Benefits Law Quarterly

A comprehensive employer's guide to recent developments in employee benefits law, including issues relating to HIPAA, COBRA, and ERISA compliance

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Final Rule Requires Clear and Consistent Information When Describing Health Benefits

People in the market for health insurance will soon have clear, understandable and straightforward information on what health plans will cover, what limitations or conditions will apply, and what they will pay for services thanks to the Affordable Care Act – the health reform law – according to final regulations published in February. Under the rule, health insurers must provide consumers with clear, consistent and comparable summary information about their health plan benefits and coverage. The new explanations, which will be available beginning, or soon after, September 23, 2012 will be a critical resource for the roughly 150 million Americans with private health insurance today.

The current patchwork of non-uniform consumer disclosure requirements makes shopping for coverage inefficient, difficult, and time-consuming, particularly in the individual and small group market, but also in some large employer plans in which workers may be confused about the value of their health benefits as part of their total compensation. As a result of this confusion, health insurance issuers and employers may face less pressure to compete on price, benefits, and quality, contributing to inefficiency in the health insurance and labor markets.

The new rules, published jointly by the Departments of Health and Human Services, Labor and Treasury, ensure consumers have access to two key documents that will help them understand and evaluate their health insurance choices:

- A short, easy-to-understand Summary of Benefits and Coverage (or "SBC"); and
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "co-payment."

A key feature of the SBC is a new, standardized plan comparison tool called "coverage examples," similar to the Nutrition Facts label required for packaged foods. The coverage examples will illustrate sample medical situations and describe how much coverage the plan would provide in an event such as having a baby (normal delivery) or managing Type II diabetes (routine maintenance, well-controlled) These examples will help consumers understand and compare what they would have to pay under each plan they are considering.

All health plans and insurers will provide an SBC to shoppers and enrollees at important points in the enrollment process, including:

- Information when shopping for coverage: In the past, consumers

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Expanded Healthcare Tax Credit Planned for Small Businesses

Currently, small businesses across America pay an average of 18 percent more than large businesses to provide health insurance. While the insurance exchanges included in the Affordable Care Act will bring these costs down starting in 2014, the Obama Administration plans to make it easier for small business owners to provide insurance to their employees right now. One important part of President Obama's

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DOL Issues Final Rule to Disclose Fees and Potential Conflicts of Interest

On February 2, 2012, the Department of Labor (DOL) published the final regulation under the Employee Retirement Income Security Act of 1974 (ERISA or the Act) requiring that certain pension plan service providers disclose information about the service providers' compensation and potential conflicts of interest. These disclosure requirements are established as part of a statutory exemption from ERISA's prohibited transaction provisions. This regulation will affect pension plan sponsors and fiduciaries and certain service providers to such plans. The final rule is effective on July 1, 2012.

The Employee Benefits Security Administration (EBSA) is responsible for administering and enforcing the fiduciary, reporting, and disclosure provisions of Title I of ERISA.
In recent years, arrangements for how services are provided to employee benefit plans and how service providers are compensated (e.g., through revenue-sharing and other arrangements) have become increasing complex. Many of these changes have improved efficiency and reduced the costs of administrative services and benefits for plans and their participants. However, the complexity resulting from these changes has made it more difficult for many plan sponsors and fiduciaries to understand how, and how much, service providers are compensated. This final rule establishes, for the first time, specific disclosure obligations for plan service providers to ensure that responsible plan fiduciaries are provided the information they need to make better decisions when selecting and monitoring service providers for their plans.

The final rule requires covered service providers (CSPs) to provide responsible fiduciaries with information they need to:

- Assess reasonableness of total compensation, both direct and indirect, received by the CSP, its affiliates, and/or subcontractors;
- Identify potential conflicts of interest; and
- Satisfy reporting and disclosure requirements under Title I of ERISA.

Who it Applies To:

The rule applies to those service providers that expect to receive $1,000 or more in compensation and provide certain fiduciary or registered investment advisory services, make available plan investment options in connection with brokerage or record-keeping services or otherwise receive indirect compensation for providing certain services to a plan.

The final rule includes a class exemption from the prohibited transaction provisions of ERISA for responsible plan fiduciaries that enter into service contracts without knowing that the CSP has failed to comply with its disclosure obligations. The class exemption requires that fiduciaries notify the Department of the disclosure failure.

Disclosures Requirements:

Information required to be disclosed by a CSP must be furnished in writing to a responsible plan fiduciary for the covered plan. The rule does not require a formal written contract delineating the disclosure obligations. CSPs must describe the services to be provided and all direct and indirect compensation to be received by a CSP, its affiliates, or subcontractors.

"Direct compensation" is compensation received directly from the covered plan. "Indirect compensation" generally is compensation received from any source other than the plan sponsor, the CSP, an affiliate, or subcontractor.

In order to enable a responsible plan fiduciary to assess potential conflicts of interest, CSPs who disclose "indirect compensation" must also describe the arrangement between the payer and CSP pursuant to which indirect compensation is paid. CSPs must identify the sources for indirect compensation, plus services to which such compensation relates.

Compensation disclosures by CSPs will include allocations of compensation made among related parties (i.e., among a CSP's affiliates or subcontractors) when such allocations occur as a result of charges made against a plan's investment or are set on a transaction basis. CSPs must also disclose whether they are providing recordkeeping services and the compensation attributable to such services, even when no explicit charge for recordkeeping is identified as part of the service "package" or contract.

The final rule contains a "pass-through" for investment-related disclosures furnished by recordkeepers or brokers. A CSP may provide current disclosure materials of an unaffiliated issuer of a designated investment alternative, or information replicated from such materials, provided that the issuer is a registered investment company (i.e., mutual fund), an insurance company qualified to do business in a State, an issuer of a publicly-traded security, or a financial institution supervised by a State or Federal agency.

Service providers may use electronic means to disclose information under the 408(b)(2) regulation to plan fiduciaries provided that the covered service provider's disclosures on a website or other electronic medium are readily accessible to the responsible plan fiduciary, and the fiduciary has clear notification on how to access the information.

Guide for Fiduciaries

EBSA strongly encourages CSPs to offer responsible plan fiduciaries a "guide," summary, or similar tool to assist fiduciaries in identifying all of the disclosures required under the final rule, particularly when service arrangements and related compensation are complex and information is disclosed in multiple documents. A Sample Guide has been provided as an appendix to the final rule that can be used on a voluntary basis by CSPs as a model for such a guide.

EBSA announced that in the near future, it intends to publish a separate proposal for public comment that would require service providers, in addition to providing the required fee and investment expense information, to furnish a guide or similar tool to assist plan fiduciaries in identifying and locating the potentially complex information that must be disclosed and which may be located in multiple documents.

Changes, Request for Information and Errors

Generally, CSPs must disclose

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FAQ - Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods

Q: What is auto enrollment?

A: Many provisions of the Patient Protection and Affordable Care Act (Affordable Care Act) that become effective beginning in 2014 are designed to expand access to affordable health coverage. These include provisions for automatic enrollment of full-time employees in an employer's health plan, shared responsibility of employers regarding health coverage, coverage to be offered through State-based Affordable Insurance Exchanges (Exchanges), premium tax credits to assist individuals in purchasing coverage through Exchanges, and other related provisions. The Departments of Labor, Health and Human Services, and the Treasury (the Departments) are working together to develop regulations and other administrative guidance that will respond to questions and assist stakeholders with implementation.

Q: What responsibility will the employer have in auto enrollment?

A: Section 18A of the Fair Labor Standards Act (FLSA), as added by section 1511 of the Affordable Care Act, directs an employer to which the FLSA applies, and that has more than 200 full-time employees, to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to continue the enrollment of current employees in a health benefits plan offered through the employer. Section 18A further requires adequate notice and the opportunity for an employee to opt out of any coverage in which the employee was automatically enrolled.

Q: What is the effective date?

A: On December 22, 2010, the Departments issued frequently asked questions (FAQ) on section 18A of the FLSA, which noted that the statute provides that employer compliance with the automatic enrollment provisions of section 18A shall be carried out "[i]n accordance with regulations promulgated by the Secretary [of Labor]."(That FAQ also stated that it is the view of the Department of Labor that, until such regulations are issued, employers are not required to comply with section 18A.) Finally, the FAQ indicated that the Department of Labor intends to complete this rulemaking by 2014 but the need for coordinated guidance and a smooth implementation process might take longer than originally anticipated.

Q: Will all employers be required to offer health insurance?

A: The Affordable Care Act does not explicitly mandate an employer to offer employees acceptable health insurance. However, certain employers with at least 50 full-time equivalent employees will face penalties, beginning in 2014, if one or more of their full-time employees obtains a premium credit through an exchange. An individual may be eligible for a premium credit either because the employer does not offer coverage or the employer offers coverage that is either not "affordable" or does not provide "minimum value."

Q: What is the 90-Day Limitation on Waiting Periods?

A: Public Health Service (PHS) Act section 2708, as added by the Affordable Care Act, provides that, in plan years beginning on or after January 1, 2014, a group health plan or group health insurance issuer shall not apply any waiting period that exceeds 90 days. PHS Act section 2704(b)(4), ERISA section 701(b)(4), and Code section 9801(b)(4) define a waiting period to be the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. In previous regulations, the Departments defined a waiting period to mean the period that must pass before coverage for an employee or dependent, who is otherwise eligible to enroll under the terms of a group health plan, can become effective. Unlike Code section 4980H, PHS Act section 2708 does not distinguish between full-time and part-time employees.

Q. When PHS Act section 2708 (which imposes a 90-day limitation on waiting periods) becomes effective in 2014, will it require an employer to offer coverage to part-time employees or to any other particular category of employees?

A. No. Many employers make distinctions in eligibility for coverage based on full-time or part-time status, as defined by the employer's group health plan (which may differ from the standard under Code section 4980H). PHS Act section 2708 does not require the employer to offer coverage to any particular employee or class of employees, including part-time employees. PHS Act section 2708 merely prohibits requiring an otherwise eligible employee to wait more than 90 days before coverage is effective. Furthermore, nothing in the Affordable Care Act penalizes small employers for choosing not to offer coverage to any employee, or large employers for choosing to limit their offer of coverage to full-time employees, as defined in the employer shared responsibility provisions.

Q. Does the Treasury and the IRS intend to issue proposed regulations or other guidance addressing how the employer shared responsibility provisions under Code section 4980H and the 90-day waiting period limitation under PHS Act section 2708 are coordinated?

A. Yes. Treasury and the IRS intend to issue proposed regulations or other guidance under Code section 4980H (which imposes shared responsibility on large employers with respect to coverage of full-time employees). That guidance is expected to address the intersection of the Code section 4980H rules and the PHS Act section 2708 rules applicable to the 90-day waiting period limitation and will be coordinated with upcoming tri-Department proposed rules under PHS Act section 2708 (discussed below). Treasury and the IRS are mindful of employers' requests for safe harbors and simplicity and will seek to accommodate those requests to the extent feasible and consistent with the terms of the statute.

The upcoming guidance is expected to provide that, at least for the first three months following an employee's date of hire, an employer that sponsors a group health plan will not, by reason of failing to offer coverage to the employee under its plan during that three-month period, be subject to the employer responsibility payment under Code section 4980H. □

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shopping for health coverage might only be able to obtain marketing materials about a policy, offering consumers only a limited understanding of what they'd be buying. Now, consumers will be able to receive the critical information on their choices upfront, before they buy coverage, helping them to choose the coverage that best meets their needs.

- Information when coverage is renewed: Consumers will receive the SBC before each new plan or policy year so they can see how their coverage is changing before deciding whether to renew or reenroll in coverage.
- Information when coverage changes: If there are any significant changes in coverage in the middle of the plan or policy year, health plans and insurers will be required to notify their enrollees and policyholders at least 60 days before the changes take effect.
- Information on demand: Whether shopping for health insurance or already enrolled in coverage, consumers will be able to request the SBC at any time, and health plans will have to provide it within seven business days. Consumers will also be able to request and receive the uniform glossary within seven business days.

Assuming certain consumer safeguards are met, the final rule ensures that in the vast majority of cases, the SBC can be provided electronically, allowing a plan or issuer to post the SBC on its website or provide it by email. Electronic disclosure is expected to reduce costs while consumer safeguards are designed to ensure actual receipt by individuals. Additionally, the final rule provides flexibility in the instructions for completing the SBC in recognition of unique plan designs. □

Benefits Law Quarterly newsletters are intended to provide you with additional guidance on HIPAA, COBRA & ERISA regulations to keep you informed and help you stay in compliance with benefit laws. If you have any employment related topics that you would like to see covered in future newsletters articles, please send your ideas to answers@personnelconcepts.com.
While all submissions will be taken into consideration, we will publish those that are most applicable to the majority of our client base and employers in general.

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Fiscal Year 2013 budget proposal expands a tax credit that does exactly that.

The Small Business Health Care Tax Credit has benefited hundreds of thousands of small businesses since the Affordable Care Act passed in 2010. After listening to business owners around the country, the Administration is proposing to make the tax credit available to more businesses. The budget increases the maximum size of eligible companies from 25 employees to 50, proposes more generous phase-out provisions and simplifies the credit process, making it easier to claim. It is estimated that if the President's proposal were enacted, the tax credit will benefit about half a million employers who provide healthcare to 4 million workers in 2012 alone. Over the next decade, this proposal would provide an additional $14 billion in tax credits to small employers across the country.

For example, a home garden center in Michigan began offering healthcare about 15 years ago to attract and retain talented employees, compete with bigger stores and to address skyrocketing healthcare costs their employees were facing. In 2010, after qualifying for the small business healthcare tax credit, they got back nearly $9,000, almost 30 percent of their costs, for offering coverage to 11 full-time employees. The money they saved helped them hire a new employee, and now, with 12 employees, their tax credit could go up to about $10,000 if the President's proposal to expand the tax credit is adopted by Congress.

The Administration recognizes that most small businesses want to offer coverage. The small business health care tax credit helps make this possible. In addition, the improvements to the tax credit President Obama is proposing will increase the number of eligible small businesses while making the process of claiming the credit easier.

For more information on the tax credit, go to www.whitehouse.gov, www.healthcare.gov and www.irs.gov, which all have special sections to answer questions and help small businesses determine if they qualify for the credit. □

(Disclose Continued from p. 2)

changes to initial information as soon as practicable, but no later than 60 days from when the CSP is informed of such change. Disclosures of changes to investment-related information are to be made at least annually.

Service providers must disclose compensation or other information related to their service arrangements upon the request of the responsible plan fiduciary or plan administrator, reasonably in advance of the date upon which such person states that they must comply with ERISA's reporting and disclosure requirements.

The final rule allows for timely corrections of an error or omission in required disclosures when a CSP is acting in good faith and with reasonable diligence. Such corrections must be made not later than 30 days from the date that the CSP knows of the error or omission.

The 3-month extension of the effective date of the final rule has been provided to allow service providers sufficient time to prepare for compliance. Service providers not in compliance as of July 1, will be in violation of ERISA's prohibited transaction rules and subject to penalties under the Internal Revenue Code. □

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