HEALTH & WELFARE PLAN LUNCH GROUP

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Employee Benefits & Executive Compensation ADVISORY

February 29, 2012

When Is a Summary More than a Summary, Part Two: Agencies Issue Final Guidance on the ACA's Uniform Summary of Benefits and Coverage Requirement

On February 14, 2012, the Departments of the U.S. Treasury ("Treasury"), Labor (DOL) and Health and Human Services (HHS) (collectively, the "Agencies") jointly published final regulations[1] that identify the standards for completing and delivering the uniform explanation of coverage ("Summary of Benefits," or SBC) required by the Patient Protection and Affordable Care Act of 2010 (ACA).[2] The final regulations clarify and revise the SBC requirements first proposed by the Agencies in the proposed regulations issued on August 22, 2011.[3]

Group health plan sponsors and health insurance carriers must act quickly. With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rule described in the final regulations is effective *on the first day of the first annual enrollment period beginning on or after September 23, 2012.* With respect to participants and beneficiaries enrolling other than during an annual enrollment period (e.g., newly eligible individuals and special enrollees), the SBC rule is effective for such enrollments that occur *on or after the first day of the plan year beginning on or after September 23, 2012.*

Practice Pointer: Applying the effective date of the SBC rules can be tricky. For some plans with fiscal years, the SBC rules may first apply to newly eligible individuals and special enrollees. See "When are SBCs required to be provided?" below for a more detailed discussion of the effective dates.

The following is the *who, what, when, where and how* of the SBC rules, as described in the final regulations. For those who simply want to know the differences between the proposed and final rules, we have attached to this advisory a quick reference chart that highlights the differences between the proposed regulations and the final regulations. We will highlight issues arising from the template and the corresponding instructions in a subsequent advisory.

NOTE: The SBC requirements also apply to health insurance issuers who issue coverage in the individual market; however, the focus of our overview below is solely on group health plans.

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1 *See* 77 Fed. Reg. 8668 (Feb. 14, 2012) at http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf. *See* also our prior advisory at http://www.alston.com/employee_benefits_SBC_regulations.

2 PHSA Section 2715, as added by Section 1001 of the ACA. This requirement is also incorporated into ERISA (ERISA Section 715) and the Internal Revenue Code (Section 9815) by reference.

3 *See* 76 Fed. Reg. 52442 (Aug. 22, 2011) at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf.

Who is required to provide an SBC?

The final regulations obligate the group health plan (including the plan administrator) **and**, if applicable, the health insurance issuer offering coverage in connection with a group health plan (i.e., if the plan is fully insured) to provide the SBC in accordance with the standards described below.

Practice Pointer: The SBC requirement applies to all self-insured and fully-insured group health plans that are otherwise subject to the health insurance reforms in Sections 1001 and 1201 of the ACA, *including grandfathered plans.* Thus, the SBC rules do not apply to benefits that qualify as "excepted benefits" under HIPAA's portability rules (e.g., non-integral dental and vision coverage, Health FSAs funded solely with employee's pre-tax salary reductions, certain specified disease and hospital indemnity insurance) and stand-alone retiree health plans.

While many Health FSAs and some health reimbursement arrangements will be excepted benefits, and thus exempt from the SBC requirements, Health FSAs and HRAs that are not excepted benefits are subject to the SBC requirements. The preamble clarifies that separate SBCs must be prepared where such arrangements are stand-alone plans (although many of the provisions applicable to traditional fee for service plans would not apply). However, for a non-exempt health FSA or HRA that has been integrated into other major medical coverage, an SBC prepared for the other major medical coverage can note the effects of the health FSA or HRA.

If the group health plan is self-insured, the obligation to provide an SBC lies solely with the plan. If the plan is fully insured, the obligation to provide an SBC lies with *both* the plan and the health insurer; however, both are deemed in compliance to the extent one of the responsible parties timely provides an SBC. Plan sponsors of fully insured plans and their health insurers must cooperate with one another to ensure an SBC is timely provided as required.

Practice Pointer: Unlike HIPAA's portability rules regarding certificates of creditable coverage, the plan or insurer will *not* avoid liability under the statute simply by entering into a written agreement with the other party that the other party will provide the SBC.

To whom must the SBCs be provided?

The final regulations indicate that a plan or insurer must generally provide an SBC in accordance with the SBC rules to a "participant" and "beneficiary" as defined in ERISA Sections 3(7) and 3(8). The terms "participant" and "beneficiary" are defined broadly by ERISA and include not only those individuals who are currently enrolled in the plan (i.e., covered employees/former employees *and* their covered dependents), but *anyone who is eligible to enroll.* Thus, a plan or insurer must provide an SBC generally to employees (including former employees) *and* dependents that are *eligible to enroll* or are enrolled in the group health plan.

Practice Pointer: The regulations indicate that a single SBC provided to participants and beneficiaries at the participant's last known address satisfies the requirement to send an SBC to all beneficiaries who reside at that address. See "How must the SBC be delivered?" below for more information.

In addition, "participant" and "beneficiary" would also appear to include self-employed individuals and their dependents that are eligible for or enrolled in the plan. ERISA's definition of "participant" does not specifically include self-employed individuals, such as independent contractors or partners covered under a plan; however, cases have held that self-employed individuals covered under an ERISA-covered plan should be treated as participants.[4]

Practice Pointer: Although both participants and beneficiaries are each entitled to receive an SBC, plans are not always required to send an SBC to both. See "How must the SBC be delivered?" below for more information.

A group health plan is also entitled to receive an SBC from a health insurer.

When are SBCs required to be provided?

Generally, plans or insurers must provide the requisite SBCs participants or beneficiaries in the following instances ("triggers"):

- upon "application" for coverage,
- upon "renewal,"
- following a request for a special enrollment (as defined by HIPAA),
- upon request by a participant or beneficiary, and
- following a material modification in the information contained in the SBC.

An SBC must also be provided by a health insurer to a plan at certain times.

See "What SBCs must a plan or insurer provide?" below for more detail on the number and the contents of the SBCs required to be provided.

Practice Pointer: The number of SBCs that a plan or insurer must provide to each participant and beneficiary is based, at least in part, on the number of "benefit options" maintained by the plan and the applicable trigger. See "What SBCs must a plan or insurer provide?" below for a more detailed discussion of the requisite SBCs.

The SBC triggers and the specific time frames for providing the SBC as a result of those triggers are discussed below.

A. From Plan to Participant/Beneficiary

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[4] *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 32 EBC 1097 (2004) (citing DOL Opinion 99-04A).

The First SBCs

The SBC rules have two different effective dates, depending on the type of enrollment period. With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rules are effective on the first day of the first annual enrollment period beginning on or after September 23, 2012.

For all other participants and beneficiaries enrolling during an enrollment period other than annual enrollment (e.g., newly eligible individuals and special enrollees), the SBC rules are first effective with any enrollment occurring on or after the plan year that begins on or after September 23, 2012.

Practice Pointer: The SBC rule will apply to the plan's first annual enrollment period based on the date that the annual enrollment period begins—not the date the plan year starts. For example, if your annual enrollment period typically begins September 1 of each year, then the first annual enrollment period to which the SBC rules apply is the annual enrollment period beginning September 1, *2013*, even if your plan year begins prior to that date. However, that does not mean you necessarily get a pass from the rules until then. Depending on when your next plan year and enrollment period start, the SBC rule applicable to all other enrollments may apply *before* your next annual enrollment period.

Consider the following examples to illustrate application of SBC effective date.

> **Example #1:** ABC sponsors a health plan that has a calendar plan year. Each year it begins the annual enrollment period for the following plan year on October 1. ABC must comply with the SBC rules with respect to individuals enrolling in the annual enrollment period that begin October 1, 2012. Thereafter, the SBC rules will apply to all initial and special enrollments that occur on or after January 1, 2013.
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> **Example #2:** XYZ sponsors a health plan that has a calendar year; however, unlike ABC Plan, XYZ typically begins annual enrollment for the following plan year on September 1 of each year. For XYZ, the first annual enrollment period to which the SBC rule will apply is the annual enrollment period beginning September 1, 2013 (for the 2014 plan year). However, the SBC rules will apply to all initial and special enrollments that occur on or after January 1, 2013.

Enrollments Other than Annual and Special Enrollments Occurring after the Effective Date (Application)

Plans and insurers must provide the requisite SBCs to individuals who become eligible to enroll (except during a special enrollment period) with any written (or electronic) enrollment materials distributed by the plan as part of the enrollment process. If the plan does not provide written or electronic enrollment materials as part of the initial enrollment process, the plan must provide the SBC *no later than the first day on which the individual is otherwise eligible to enroll.* If any of the information required to be in the SBC that was provided changes before the first day of coverage (e.g., prior to the effective date of coverage), then an updated SBC must be *provided no later than the first day of coverage.*

Practice Pointer: Plans that typically do not provide written enrollment materials in connection with the initial enrollment will nevertheless have to provide an SBC in accordance with the SBC rules. This could pose administrative issues if the enrollment period for newly eligible individuals begins shortly after the individual becomes eligible for coverage.

Consider the following examples to illustrate the application of this rule:

> **Example #3:** Bob is hired by ABC on October 1, 2013, and he becomes eligible for coverage under ABC's group health plan on that date. ABC's plan administrator sends Bob written enrollment materials on October 5, 2012. ABC satisfies the SBC rules if ABC provides the requisite SBCs (or a postcard with a link to the SBCs, as permitted by the SBC rules) with the written enrollment materials sent to Bob on October 5, 2012.
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> **Example #4:** This example presents the same facts as Example #3, except that ABC does not send written enrollment materials. Instead, ABC typically instructs new employees on the enrollment process, which begins immediately, during the employee orientation. In that case, ABC would need to provide the requisite SBCs in accordance with the SBC rules on the date of the employee's orientation.

Special Enrollments Occurring after the Effective Date

Plans must provide the requisite SBCs to special enrollees during a special enrollment period, as defined by HIPAA's portability rules, within 90 days of becoming covered under the plan (i.e., the date that a Summary Plan Description is otherwise required to be provided under ERISA). Unlike the other enrollment periods, a plan and insurer are not required to provide an SBC at the beginning of a special enrollment period. This seems to be the applicable rule without regard to whether the employee was previously enrolled in the plan prior to requesting a special enrollment.

Practice Pointer: Special enrollments under HIPAA's portability rules are not the only situations in which an individual may be able to enroll him/herself or a beneficiary in a plan during the plan year. For example, an employee's election for a group health plan benefit offered through a cafeteria plan may, to the extent permitted by a cafeteria plan, be changed mid-year to add a spouse whose coverage period under the spouse's employer's plan is different than the employee's plan, or where the spouse's employer significantly increased the cost of the spouse's coverage. These events that enable an individual to request mid-year enrollment are not special enrollment events as defined by HIPAA. Unfortunately, it isn't clear which SBC rules apply to such mid-year enrollments. Are such enrollments treated as "applications," which require plans or insurers to provide an SBC automatically, or would they be subject to the request rule (see below), which requires an SBC only if an SBC is specifically requested?

Annual Enrollment (Renewal)

If a written annual enrollment is required, the Plan or insurer must provide the requisite SBCs with the written enrollment materials provided in connection with annual enrollment. If annual enrollment is automatic, the Plan or insurer must provide the requisite SBCs no later than 30 days prior to the first day of the new plan year. With insured plans, however, if the policy, certificate or contract of insurance has not been issued or

renewed before this 30-day period, the SBC must be provided as soon as practicable, but no later than seven *business* days after issuance of the new policy or receipt of written confirmation of intent to renew, whichever is earlier.

Practice Pointer: Many plans utilize a "negative" or "passive" enrollment process where affirmative elections are made by participants only if the participant wishes to change his/her prior election. Are these enrollments considered "automatic" enrollment? We all would like to treat them that way, but conservative plan sponsors should carefully consider this issue with counsel absent further favorable clarification on this point from the agencies.

Unlike the SBC rules applicable to other enrollments, the final regulations do not specifically require plans and insurers to issue a new SBC for annual and special enrollments if there are changes to the information in the SBC before the first day of coverage.

Upon Request by a Participant or Beneficiary

A plan or insurer must provide the requisite SBCs to a participant or beneficiary upon request as soon as practicable, but no later than seven *business days* following the receipt of the request.

Practice Pointer: May plans and insurers charge for requested SBCs? Neither the statute nor the regulations address charges for requested SBCs. Absent guidance that specifically permits plans and insurers to charge for requested SBCs, plans and insurers would be wise to provide them free of charge.

Material Modifications

The SBC rules affect the timing for providing a summary of material changes (i.e., a summary of modification, or SMM) to participants. For covered plans, the revised process will subsume the process for distributing SMMs for covered plans. The timing will vary depending on whether the change is effective during the plan year or on the first day of the next plan year. Where a material modification (as defined in ERISA Section 102) is made to the terms of the plan that would impact the information in the most recently distributed SBC, and such change is effective during the plan year (i.e., prior to the first day of a subsequent plan year), a plan or insurer must provide notice of the material modification to "enrollees" at least 60 days prior to the effective date of the change. If it is a change effective as of the first day of the next plan year, a plan or insurer must provide an updated SBC in accordance with the SBC rules applicable to annual enrollment (see above).

Practice Pointer: Although the statute uses the term "enrollee," the section of the regulations explaining material modifications is the only time in the regulations in which the term "enrollee" is used. The isolated use of this term raises questions with respect to the scope of individuals to whom a plan or insurer must provide the notice of material modification: Does this requirement apply only to those enrolled in the benefit package affected by the material modification or everyone who previously received an SBC for that benefit package? The preamble to the regulations indicates that "enrollee" is interpreted by the agencies to mean "participant" and "beneficiary"; therefore, a plan or insurer must arguably send an SBC notice of material modifications for a benefit package to everyone who previously received an SBC for that benefit package.

A "material modification" is generally any modification that, standing alone or in conjunction with other modifications, an average plan participant would consider an important change. A material modification could include an enhancement to coverage or a reduction in services.[5]

The preamble to the final regulations states that the mid-year notice of material modifications can be in the form of a stand-alone notice that describes the material modification or an updated SBC. In either case, a plan or insurer must provide the notice of material modification in accordance with the SBC rules.

Practice Pointer: The preamble indicates that an updated SBC or notice of modification provided in accordance with SBC rules will satisfy ERISA's SMM requirements as well.

B. From Health Insurance Issuer to Plan

Beginning September 23, 2012, an insurer must provide an SBC to a group health plan (or its sponsor) at the following times:

- With the plan's application or as soon as reasonably practicable, but no later than seven business days following receipt of the application by the group health plan.
- If there is a change in the information required to be in the SBC provided upon application or before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.
- If written application for renewal is required, then the SBC must be provided when the written application materials are provided.
- If renewal is automatic, then the SBC must be provided to the plan no later than 30 days prior to the first day of the new policy year. However, if the policy, certificate or contract of insurance has not been issued or renewed before this 30-day period, the SBC must be provided as soon as practicable, but no later than seven business days after issuance of the new policy or receipt of written confirmation of intent to renew, whichever is earlier.
- As soon as practicable, but no later than seven business days following receipt of a request by a plan for an SBC or summary information about a health insurance product.

What SBCs must a plan or insurer provide?

As noted above, the number of SBCs a plan or insurer must provide to a participant or beneficiary is based on the number of "benefit packages" maintained under the plan that are otherwise subject to the ACA's health insurance reforms and the specific triggers identified above.

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[5] *See* DOL Information Letter, Washington Star/Washington-Baltimore Newspaper Guild to Munford Page Hall, II, Baker & McKenzie (February 9, 1985).

Practice Pointer: The regulations clarify that stand-alone HRAs are generally required to provide an SBC and the effects of an "integrated" HRA must generally be noted on the SBC for the health plan into which the HRA is "integrated." No guidance is provided regarding (i) the time period for providing an SBC for a stand-alone HRA, which typically has no enrollment period, and (ii) the definition of an "integrated" HRA.

The final regulations do not define "benefit package"; however, the special enrollment regulations under HIPAA's portability rules (the same subpart in ERISA, the PHSA and the Code to which the health insurance reforms were added by the ACA) define a benefit package as any coverage arrangement with a difference in benefits or cost sharing (e.g., deductibles or out-of-pocket maximum).

Practice Pointer: From a practical perspective, any option that can be elected separately by a participant is presumably a "benefit package." For example, assume employees may elect any of the following benefit options maintained by the employer: (i) a PPO with a $1200 deductible, (ii) a self-insured PPO with a $2,000 deductible and (iii) an HMO. Presumably, each option is a separate benefit package.

The triggers identified above also determine the number of SBCs a plan or insurer must provide to a participant and beneficiary.

Enrollments Other than Annual and Special Enrollments (Application)

With respect to individuals enrolling during an enrollment period other than an annual or special enrollment period, a plan or insurer must provide to the participant and beneficiary an SBC for each benefit package for which the participant or beneficiary is eligible.

> **Example #5:** Bob is hired by Acme, Inc., on January 5, 2013, and he is sent written enrollment materials on January 10, 2013. Acme, Inc., maintains a PPO, HMO and indemnity option, and Bob is eligible for each one. Acme, Inc., must provide three SBCs to Bob with the written enrollment materials: one each for the PPO, HMO and indemnity options.

Annual Enrollment (Renewal)

With respect to individuals enrolled in a benefit package, a plan or insurer must only provide an SBC during annual enrollment for the benefit package in which the individual is actually enrolled. A plan or insurer is not required to automatically provide an SBC to an enrolled individual for any benefit package in which the individual is not enrolled, but the participant or beneficiary may request an SBC for the other benefit packages for which the individual is otherwise eligible.

Practice Pointer: What if the employee is enrolled in a benefit package under the plan, but the employee's spouse is not? Must a plan or insurer provide the employee with an SBC for the benefit package in which the employee is enrolled and an SBC to the spouse for each benefit package for which the spouse is eligible? Presumably, the plan or insurer is only obligated to send an SBC for the benefit package in which the participant is enrolled; however, the participant or spouse may request an SBC for the other benefit packages for which they are eligible. Further guidance from the agencies on this issue would be helpful.

Special Enrollment

The final regulations do not clearly define the scope of SBCs that plans or insurers must provide to special enrollees. As noted above, a plan or insurer must provide an SBC to a special enrollee no later than the date an SPD is required to be provided, which is 90 days after the individual becomes covered under the plan. This strongly suggests that a plan or insurer must only be provided an SBC for the option in which the special enrollee actually enrolls; however, additional guidance would be welcomed.

Material Modifications

Plans or insurers must provide a notice of material modification or an updated SBC only for the benefit package affected by the material modification. However, as noted above, the regulations do not clearly indicate to whom the notice of material modification should be provided (i.e., only those currently enrolled in the affected option or all eligible employees).

How must the SBC be delivered?

At a minimum, a plan or insurer must provide the requisite SBCs in paper form. However, plan or insurers may provide an SBC electronically according to the following rules:

- For plans and issuers subject to ERISA (plans sponsored by private employers) and/or the Internal Revenue Code (e.g., church plans), a plan or insurer may provide the SBC electronically to individuals *covered* by the plan, but only if the requirements of the DOL's electronic disclosure safe harbor at 29 CFR Section 2520.104b-1(c) are met.

Practice Pointer: ERISA's electronic disclosure safe harbor currently set forth in its regulations imposes strict requirements on plan administrators. For example, while SBCs may automatically be provided to employees who have routine access to the electronic medium as part of their job function, plans or insurers may generally provide the SBC electronically to employees who do not have routine access and non-employees (e.g., retirees, spouses, COBRA continuees) only if such individual provides affirmative electronic consent. Obtaining consent may pose administrative difficulties for plans or insurers. Perhaps the agencies will relax this rule in the future to more closely align with the rule noted below for distributing SBCs to non-enrollees.

For those who are *eligible* for coverage but *not enrolled*, a plan may provide an SBC electronically if the following requirements are satisfied:

- the format is readily accessible;

- a paper copy is available free of charge upon request; and
- if the electronic form is an internet posting, the individual is notified (by paper or email) that the documents are available online, informed of the web address and notified that paper copies are available upon request.

Practice Pointer: The final regulations provide much-needed relief for plans and insurers who desire to send the SBCs electronically, but only with respect to those who are not currently enrolled.

Nonfederal governmental plans may comply with either ERISA's electronic disclosure safe harbor requirements or, alternatively, the requirements applicable to insurers in the individual market. Nonfederal governmental plans that wish to comply with the electronic disclosure requirements for insurers in the individual market may provide the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosure by email, or post the SBC on the Internet if they advise the individual or dependent in paper or electronic form that the SBC is available online and provide the applicable web address. However, a nonfederal governmental plan cannot disclose an SBC electronically unless the format is accessible; the SBC is placed in a prominent, accessible location; the electronic form can be electronically retained and printed; the SBC appearance, content and language requirements are satisfied; and the recipient is informed a paper copy is available free of charge.

The preamble to the final regulations states an SBC may be provided as either a stand-alone document or in combination with other summary materials (e.g., an SPD), if the SBC information is displayed prominently at the beginning of the materials (after the table of contents in an SPD) and in accordance with the timing requirements for SBCs.

Like the proposed regulations, the final rules contain a "single notice" rule that allows plans or insurers to satisfy the SBC requirement for a participant and beneficiary with a single notice sent to the participant and beneficiaries at the participant's last known address, *unless the beneficiary is known to reside at a different address*. However, the proposed regulation seemed to limit application of the single notice rule to situations where the plan or insurer *knew* the participant and beneficiaries resided at the same address. The final regulations clarify that an SBC sent to the participant and beneficiaries at the participant's last known address satisfies the requirement with respect to all beneficiaries residing at the participant's address, even if the plan or insurer does not know that they reside there. However, like the proposed rule, the final regulations indicate that a plan or insurer must send a separate SBC to a beneficiary it knows resides at a different address.

Practice Pointer: The single notice rules does not appear to go so far as to say that a plan or insurer does not have to send an SBC to a beneficiary who is enrolling subsequent to a participant solely because that SBC has already been provided to that address. For example, if a spouse is enrolled via special enrollment *subsequent* to the participant, then the plan or insurer arguably has to send an SBC to that spouse, in accordance with the SBC rules for special enrollment, even though that SBC has already been provided to that address as part of the participant's initial enrollment.

For an SBC provided by an issuer to a plan, the SBC may be provided in paper form or electronically. For electronic forms, the format must be readily accessible by the plan, the SBC must be provided in paper form upon request free of charge, and if the electronic form is an Internet posting, the issuer must notify the plan the documents are available online and provide the web address.

What are the format and content requirements for an SBC?

An SBC must satisfy the following format requirements:

- four double-sided pages (i.e., a total of eight printed pages, front and back); and
- no less than 12-point font (and the instructions to the draft template reflect that the font must be Times New Roman).

An SBC must generally satisfy the following content requirements:

- uniform definitions of standard insurance terms and medical terms, so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
- a description of the coverage, including cost-sharing, for each category of benefits identified by the Agencies;
- the exceptions, reductions and limitations on coverage;
- the cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;
- the renewability and continuation of coverage provisions;
- coverage examples that illustrate common benefits scenarios (a normal childbirth, diabetes management) and related cost-sharing based on recognized clinical practice guidelines;
- a statement about whether the plan provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements (this information does not have to be provided until on or after January 1, 2014);
- a statement that the SBC is only a summary and that the plan document, policy certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;
- a contact number to call with questions and an Internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;
- for plans and issuers that maintain more than one network of providers, an Internet address (or similar contact information) for obtaining a list of network providers;
- for plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage; and

- an Internet address where an individual may review and obtain the uniform glossary, as well as a phone number to obtain a paper copy and a disclaimer that paper copies are available.

Practice Pointer: The SBC must be completed in accordance with the instructions to the template provided by the agencies. The instructions to the template are very rigid and generally instruct the plan or insurer to use language and formatting precisely as required by the instructions, except where otherwise permitted by the instructions. However, if a plan's terms required to be described in the template cannot be reasonably described in a manner consistent with the template's instructions, then plans or insurers must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is as consistent with the instructions as possible.

For items and services provided outside the United States, the final regulations allow a plan or issuer to provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. However, an SBC that summarizes benefits and coverage available within the United States still must be provided.

In addition, if at least 10 percent of the population in the county are literate only in the same non-English language, as determined by the American Community Survey data published by the United States Census Bureau, then each SBC sent to a recipient with an address in that county must include a one-sentence statement in that non-English language about the availability of language services provided by the plan.

What happens if I don't comply?

Potential penalties for failure to comply with the SBC requirement are severe, including agency-induced fines of up to $1,000 for each failure to distribute an SBC and the self-reported excise tax applicable to group health plans (other than governmental plans) under Section 4980D of the Internal Revenue Code. The Department of Labor (which has enforcement authority over ERISA plans) has indicated that it will issue separate enforcement penalty regulations in the near future.

This advisory was written by **Ashley Gillihan** *and* **John Hickman**.

Chart of Differences Between Proposed Rules and Final Rules

For those familiar with the guidance in the proposed regulations and only want to understand the differences between the final and proposed rules, a summary is provided below.

Item	Proposed Regulations	Final Regulations
Effective date	Enrollments occurring on or after March 23, 2012	With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rules are effective on the first day of the first annual enrollment period beginning on or after September 23, 2012. For all other participants and beneficiaries enrolling during an enrollment period other than annual enrollment (e.g., newly eligible individuals and special enrollees), the SBC rules are first effective with any enrollment occurring on or after the plan year that begins on or after September 23, 2012.
Stand-alone document	SBC must be provided as a stand-alone document.	The final regulations eliminate the requirement that an SBC be provided as a stand-alone document to the extent certain conditions are satisfied.
Time period to respond to request for an SBC	Within seven (7) calendar days	Within seven (7) business days
Changes to SBC prior to first day of coverage	If there is any change before the coverage is offered or before the first day of coverage, an updated SBC must be provided no later than the date of the offer, or the first day of coverage, as applicable.	The final regulations state if there is any change to information required to be in the SBC that was provided upon application and before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.
SBCs for automatic renewals	SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.	The final regulations state that if renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. However, with an insured plan coverage, if the policy, certificate or contract of insurance has not been issued or renewed before this 30-day period, the SBC must be provided as soon as practicable, but in no event later than seven business days after issuance of the policy, certificate, or contract of insurance, or receipt of written confirmation of intent to renew, whichever is earlier.
Special enrollment	SBC must be provided within seven days of requesting enrollment.	The final regulations state that special enrollees must be provided an SBC no later than when an SPD is required to be provided under the timeframe set forth in ERISA Section 104(b)(1)(A), which is 90 days from enrollment.
Contents-premium information	Required	Not required
Coverage and services outside the United States	Required to be described in SBC	Instead of summarizing coverage for items and services provided outside the United States, the final regulations indicate that a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. Of course, the plan or insurer must still provide an SBC that summarizes benefits and coverage available within the United States.
Electronic disclosure	All plans subject to ERISA and the Code must provide SBC electronically according to ERISA safe harbor.	Special, less burdensome rules apply to individuals that are eligible but not enrolled.

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Employee Benefits & Executive Compensation ADVISORY

May 2, 2012

New Agency Guidance on Required Contraceptive Coverage under Group Health Plans:

- **Permanent Exemption for "Religious Employers"**
- **One-Year Delay for Certain Nonprofit Employers**
- **Proposed Rule Would Require Health Insurers and TPAs to Provide Free Contraceptive Coverage Beginning in 2013 for Certain Religious Organizations**

On August 1, 2011, the Health Resources and Services Administration (HRSA), a part of the Department of Health and Human Services (HHS), issued Guidelines on Women's Preventive Health (the "HRSA Guidelines").[1] Under Section 2713 of the Public Health Service Act (PHSA), as added by the Affordable Care Act (ACA) and incorporated by reference into ERISA and the Internal Revenue Code, a non-grandfathered group health plan and a health insurance issuer offering group or individual health insurance coverage must provide benefits for, and may not impose cost-sharing with respect to, preventive care and screening provided for under the HRSA Guidelines.[2] The HRSA Guidelines supplement the previously adopted preventive care guidelines and are subject to the same rules regarding cost-sharing.[3] Non-grandfathered plans and issuers generally are required to provide the preventive coverage specified in the HRSA Guidelines beginning with the first plan year (or, in the individual market, the first policy year) that begins on or after August 1, 2012. Thus, for non-grandfathered plans that have a calendar year plan year, the HRSA Guidelines are effective starting with the plan year beginning January 1, 2013.

Among other things, the HRSA Guidelines require coverage of prescribed contraceptive methods and counseling. This requirement has generated substantial controversy from employers who object to providing such coverage on religious grounds, resulting in further guidance with respect to such situations, including a final regulation that provides that certain "religious employers" are exempt from the requirement to provide contraceptive coverage, a one-year delay for certain nonprofit organizations that do not qualify under the religious exemption, and a proposal that, if finalized, would require third-party administrators (TPAs) and health insurance issuers to provide contraceptive benefits free of charge to nonexempt religious employers (and their plan participants and beneficiaries).

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1 *See* http://www.hrsa.gov/womensguidelines/.

2 The preventive care guidelines (including the religious employer exception) apply to student health plans. *See* 77 Fed Reg. 16453 (March 21, 2012).

3 For more on the preventive care requirements, see our prior Employee Benefits advisory here.

This advisory discusses the recent guidance relating to the contraceptive coverage requirement as applied to group health plans of religious employers.[4]

Required Contraceptive Services

The HRSA Guidelines provide that required preventive services include all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider. According to agency statements, condoms, vasectomies, and abortifacient drugs are not covered by the HRSA Guidelines. As is the case with other preventive care required under ACA, a group health plan or health insurance issuer may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the applicable guideline. HHS, the Department of Labor (DOL), and the Department of Treasury (collectively, the "Departments") have recently noted that they have received questions regarding the scope of required contraceptive coverage and that they intend to issue future guidance to address these questions.

Religious Employer Exemption

Final regulations provide that group health plans of "religious employers" (and health insurance coverage provided in connection with such group health plans) are not required to provide contraceptive coverage.[5] For this purpose, a religious employer is an employer that (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization as described in Section 6033 of the Internal Revenue Code.

The religious employer exemption applies only for purposes of the requirements of PHSA Section 2713. Many states have mandates relating to contraceptive coverage. Although the federal religious employer exemption was modeled after existing state law, state law requirements differ. Some states do not provide an exemption for religious employers and some include an exemption that is narrower than the federal law exemption. ACA generally does not preempt state law that is more restrictive than federal law. Thus, if the plan (or health insurance coverage offered under the plan) is subject to state law mandates, these mandates generally will continue to apply unless the plan qualifies for an exemption under the applicable state law.

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[4] For more information on the other preventive services required under the HRSA Guidelines, *see* our prior Employee Benefits advisory here.

[5] The final regulations are published in 77 Fed Reg. 8725 (February 15, 2012), which may be found at http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=25828. The final regulations authorize HRSA to determine required women's preventive care. The text of the religious employer exemption does not appear in the final regulations, but in the HRSA guidelines, which are found at http://www.hrsa.gov/womensguidelines/.

One-Year Delay for Certain Nonprofit Employers

Contemporaneous with the issuance of the final regulations adopting the religious employer exemption, the Departments issued a bulletin announcing a one-year enforcement safe harbor for certain plans that do not qualify for the religious employer exemption (the "Bulletin").[6] The enforcement safe harbor applies until the first plan year beginning on or after August 1, 2013, and protects employers, group health plans, and health insurance issuers from enforcement action by the Departments for failure to provide contraceptive coverage with respect to a group health plan.

In order for the enforcement safe harbor to apply to a plan maintained by an organization, all of the following requirements must be satisfied:

1. The organization must be organized and operated as a nonprofit entity.[7]
2. From February 10, 2012 (the date of issuance of the Bulletin), onward, contraceptive coverage has not been provided at any point by the group health plan established or maintained by the organization, consistent with any applicable state law, because of the religious beliefs of the organization.
3. The group health plan (or another entity on behalf of the plan, such as a health insurance issuer or third-party administrator) provides a notice to participants stating that contraceptive coverage will not be provided under the plan for the first plan year beginning on or after August 1, 2012. The Bulletin includes the text of the required notice to participants.
4. The organization self-certifies that it satisfies criteria 1-3 above, and documents its self-certification in accordance with the procedures detailed in the Bulletin. The Bulletin contains a form to be used for the self-certification.

Note that, as with the case of the religious employer exemption, the enforcement safe harbor applies only for purposes of federal law. Further, because one of the requirements to qualify for the enforcement safe harbor is that the plan is not required to provide contraceptive coverage under state law, a plan that is subject to a state law mandate to provide contraceptive coverage generally will not qualify for the safe harbor.

Proposed Rule Will Require Health Insurance Issuers and TPAs to Provide Free Contraceptive Coverage Beginning in 2013 for Certain Religious Organizations

In order to address the continuing concerns of organizations with religious objections to providing contraceptive coverage, but that do not qualify for the religious employer exemption, the Departments have requested comments on a proposal to provide a "religious accommodation" to required contraceptive coverage.[8]

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[6] The Bulletin, titled "Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans and Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under Section 2713 of the Public Health Service Act, Section 715(a)(1) of the Employee Retirement Income Security Act, and Section 9815(a)(1) of the Internal Revenue Code," may be found at http://cciio.cms.gov/resources/files/Files2/02102012/20120210-Preventive-Services-Bulletin.pdf.

[7] The one-year delay would generally apply to student health plans sponsored by such institutions as well. *See* 77 Fed Reg. 16453, 16456-16457 (March 21, 2012).

[8] The proposal was described in an advance notice of proposed rulemaking published on March 21, 2012, and may be found at http://www.gpo.gov/fdsys/pkg/FR-2012-03-21/pdf/2012-6689.pdf. The proposal similarly applies to student health plans sponsored by entities that qualify for the religious accommodation.

The proposal is designed to relieve objecting religious employers of the obligation to provide and pay for contraceptive coverage, while making the coverage available to participants and beneficiaries without charge.

In the case of self-funded plans, the proposal would make the third-party administrator (TPA) of the plan (or possibly some other independent party) responsible for providing contraceptive benefits. The TPA would be considered the designated plan administrator under ERISA, and, therefore, a fiduciary, with respect to such coverage. The TPA would not be permitted to charge the plan (or its participants and beneficiaries) for such coverage. In the case of a fully-insured plan, the insurer would be required to provide contraceptive coverage directly to plan participants and beneficiaries free of charge.

The proposal raises a number of significant questions, including how TPAs are expected to fund such coverage and whether the provision of such coverage by a TPA (which presumably would be considered insurance for state law purposes) is permitted under applicable state law. Comments on the proposal are due by June 19, 2012. The goal of the Departments is to finalize a rule before the expiration of the temporary enforcement safe harbor.

Further details of the proposal are discussed below.

What organizations are eligible for a religious accommodation?

The proposal does not contain a specific definition of religious organizations that would qualify for the accommodation, but suggest some possible definitions that might be used, such as pre-existing definitions under federal or state law. Comments are also requested as to whether the accommodation should be limited to nonprofit organizations (as is the religious employer exemption and the temporary enforcement safe harbor) or should also be available to certain for-profit organizations.

In order to be eligible for an accommodation, a qualifying organization would have to make a self-certification and provide notice to participants in a manner similar to the provisions of the temporary enforcement safe harbor.

How is the religious accommodation to be administered by a TPA in the case of a self-funded plan?

A self-funded group health plan of a religious organization that self-certifies itself as being eligible for the religious accommodation is not required to provide contraceptive coverage if the organization (1) contracts with one or more third parties for the processing of benefit claims; (2) before entering into each such contract, the employer provides notice to the TPA, as required in the proposal, that the employer will not be responsible for providing contraceptive coverage; and (3) with respect to contraceptive coverage, the TPA has the authority and control over the funds available to pay the benefit, authority to act as claims administrator and plan administrator, and access to information necessary to communicate with the plan's participants and beneficiaries. The proposal further provides that the required notice will be an instrument under which the plan is operated and shall have the effect of designating the TPA as the plan administrator under Section 3(16) of ERISA for those contraceptive benefits for which the TPA processes claims in its normal course of business.

A TPA that becomes a plan administrator in accordance with this process will be responsible for providing those categories of contraceptive services for which the TPA processes claims in its normal course of business. Thus, for example, if the TPA is responsible for processing surgical claims in its normal course of business, it would be responsible for providing required contraceptive coverage consisting of surgical services. Presumably, the requirement would apply to TPAs of health reimbursement arrangement (HRA) coverage where such coverage is sponsored by an employer that qualifies for the religious accommodation.

The proposal suggests a number of possible funding sources that a TPA could draw upon to provide contraceptive benefits, including revenue received by the TPA that is not already obligated to the plan sponsor, such as drug rebates and service fees. The proposal indicates the Departments' belief that some of these sources of revenue may be larger if contraceptive benefits are provided (e.g., drug rebates). Another suggested option would be to provide a TPA with a credit or rebate against the amount it pays under the temporary reinsurance program established under Section 1341 of ACA. Under recently issued final regulations under the reinsurance program, TPAs are responsible for making contributions to HHS "on behalf of" self-funded plans.[9] The Departments also suggest that TPAs could receive funding to pay for required contraceptive services from nonprofit organizations.

The Departments are also considering having the TPA separately arrange for contraceptive coverage, such as through an insurer. One possibility is to use insurers in the multistate option established by ACA and administered by the Office of Personnel Management. In such cases, the insurer would become responsible for providing the coverage.

The Departments note that religious organizations have commented that tax-favored individual employee accounts could be used to pay for contraceptive benefits. Some religious organizations have also commented that using public funds to pay for contraceptive coverage is not objectionable to the organizations.

How is the religious accommodation to be administered by a health insurer in the case of a fully-insured plan?

A fully-insured group health plan of a religious organization that self-certifies itself as being eligible for the religious accommodation is not required to provide contraceptive coverage if the organization (1) provides written notice to the insurer, as provided in the proposal, that the organization will not be responsible for providing contraceptive coverage; and (2) the insurer has access to information necessary to communicate with the plan's participants and beneficiaries and to act as a claims administrator or plan administrator with respect to contraceptive benefits.

A health insurer that receives such a notice must offer health insurance to the organization that does not include contraceptive benefits and must separately provide to the plan's participants and beneficiaries health insurance coverage consisting only of required contraceptive benefits. This coverage must be provided free of charge—i.e., without any charge to the participant/beneficiary, the organization, or the plan. The insurer will also be required to provide notice to participants and beneficiaries of the availability of the coverage. The Departments are considering classifying this separate contraceptive coverage as a new type of "excepted benefit" in the individual market that would be subject to some, but not all, of the ACA heath reforms (e.g., the new claims and appeals requirements might apply, but the separate contraceptive coverage would not be required to provide all essential health benefits).

The proposal states that the Departments expect savings generated from the provision of the contraceptive coverage will pay for the coverage.

This advisory was written by **Carolyn Smith, John Hickman,** *and* **Ashley Gillihan.**

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[9] Further discussion of the contribution requirements imposed on TPAs under the temporary reinsurance program may be found in our prior Employee Benefits advisory here.

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FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART VIII)

March 19, 2012

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the summary of benefits and coverage (SBC) provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments). Like previously issued FAQs (available at **http://www.dol.gov/ebsa/healthreform/** and **http://cciio.cms.gov/resources/factsheets/**), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

On February 14, 2012, the Departments published the final rules regarding the SBC.[1] These FAQs aim to answer some of the questions that have been raised to date. We intend to release additional FAQs. The Administration is committed to promoting operational efficiencies and clarifying the final regulations to ensure successful implementation.

Q1: When must plans and issuers begin providing the SBC?

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

For disclosures from issuers to group health plans, and with respect to individual market coverage, the SBC must be provided beginning September 23, 2012.

Q2: What is the Departments' basic approach to implementation of the SBC requirement during the first year of applicability?

The Departments' basic approach to ACA implementation, as stated in a previous FAQ (see **http://www.dol.gov/ebsa/faqs/faq-aca.html**), is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans,

[1] See 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200, published February 14, 2012 at 77 FR 8668.

issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices."

In addition to the general approach to implementation, in the instructions for completing the SBC, we stated: "To the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms. This may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program."

Consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations. The Departments intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community.

Q3: 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?

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.

Q4: 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?

No, as with the response to Q-3, 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 Departments' sample completed SBC.[2]

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[2] The Departments' sample completed SBC is available at: www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf or http://cciio.cms.gov/resources/files/Files2/02102012/sample-completed-sbcfinal.pdf.pdf.

Q5: If a group health plan is insured and utilizes "carve-out arrangements" (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, who is responsible for providing the SBC with respect to the plan?

The Departments recognize that different combinations of plans, issuers, and their service providers may have different information necessary to provide an SBC, including the coverage examples.

The Departments have determined that, until further guidance is issued, where a group health plan or group health insurance issuer has entered into a binding contractual arrangement under which another party has assumed responsibility (1) to complete the SBC, (2) to provide required information to complete a portion of the SBC, or (3) to deliver an SBC with respect to certain individuals in accordance with the final regulations, the plan or issuer generally will not be subject to any enforcement action by the Departments for failing to provide a timely or complete SBC, provided the following conditions are satisfied:

- The plan or issuer monitors performance under the contract,
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practicable, and
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.

Q6: If a plan offers participants add-ons to major medical coverage that could affect their cost sharing and other information in the SBC (such as a health flexible spending arrangement (health FSA), health reimbursement arrangement (HRA), health savings account (HSA), or wellness program), is the plan permitted to combine information for all of these add-ons and reflect them in a single SBC?

Yes. As stated in the preamble to the final regulations and the instructions for completing the SBC template,[3] plans and issuers are permitted to combine such information in one SBC, provided the appearance is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them. (The Departments' sample completed SBC[4] provides an example of how to denote the effects of a diabetes wellness program.)

Q7: 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?

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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[3] See 77 FR 8668, 8670-71 (February 14, 2012) and page 1 of Instruction Guide for Group Coverage at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf.

[4] See www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf or http://cciio.cms.gov/resources/files/Files2/02102012/sample-completed-sbcfinal.pdf.pdf.

Q8: Are plans and issuers required to provide SBCs to individuals who are COBRA qualified beneficiaries?

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. See 26 CFR 54.4980B-5, Q&A-4(c) (requirement to provide election) and 54.4980B-3, Q&A-3 (definition of similarly situated non-COBRA beneficiary). 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. See 26 CFR 54.4980B-5, Q&A-4(b).

Q9: What circumstances will trigger the requirement to provide an SBC to a participant or beneficiary in a group health plan? In particular, how do the terms "application" and "renewal" apply to a self-insured plan?

The final regulations require that the SBC be provided in several instances:

- Upon application. If a plan (including a self-insured group health plan) or an issuer distributes written application materials for enrollment, the SBC must be provided as part of those materials. For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage.

- By first day of coverage (if there are any changes). If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC no later than the first day of coverage.

- Special enrollees. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment).

- Upon renewal. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.[5]

[5] The final regulations provide an accommodation for insured coverage if the policy, certificate, or contract of insurance has not been renewed or reissued prior to the date that is 30 days prior to the first day of the new plan or policy year. In such

- Upon request. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practicable but in no event later than seven business days following receipt of the request.

Q10: What are the circumstances in which an SBC may be provided electronically?

With respect to group health plan coverage, an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries *who are eligible but not enrolled for coverage*, if:

- The format is readily accessible (such as in an html, MS Word, or pdf format);
- The SBC is provided in paper form free of charge upon request; and
- If the SBC is provided via an Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email.

An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary *who is covered under a plan* in accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.

With respect to individual market coverage, a health insurance issuer must provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless:

- The format is readily accessible;
- If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible;
- The SBC is provided in an electronic form which can be retained and printed; and
- The issuer notifies the individual that the SBC is available free of charge in paper form upon request.

In addition, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application. However, issuers must

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cases, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations.

In addition, as stated in the regulations, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

Q11: Are issuers who have provided individual market plan information to HealthCare.gov in compliance with PHS Act section 2715 and its implementing regulations already?

The deemed compliance provision in the regulation requires issuers in the individual market to provide all of the data elements that are needed to complete the SBC template to HealthCare.gov. If the issuer fails to provide all of the data elements, it would not be deemed to be in compliance with the regulation. Today, HealthCare.gov does not collect all of the elements of an SBC, such as information necessary to complete the coverage examples. However, HHS will collect this information and display it in the format of the SBC template by September 23, 2012, so that providing information to HealthCare.gov fulfills the deemed compliance provision.

Q12: Can the Departments provide model language to meet the requirement to provide an e-card or postcard in connection with evergreen website postings?

Yes. Plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways. One example is:

> **AVAILABILITY OF SUMMARY HEALTH INFORMATION**
>
> As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
>
> Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
>
> The SBC is available on the web at: **www.website.com/SBC**. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

Q13: The regulations state that in order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Does this mean that the SBC must include a sentence on the availability of language assistance services?

Yes, if the notice is sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. The final SBC regulations provide that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of the claims and appeals regulations are met.[6] The claims and appeals regulations outline three requirements that must be satisfied for notices sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. In such cases, the plan or issuer is generally required to provide oral language services in the non-English language, provide notices upon request in the non-English language, and include in all English versions of the notices a statement in the non-English language clearly indicating how to access the language services provided by the plan or issuer.

Accordingly, plans and issuers must include, in the English versions of SBCs sent to an address in a county in which ten percent or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer. In this circumstance, the plan or issuer should include this statement on the page of the SBC with the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections.

Sample language for this statement is available on the model notice of adverse benefit determination at **http://www.dol.gov/ebsa/IABDModelNotice2.doc**. Current county-by-county data can be accessed at **http://www.cciio.cms.gov/resources/factsheets/clas-data.html**.

Even in counties where no non-English language meets the ten percent threshold, a plan or issuer can voluntarily include such a statement in the SBC in any non-English language. Moreover, nothing in the SBC regulations limits an individual's rights to meaningful access protections under other applicable Federal or State law, including Title VI of the Civil Rights Act of 1964.

Q14: Where can plans and issuers find the written translations of the SBC template and the uniform glossary in the non-English languages?

Written translations in Spanish, Chinese, Tagalog and Navajo will be available at **http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html**.

Q15: Is an SBC permitted to simply substitute a cross-reference to the summary plan description (SPD) or other documents for a content element of the SBC?

No, an SBC is not permitted to substitute a reference to the SPD or other document for any content element of the SBC. However, an SBC may include a reference to the SPD in the SBC footer. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.") In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information

[6] See 26 CFR 54.9815-2719T(e), 29 CFR 2590.715-2719(e), and 45 CFR 147.136(e), originally published on July 23, 2010, at 75 FR 43330 and amended on June 24, 2011, at 76 FR 37208.

a reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.

Q16: Can a plan or issuer add premium information to the SBC form voluntarily?

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.

Q17: Must the header and footer be repeated on every page of the SBC?

No. If a plan or issuer chooses, it may include the header only on the first page of the SBC. In addition, a plan or issuer may include the footer only on the first and last page of the SBC, instead of on every page.

The OMB control numbers (which were displayed on the SBC template and the Departments' sample completed SBC to inform plans and issuers that the Departments had complied with the Paperwork Reduction Act) should not be displayed on SBCs provided by plans or issuers.

Q18: For group health plan coverage, may the coverage period in the SBC header reflect the coverage period for the group plan as a whole, or must the coverage period be the period applicable to each particular individual enrolled in the plan?

The SBC may reflect the coverage period for the group health plan as a whole. Therefore, if a plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.

Q19: 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?

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.

Rolling over information from one page to another is permitted.

Q20: Can plan names be generic, such as "Standard Option" or "High Option"?

Yes, generic terms may be used.

Q21: Can the issuer's name and the plan name be interchangeable in order?

Yes.

Q22: Can barcodes or control numbers be added to the SBC for quality control purposes?

Yes, they can be added.

Q23: Is the SBC required to include a statement about whether the plan is a grandfathered health plan?

No, although plans may voluntarily choose to add a statement to the end of the SBC about whether the plan is a grandfathered health plan.

Q24: My plan is moving forward to implement the SBC template for the first year of applicability. Are significant changes anticipated for 2014?

No. The Departments identified in the preamble to the final regulations certain discrete changes that would be necessary for plan years (or, in the individual market, policy years) beginning after the first year of applicability. These changes include the addition of a minimum value statement and a minimum essential coverage statement, changes to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits, and the Departments' intent to add additional coverage examples. The Departments are also considering making some refinements consistent with these FAQs and other requests from plans and issuers for clarification and to promote operational efficiencies. No other changes are planned at this time.

IRS

Medical Loss Ratio (MLR) FAQs

On December 7, 2011, the Department of Health and Human Services (HHS) issued final rules on the calculation and payment of medical loss ratio (MLR) rebates to health insurance policyholders. Rebates are scheduled to begin being paid during 2012. The following questions and answers provide information on the federal tax consequences to a health insurance issuer that pays a MLR rebate and an individual policyholder that receives the MLR rebate. Information is also provided on the federal tax consequences to employees when a MLR rebate stems from a group health insurance policy. These FAQs were last revised on April 2, 2012.

A. Insurance Company

Q1. Insurance Company issues health insurance both in the individual market and the group market during 2011. After determining that it is required to pay MLR rebates on both types of policies issued by Insurance Company during 2011, Insurance Company pays the rebates to the individual policyholders as cash payments in July 2012, and pays the rebates to the group policyholders as premium reductions for coverage in July 2012.

What are the federal tax consequences to Insurance Company?

A1. MLR rebates paid by Insurance Company, either as cash payments or as premium reductions, are return premiums. Return premiums reduce Insurance Company's taxable income. The year in which Insurance Company takes the reduction and whether Insurance Company may take an estimated reserve for the return premium are not addressed by this FAQ.

For a cash rebate paid to an individual policyholder, Insurance Company is not required to file a Form 1099-MISC with respect to that payment or furnish a Form 1099-MISC to the individual policyholder unless (1) the total rebate payments made to that policyholder during the year total $600 or more, and (2) Insurance Company knows that the rebate payments constitute taxable income to the individual policyholder or can determine how much of the payments constitute taxable income. If Insurance Company is required to file a Form 1099-MISC with respect to the rebate payment, it must also furnish a copy to the individual policyholder. See Q&As 2 through 4 below for guidance on whether a cash payment or premium reduction constitutes taxable income to an individual policyholder.

For a rebate paid to a group policyholder as a premium reduction, Insurance Company is not required to file a Form 1099-MISC or furnish a copy to the group policyholder unless (1) the group policyholder is not an exempt recipient for Form 1099 purposes, (2) the total rebate payments to that group policyholder during the year total $600 or more, and (3) Insurance Company knows that the rebate payments constitute taxable income to the group policyholder or can determine how much of the payments constitutes taxable income. Exempt recipients for which Forms 1099 generally are not required to be provided include corporations, tax exempt organizations, and federal and state governments. Insurance Company can rely on a recipient's claim of exempt recipient status on a Form W-9; see the Instructions for Form W-9 or the General Instructions for Certain Information Returns. See Q&As 5-14 for guidance on whether a premium reduction or cash payment constitutes taxable income to employees participating in a group health plan. (Q&As 5-9 address after-tax premium payments and Q&As 10-14 address pre-tax payments.)

B. Policies Purchased on the Individual Market

Q2. In 2011, Aaron purchased and paid premiums for a health insurance policy for himself. Aaron does not deduct the premium payments on his 2011 Form 1040 and does not receive any reimbursement or subsidy for the premiums. Based on his enrollment during 2011, Aaron receives a MLR rebate on July 1, 2012.

Is Aaron's MLR rebate subject to federal income tax?

A2. No. The MLR rebate that Aaron receives on July 1, 2012, is a rebate of part of his 2011 insurance premiums (a purchase price adjustment). Because Aaron did not deduct the premium payments on his 2011 Form 1040, the rebate is not taxable whether received as a cash payment or applied as a reduction in the amount of premiums due for 2012.

Q3. The facts for Beatrice are the same as the facts for Aaron in Question 2 except that she deducts the premium payments on Schedule A of her 2011 Form 1040.

Is Beatrice's MLR rebate subject to federal income tax?

A3. Yes. The MLR rebate that Beatrice receives on July 1, 2012, is a rebate of part of her 2011 insurance premiums (a purchase price adjustment). Because Beatrice deducted the premium payments on Schedule A of her 2011 Form 1040, the MLR rebate that Beatrice receives on July 1, 2012, is taxable to the extent that she received a tax benefit from the deduction, whether the rebate is received as a cash payment or applied as a reduction in the amount of premiums due for 2012. For more information on determining whether there is a tax benefit from the deduction, see Itemized Deduction Recoveries in Publication 525, Taxable and Nontaxable Income.

Q4. The facts for Charlie are the same as the facts for Beatrice in Question 3, except that Charlie is self-employed so that he deducts the premium payments on line 29 of his 2011 Form 1040.

Is Charlie's MLR rebate subject to federal income tax?

A4. Yes. The MLR rebate that Charlie receives on July 1, 2012, is a rebate of part of his 2011 insurance premiums (a purchase price adjustment). Because Charlie deducted the premium payments on line 29 of his 2011 Form 1040, the MLR rebate that Charlie receives on July 1, 2012, is taxable to the extent that he received a tax benefit from the deduction, whether the rebate is received as a cash payment or as a reduction in the amount of premiums due for 2012. For more information on determining whether there is a tax benefit from the deduction, see Non-Itemized Deduction Recoveries in Publication 525, Taxable and Nontaxable Income.

C. Group Policies – Employee After-Tax Premium Payments

In Questions 5 through 7, assume that the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012).

Q5. In 2011, Daniel participated in his employer's group health plan and received health coverage under the group health insurance policy purchased directly by his employer under the plan. The plan provides that Daniel's employer pays for 60% of the premium for each employee, and the employee pays for 40% of the premium on an after-tax basis. Daniel does not deduct the premiums on his 2011 Form 1040.

On July 1, 2012, Daniel's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and consistent with applicable Department of Labor (DOL) guidance, 60% of the rebate is used to reduce the employer portion of the premium due for 2012, and 40% of the rebate is used to reduce the employee portion of the premium due for 2012, but only for participants under the plan who also were participants under the plan during 2011.

Because Daniel participated in the plan during 2011 and 2012, he is entitled to a MLR rebate. As a result of the rebate and corresponding premium reduction, Daniel's premium for 2012 coverage under the group health plan is reduced.

Is Daniel's MLR rebate income subject to federal income tax?

A5. No. The MLR rebate that Daniel receives in 2012 is a rebate of part of his 2011 insurance premiums (a purchase price adjustment). Daniel paid taxes on his compensation as an employee and used part of the after-tax income to pay his portion of the 2011 premiums. He did not deduct the premiums; therefore, the rebate is not taxable when applied as a reduction in the amount of premiums due for 2012. In addition, because the MLR rebate is a return of amounts that have already been subject to federal employment taxes, the rebate is not subject to federal employment taxes.

Q6. Would Daniel's MLR rebate be subject to federal income tax if the insurance company had paid the MLR rebate in cash and then the employer distributed the MLR rebate in cash to Daniel (consistent with applicable Department of Labor (DOL) guidance) rather than reducing the premiums due for 2012?

A6. No. If Daniel receives a cash distribution because of the MLR rebate, the cash also is a reduction in the cost of his 2011 insurance premiums (a purchase price adjustment) and is not taxable. In addition, because the MLR rebate payment is a return of amounts that have already been subject to federal employment taxes, the payment is not subject to federal employment taxes.

Q7. Would Daniel's MLR rebate be subject to federal income tax if Daniel had deducted his premium payment on his 2011 Form 1040?

A7. Yes. If Daniel deducted the premium payments on his 2011 Form 1040 and receives a MLR rebate in 2012, the MLR rebate is taxable to the extent that he received a tax benefit from the deduction, regardless of whether the rebate is provided as a cash payment or a reduction in the premium due for 2012. For more information on determining whether there is a tax benefit from the deduction, see Itemized Deduction Recoveries in Publication 525, Taxable and Nontaxable Income. Because the MLR rebate is a return of amounts that have already been subject to federal employment taxes, the rebate (whether applied to reduce Daniel's 2012 premium or provided as a cash payment) is not subject to federal employment taxes.

In Questions 8 and 9, assume that the MLR rebates are provided to all employees participating in a group health plan in the year the MLR rebates are paid (in these examples, 2012), regardless of whether an employee participated in the plan in the year the employees paid the premiums being rebated (in these examples, 2011).

Q8. In 2011, Doris participated in her employer's group health plan and received health coverage under the group health insurance policy purchased directly by her employer under the plan. The plan provides that Doris's employer pays for 60% of the premium for each employee, and the employee pays for 40% of the premium on an after-tax basis.

On July 1, 2012, Doris's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The employer may distribute the MLR rebate in cash or in the form of a reduction in the current year premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and the applicable DOL guidance, the employer applies 60% of the MLR rebate to reduce the employer portion of the premium due for 2012, and 40% of the rebate to reduce the employee portion of the premium due for 2012 for all participants under the plan, regardless of whether the employee who receives the MLR rebate participated in the plan during 2011.

Because Doris participates in the plan during 2012, she is entitled to a MLR rebate. As a result of the rebate and the corresponding premium reduction, Doris's premium for 2012 coverage under the group health plan is reduced.

Is Doris's MLR rebate subject to federal income tax?

A8. No. Doris receives the MLR rebate due to her participation in her employer's group health plan during 2012, and would not have received the MLR rebate had she failed to participate in the plan during 2012. Therefore, the MLR rebate is a purchase price adjustment that reduces the cost of her 2012 insurance premiums and is not taxable regardless of whether Doris deducted the 2011 premium payments on her 2011 Form 1040. If Doris deducts the premiums she pays for health care coverage on her 2012 Form 1040, the amount of the MLR rebate reduces the amount of her deduction because she is paying less for premiums. If Doris had received the MLR rebate in cash, instead of as a premium reduction, Doris's rebate also would not be subject to federal income tax and would reduce the amount of any 2012 deduction for premiums paid by Doris on her Form 1040. In either case, Doris's rebate would not be wages subject to employment taxes.

Q9. In 2012, Edwin begins working for the same employer as Doris (and thus he did not participate in the plan during 2011). Edwin participates in the plan beginning on his first day of employment. When his employer distributes the MLR rebate as a reduction in Edwin's 2012 premiums, Edwin's premium for 2012 coverage under the group health plan is reduced.

Is Edwin's MLR rebate subject to federal income tax?

A9. No. The MLR rebate Edwin receives is a purchase price adjustment that reduces the cost of his 2012 insurance premiums and is not taxable. If Edwin deducts the premiums he pays for health care coverage in 2012 on his Form 1040, the amount of the rebate reduces the amount of his deduction because he is paying less for premiums. If Edwin had received the MLR rebate in cash, instead of as a premium reduction, Edwin's rebate also would not be subject to federal income tax and would reduce the amount of any 2012 deduction for premiums paid by Edwin on his Form

1040. In either case, Edwin's rebate would not be wages subject to employment taxes.

D. Group Policies - Employee Pre-Tax Payments

In Questions 10 and 11, assume the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012).

Q10. Frances participates in her employer's group health plan and receives health coverage under the group health insurance policy purchased directly by her employer under the plan. Frances pays her portion of premiums on a pre-tax basis under her employer's cafeteria plan. The plan provides that Frances's employer pays for 60% of the health insurance premium for each employee, and the employee pays for 40% of the premium.

On July 1, 2012, Frances's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year's premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and consistent with applicable DOL guidance, the employer applies 60% of the rebate to reduce the employer portion of the premium due for 2012, and 40% of the rebate to reduce the employee portion of the premium due for 2012, but only for participants under the plan who also were participants under the plan during 2011.

Because Frances participates in the plan during 2011 and 2012, she is entitled to a rebate of $X. As a result of the rebate and corresponding premium reduction, Frances's salary reduction contribution under the cafeteria plan for 2012 is reduced by $X.

Is Frances's MLR rebate subject to federal income tax?

A10. Yes. Because the MLR rebate is distributed as a premium reduction, the amount Frances pays for premiums through a salary reduction contribution in 2012 is decreased by $X. Consequently, in 2012 there is a corresponding increase of $X in her taxable salary that is also wages subject to employment taxes.

Q11. Will Frances also have an $X increase in taxable income during 2012 if the MLR rebate is provided in the form of a cash payment and the employer distributes the MLR rebate to Frances in cash (consistent with applicable DOL guidance) instead of reducing premiums for 2012 coverage?

A11. Yes. Frances will have $X more taxable income in 2012. The amount that Frances paid for premiums for health insurance was subtracted from her salary on a pre-tax basis under her employer's cafeteria plan because it was used to pay for health insurance premiums. The MLR rebate is a return to Frances of part of that untaxed compensation that is no longer being used to pay for health insurance. Therefore, the MLR rebate that Frances receives in 2012 is an increase in taxable income that is also wages subject to employment taxes.

In Questions 12 through 14, assume the MLR rebates are provided to all employees participating in a group health plan during the year the MLR rebates are paid (in these examples, 2012), regardless of whether the employee who receives the MLR rebate participated in the plan during the plan year covered by the MLR rebate (in these examples, 2011).

Q12. Fred participates during 2011 and 2012 in his employer's group health plan and receives health coverage under the group health insurance policy purchased directly by his employer under the plan. Fred pays his portion of premiums on a pre-tax basis under his employer's cafeteria plan. The plan provides that Fred's employer pays for 60% of the health insurance premium for each employee, and the employee pays for 40% of the premium.

On July 1, 2012, Fred's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year's premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and consistent with applicable DOL guidance, the employer applies 60% of the rebate to reduce the employer portion of the premium due for July 2012, and 40% of the rebate to reduce the employee portion of the premium due for 2012, for all participants in the plan (regardless of whether a participant was also a participant in the plan during 2011).

Because Fred participates in the plan during 2012, he is entitled to a rebate of $X. As a result of the rebate and corresponding premium reduction, Fred's salary reduction contribution under the cafeteria plan for 2012 is reduced by $X.

Is Fred's MLR rebate subject to federal income tax?

A12. Yes. Because the MLR rebate is distributed as a premium reduction, the amount Fred pays for premiums through a salary reduction contribution in 2012 is decreased by $X. Consequently, in 2012 there is a corresponding increase of $X in his taxable salary that is also wages subject to employment taxes.

Q13. Will Fred also have an $X increase in income during 2012 if the MLR rebate is made in the form of a cash payment and the plan distributes the MLR rebate to Fred in cash instead of reducing premiums for 2012 coverage?

A13. Yes. Fred will have $X more taxable income in 2012. The amount that Fred paid for premiums for health insurance was subtracted from his salary on a pre-tax basis under his employer's cafeteria plan because it was used to pay for health insurance premiums. The MLR rebate is a return to Fred of part of that untaxed compensation that is no longer being used to pay for health insurance. Therefore, the MLR rebate that Fred receives in 2012 results in an increase in taxable income that is also wages subject to employment taxes.

Q14. George begins working for the same employer as Fred in 2012 (and thus he did not participate in the plan during 2011). He participates in the plan during 2012. As a result of the rebate and corresponding premium reduction, George's salary reduction contribution under the cafeteria plan for July 2012 is reduced by $X.

Is George's MLR rebate income subject to federal income tax?

A14. Yes. Because the MLR rebate is distributed as a premium reduction, the amount George pays for premiums through a salary reduction contribution is decreased by $X. Consequently, there is a corresponding increase of $X in his salary and the additional salary is taxable income that is also wages subject to employment taxes.

If George receives an $X cash payment, he will have $X more taxable income in 2012. The amount that George paid

for premiums for health insurance was subtracted from his salary on a pre-tax basis under his employer's cafeteria plan because it was used to pay for health insurance premiums. The MLR rebate is a return to George of part of that untaxed compensation that is no longer being used to pay for health insurance. Therefore, the MLR rebate that George receives in 2012 is an increase in taxable income that is also wages subject to employment taxes.

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