UNIFORM SUMMARY OF BENEFITS AND COVERAGE

The Departments of Health and Human Services, Labor and Treasury (Departments) released final guidance under the Patient Protection and Affordable Care Act (PPACA) on the requirement for health plans and health insurance issuers to provide a summary of benefits and coverage to applicants and enrollees.

The health care reform law created the summary of benefits and coverage, or SBC, to provide consumers with simple and straightforward information on plan coverage in a uniform format. According to the Departments, the SBC will help consumers better understand the coverage they have and compare differences in benefits and coverage when they are shopping for a new plan. Specifically, the rules ensure individuals have access to two key documents:

- A summary of benefits and coverage (SBC)
- A uniform glossary of terms commonly used in health insurance coverage

As a reminder, responsibility for distributing the Summary of Benefits and Coverage falls on the health insurance issuer for fully-insured plans. For self-funded plans, responsibility lies with the plan sponsor or plan administrator. A third party administrator may distribute the Summary of Benefits and Coverage on behalf of a self-funded group health plan.

The Summary of Benefits and Coverage must be distributed to each participant or beneficiary for each benefit package offered by the plan if the individual is eligible. If multiple participants reside at the same address, a single Summary of Benefits and Coverage provided to that address satisfies the requirement with respect to all individuals residing at that address.

Final Guidance

To implement this disclosure requirement, the Departments released final regulations outlining standards for preparing and providing the SBC. The final regulations modify proposed guidance issued in August 2011.

In addition to the final regulations, the Departments also provided a final template for the SBC (along with instructions, samples and a guide for the coverage example calculations to be included in the SBC) and the uniform glossary explaining terms commonly used in health coverage.

The final regulations, template and uniform glossary are available through the Department of Health and Human Services at: http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

Deadlines

The original deadline was March 23, 2012. Now that final guidance has been released, plans and issuers must prepare to start providing the SBC beginning:

- On the first day of the first open enrollment period that begins on or after Sept. 23, 2012, plans must provide the SBC to participants and beneficiaries who enroll or re-enroll for coverage during the open enrollment period. (If your open enrollment period begins November 1, 2012, for a plan year beginning January 1, 2013, you need to provide the SBC on November 1, 2012.)
- On the first day of the first plan year that begins on or after Sept. 23, 2012, plans must provide the SBC to participants and beneficiaries who enroll for coverage other than through an open enrollment period, such as newly eligible individuals and special enrollees. (If your plan year begins January 1, 2013, you need to provide the SBC to newly eligible participants starting January 1, 2013.)
- Issuers must begin providing the SBC to plans on Sept. 23, 2012.

Calendar year plans with an annual open enrollment period that takes place before the start of the plan year will generally need to start providing the SBC on the first day of the open enrollment period for the 2013 plan year.
DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND TREASURY ISSUE TECHNICAL RELEASE 2012-01 ON AUTOMATIC ENROLLMENT, WAITING PERIODS, AND SHARED RESPONSIBILITY

This release provides information to employers and other stakeholders regarding questions pertaining to the implementation of these provisions that become effective in 2014. Following is a summary of some of the key takeaways. Click here to view the full release or go to http://www.dol.gov/ebsa/newsroom/tr12-01.html.

Automatic Enrollment

Taking into consideration the need to give employers time to comply, the need for detailed guidance, and a need to for smooth implementation processes, the Department of Labor concluded that automatic enrollment will not be ready to take effect in 2014. Until final regulations are issued and become applicable, employers are not required to comply with this provision.

Employer Shared Responsibility

Employer shared responsibility provisions provide that large employers can be subject to applicable penalties if any full-time employee receives a premium tax credit or cost-sharing reduction payment. This generally happens when:

- The employer does not offer employer-sponsored health benefits, or
- The employer-sponsored coverage is not considered affordable relative to household income or does not provide minimum value.

Related to implementation of this provision, the Department of Treasury and IRS intend to issue guidance in the following areas:

- The ability to use employee W-2 wages as a safe harbor in determining the affordability of employer coverage
- The coordination of the 90-day waiting period and any applicable shared responsibility penalties (The expectation is that at least for the first three months following date of hire, no penalty will be assessed by reason of failing to offer coverage)
- The ability to use a look-back/stability period in determining whether an employee is a full-time employee (It is expected that guidance will allow such periods as long as they do not exceed 12 months)
- The applicability of shared responsibility payments with respect to newly-hired employees and those transferring from one employment status to another

90-Day Limitation on Waiting Periods

Effective January 1, 2014, group health plans and health insurance issuers may not apply a waiting period that exceeds 90 days. Based on existing regulations, the 90-day waiting period begins when an employee is otherwise eligible for coverage under the terms of the plan. This is the definition the Departments intend to retain. If an employee is hired full time and must only be a full-time employee to be eligible for the plan, a wait of no more than 90 days from the date of hire could be imposed before coverage begins. Other eligibility provisions are permissible as long as they are not designed to avoid compliance with the 90-day limitation.

Upcoming guidance is also expected to address situations under an employer’s plan where employees or certain classes of employees are eligible for coverage once they complete a specified number of hours of service within a specified time period. These types of provisions will not be viewed as designed to avoid compliance as long as the cumulative hours do not exceed a number of hours expected in the guidance. Comments are requested on how this approach applies to plans that credit hours of service from multiple employers and plans that use hour banks.

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