year ends between 1/1/13 and 12/31/13 – first fee due by July, 31, 2014
Fee amount	Plan years ending between 10/1/12 and 9/30/13: $1 times average number of covered lives Plan years ending between 10/1/13 and 9/30/14: $2 times average number of covered lives Plan years ending between 10/1/14 and 9/30/19: Prior year amount + adjustment indexed to national health expenditures
Reporting method	Annually by plan sponsors on federal excise tax Form 720
Defining "average covered lives" ***Special Transition Rule*** *– for the first year, plans with plan years starting before July 11, 2012 and ending on or after October 1, 2012 may determine the average number of covered lives using any reasonable method*	Employers may choose from three methods of counting covered lives: Actual Count Method Add all covered lives for each day of plan year, then divide by number of days in plan year (usually 365) Snapshot Method Add covered lives on one day from each quarter and divide by 4 *Note:* At your request, ***Health Plans*** *can provide you with a quarterly census report to use with this method* Form 5500 Method For plans that provide coverage to employees and dependents, the sum of number of participants on Form 5500 at beginning and at end of plan year For plans that provide employee only coverage, the sum of number of participants on Form 5500 at beginning and at end of plan year, divided by 2

PCORI Fee Action Item

Plan Sponsors: Contact Your Tax Advisor
Unlike state assessments that **Health Plans** collects and pays on behalf of plan sponsors, this fee must be filed on a plan sponsor's tax form and must be paid directly to the IRS by the plan sponsor.

Plan sponsors will want to work with their tax advisors to calculate and pay this assessment.

Health Plans will continue to update you as additional regulations and guidance are issued by the Departments about the provisions of the Affordable Care Act.

In the meantime, please contact your **Health Plans** Account Manager if you have questions about any of the provisions addressed in this *Compliance Bulletin*.

Future *Compliance Bulletins* and *Alerts* will address provisions that take effect later in 2013 and beginning in 2014 as implementing regulations are issued and their effective dates approach:

2013:
- Notification to employees of availability of health insurance exchanges (March 2013)
- Expansion of FICA to include additional 3.8% tax on unearned income of high income individuals (for 2013 tax year)
- Elimination of employer tax deduction for Retiree Drug Subsidy program (for 2013 tax year)

2014:
- Elimination of overall annual limits on essential health benefits
- Elimination of pre-existing condition exclusions for all participants
- Adoption of:
  - ◊ Coverage to age 26 for subscribers' children, regardless of eligibility for other coverage and regardless of plan grandfather status
  - ◊ Individual mandate provisions
  - ◊ "Play or pay" provisions applicable to employers
  - ◊ Health insurance exchanges
  - ◊ 90-day limit on waiting periods
  - ◊ Coverage of certain approved clinical trials for non-grandfathered plans
  - ◊ Possible limitations on deductibles and out-of-pocket maximums for non-grandfathered plans (additional guidance needed; these limits may apply only to plans offered through Exchanges)
  - ◊ State reinsurance pool fees
  - ◊ Automatic enrollment of new employees in health plan (effective date TBD; may be later than 2014)
  - ◊ Increase in wellness incentive caps from 20% to 30% of the cost of health care

2015:
- Implementation of detailed reporting to IRS regarding covered employees, contribution levels, "minimum essential coverage" under plan, and other plan provisions

2018:
- Adoption of:
  - ◊ "Cadillac" plan tax