Benefits Update

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Guidance On MLR Rebates For Insured Plans

By Callan Carter (San Francisco)

One of the provisions in the recent healthcare reform law is the medical loss ratio (MLR) that requires insurance companies to spend a certain proportion of their income on healthcare benefits for their customers. If an insurance company does not meet its MLR standard, it is required to issue a rebate to its policyholders. (The MLR standards do not apply to self-insured medical plans.) In 2011, the Labor Department issued a Technical Release, which provided guidance on how sponsors of group health plans covered by ERISA should handle such rebates.

The MLR Requirements

The Affordable Care Act requires insurance companies in the large-group market (employers with at least 100 employees) to spend at least 85% of premiums on medical benefits and quality-improvement activities. Insurance companies in the small-group and individual markets must spend at least 80% of premiums.

Beginning this summer, insurance companies will be required to report 2011 MLR data to each state in which they do business. They will report aggregate premium, claims experience, and quality-improvement expenditures for their large-group, small-group and individual markets in each state. Insurers will be calculating MLR based on their entire business in the large-group or small-group market, not based on a particular group health plan's experience.

In August 2012, insurance companies that did not meet the MLR standards in 2011 will be required to provide a rebate to their customers. Health and Human Services (HHS) has directed insurers in the group market to provide rebates to the group policyholder and to include protections designed to benefit plan participants.

Details Of The Rule

When rebates are paid to a group policyholder that is an ERISA plan sponsor, the rebates may be plan assets, and thus subject to rules under Title I of ERISA relating to fiduciary responsibilities and prohibited transactions. The DOL's Technical Release provides guidance regarding the duties of employers, plan sponsors, and other fiduciaries' responsibilities for decisions related to the MLR rebates they receive from insurance companies.

If the plan or its trust is the policyholder, then the policy and the rebate are definitely plan assets. When a rebate is a plan asset, fiduciaries must act prudently, solely in the interest of the plan participants, and in accordance with the terms of the plan document when handling the assets. If distributing payments to any participant is not cost effective, the fiduciary may apply the rebate toward future participant premium payments or toward benefit enhancements.

Insurance companies must provide notices of rebates to current group health plan participants and group policyholders. The notice must include general information about the MLR standard, the issuer's actual MLR, and the rebate. To prepare for the possibility of receiving rebates, plan sponsors with insured group health plans should review their plan documents now to determine whether they address payment of rebates.

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HHS Begins HIPAA Privacy and Security Audits

By Callan Carter (San Francisco)

As you may recall, the HITECH Act required Health and Human Services (HHS), the federal agency in charge of administering HIPAA, to affirmatively conduct periodic audits to ensure that covered entities and business associates are complying with HIPAA's privacy and security rules. Before HITECH, HHS was mostly responding to complaints and not conducting random audits of HIPAA compliance.

HHS's Office for Civil Rights (OCR) has launched a pilot audit program and expects to complete 150 audits by the end of 2012. These audits will include requesting documentation as well as onsite visits and a final report noting compliance issues.

These HHS audits can lead to compliance reviews, resulting in monetary settlements or the imposition of civil money penalties. Covered entities and business associates, including employer-provided health plans and their service providers, should make sure their workforce training, policies and procedures, and security risk assessments are in place, easily accessible and up-to-date.

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FAQs Regarding Summary Of Benefits And Coverage

In response to the February 14, 2012 final rules and regulations issued by the Labor Department regarding the summary of benefits and coverage (SBC) provisions of Health Care Reform, the DOL, in conjunction with Health and Human Services and the Treasury Department issued a new set of 24 Frequently Asked Questions to address some of the pertinent questions raised to date and to help consumers, employers and individuals understand the new law.

Although a more detailed description is provided at www.dol.gov the following provides a brief summary of the highlights within the FAQs.

Issue	Comments/FAQ Response
Effective Date ***(when to comply with the new rules)***	No extension of the generally applicable September 23 effective date was provided, i.e., the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012; with any other enrollment, the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.
Enforcement vs. Assistance	The Departments will continue to take an "assistance" framework (as opposed to imposing penalties) during the transition as long as employers are making good faith efforts.
Coverage Tiers – Separate SBCs?	Plans and issuers are not 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. This includes arrangements where the participant is able to select the levels of deductible, copayments, and co-insurance for a particular benefit package (these can be presented as options and a model sample is provided by the Departments).
Carve-Out Arrangements	A plan or issuer with a carve-out arrangement with a Pharmacy Benefit Manager or other organization can delegate to that organization the duty to provide the SBC, but the plan or issuer remains responsible if the plan or issuer knows the SBC hasn't been done properly.
How are FSA, HRA, HSA, and Wellness "Add-Ons" handled?	FSA, HSA, HRA, Wellness and other similar benefit add-ons can be described in the same SBC document used for the health plan.
Seven "Business Day" Rule (*mailbox rule*)	The final regulation that require the SBC to be provided in certain circumstances within seven business days means that the SBC be "sent" within seven business days, not "received" within seven business days.
COBRA Qualified Beneficiary Implication	While a qualifying event does not itself trigger an SBC, during an open enrollment period any COBRA qualified beneficiary who is receiving COBRA coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary.
What "triggers" the SBC Requirement?	The Department sets forth guidance on providing an SBC particularly 1) upon application; 2) by first day of coverage (if there are any changes); 3) to special enrollees; 4) upon renewal; and 5) upon request.
Electronic Delivery	With respect to group health plan coverage, an SBC may be provided electronically: 1) by an issuer to a plan, 2) by a plan or issuer to participants and beneficiaries *who are eligible but not enrolled for coverage* (if the format is readily accessible, it's provided in paper form free of charge upon request and, if via an Internet posting, the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that it's available on the Internet and provides the Internet address), and 3) by a plan or issuer to participants and beneficiaries w*ho are covered under a plan* in accordance with the DOL's disclosure regulations
Evergreen Website Postings (e-card/postcard)	Model language is provided for postcards or emails about evergreen website postings.
Culturally/Linguistically Appropriate Manner	SBCs must include a sentence on the availability of language assistance services (similar to claims appeal requirements). Written SBC translations in Spanish, Chinese, Tagalog and Navajo are available at http://cciio.cms.gov.
SPD Cross-Reference?	The SBC cannot simply cross-reference the terms of a Summary Plan Description.
Grandfathered Notice	The SBC is not required to indicate the plan's grandfathered status. However, a plan may voluntarily add such information if desired.

For more information contact any member of the Fisher & Phillips Employee Benefits Practice Group.