



December 2011

## LEGISLATIVE UPDATE

by Jennifer Lunski, Esq.

At Woodruff-Sawyer, we offer frequent updates on legislative changes that impact employee benefit plans. Employers should review the updates to ensure their plans and policies are in compliance with the newest legislation and regulations. This update includes articles on the following topics:

1. CLASS Act Implementation Suspended by the Obama Administration
2. DOL Delays Implementation of Summary of Benefits and Coverages (SBC) Rules
3. San Francisco Health Care Security Ordinance (HCSO) Regulations
4. DOL Gives Guidance on Medical Loss Ratio Requirements
5. Michigan to Impose Assessment of Health Care Claims
6. Department of Health and Human Services Launches a HIPAA Audit Program
7. Blue Shield Credits

### CLASS ACT IMPLEMENTATION SUSPENDED BY THE OBAMA ADMINISTRATION

The Secretary of Health and Human Services (HHS), Kathleen Sebelius, released a report to Congress October 14th regarding HHS' analysis of the CLASS Act—the long term care program passed as part of the Affordable Care Act (ACA). In a letter sent with the report, Sebelius announced the Administration has decided not to move forward with the implementation of the CLASS program.

In the letter Sebelius states, *"In 2009, the actuary at [CMS] released a report to Congress...that raised concerns about the (CLASS) program's viability. Because of such concerns, the law passed by Congress required me to design a plan*

*that would be actuarially sound and financially solvent for at least 75 years."* HHS has concluded that it cannot certify the plan's long term financial viability as currently structured. As a result of this decision, for all practical purposes, the CLASS Act is dead.

The Secretary's letter can be read in its entirety at <http://www.hhs.gov/secretary/letter10142011.html>.

### DOL DELAYS IMPLEMENTATION OF SUMMARY OF BENEFITS AND COVERAGE (SBC) RULES

In a short statement released on its website on November 17th, the Department of Labor (DOL) has provided a welcome delay in the implementation of the new Summary of Benefits and Coverage (SBC) Rules contained in the Affordable Care Act (ACA).

The ACA requires that health insurance carriers, and employer sponsored health plans, provide an SBC to participants and enrollees beginning in March 2012. Proposed regulations were released in August 2011 which contained very specific content and delivery requirements. The regulatory agencies collected public comments on the proposed regulations through October. During the comment period there was significant concern expressed by health insurers and employers about the short timeframe before the requirement was scheduled to go into effect.

In response to these concerns, the DOL has stated that carriers and plans will not be required to provide the SBC until after final regulations are issued. The announcement also states the actual effective date of the SBC rules will be announced in the final regulations and *"the final regulations...will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply"*.



Final regulations are expected soon. However, based on the DOL statement, it is anticipated that there will be a significant period of time provided after the rules are released to allow health plans and employers to implement the necessary changes.

The complete DOL statement is included below:

*The Departments received many comments on the proposed regulations and templates and intend to issue, as soon as possible, final regulations that take into account these comments and other stakeholder feedback.*

*PHS Act section 2715 provides that group health plans and health insurance issuers shall provide the Summary of Benefits and Coverage and Uniform Glossary pursuant to standards developed by the Departments. Accordingly, until final regulations are issued and applicable, plans and issuers are not required to comply with PHS Act section 2715.*

It is anticipated that the Departments' final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply. As the regulations are written now, the insurance carrier is responsible for providing the Summary of Benefit Coverage for plans which are fully insured, and employers are responsible for providing the Summary of Benefits Coverage for self-funded plans.

### SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO) REGULATIONS

The Woodruff-Sawyer compliance team has been following the development of amendments to HCSO by the Board of Supervisors. The amendments were an attempt by the Board of Supervisors to address the fact that employees were forfeiting on average eighty percent of available Health Reimbursement Account (HRA) funds. In November, San Francisco Mayor Ed Lee signed legislation that significantly revises parts of the city's Health Care Security Ordinance (Ordinance).

Beginning in 2012, the revised Ordinance requires employers that use an HRA account to do the following:

- Keep employer contributions available for at least 24 months after the date of the contribution
- Provide a detailed written account summary to the employee (including the account balance and

any applicable forfeiture rules) 15 days after each quarterly contribution.

- Allow reimbursements from the account for at least 90 days after termination of employment.
- Provide a written notice (including the balance in the account and any applicable forfeiture rules) within three days after termination of employment.
- Annually report account terms to the city (including which expenses are eligible for reimbursement under the account).
- Annually post a new city-provided notice addressing employee rights and employer obligations under the Ordinance.

Further, the Ordinance requires employers to "roll over" any December 31, 2011 account balance to January 1, 2012 in order to ensure that participants start 2012 with an account balance.

### DOL GIVES GUIDANCE ON MEDICAL LOSS RATIO REQUIREMENTS

On December 2, 2011 the Department of Labor issued Technical Release 2011-04 relating to medical loss ratio (MLR) standards of the Patient Protection and Affordable Care Act (ACA). Specifically, ACA mandates that health insurance companies in the individual and small group markets spend at least 80% of premium dollars on medical care and health care quality improvement. In the large group market, health insurance issuers are required to spend at least 85% of premium dollars on medical care and health care quality improvement. If health insurers do not meet this threshold, in 2012 they must rebate the difference to their customers. The guidance specifies that medical loss ratio refunds may constitute plan assets. ERISA plan assets are required to comply with the fiduciary provisions of ERISA. Absent plan document language that specify the contrary, the portion of MLR rebates that are attributable to participant contributions would be considered plan assets. The guidance also directs issuers to provide a notice of rebates to current group health plan subscribers as well as group policyholders, and to subscribers in the individual market. The notice must include information about the MLR standard and the rebate being provided. If the plan is subject to ERISA, the notice to policyholders and subscribers must contain an explanation that the policyholder may have obligations under ERISA's



fiduciary responsibility provisions with respect to the handling and allocation of the rebate and contact information for questions concerning the handling and allocation of the rebate under their plan.

Employers who receive MLR rebates will want to work closely with their benefits consultant to ensure that MLR rebates attributable to plan assets are treated appropriately.

### MICHIGAN TO IMPOSE ASSESSMENT ON HEALTH CARE CLAIMS

Beginning January 1, 2012, Michigan will impose a 1% assessment on most health insurance claims. The fee will apply only to claims incurred by residents of Michigan for care received from providers in the state. The law is scheduled to be in force for two years and will end on December 31, 2013.

The assessment generally applies to all group health plans, whether insured or self-insured. Self-funded employers may feel that ERISA should pre-empt the law from applying to their plans, however, the Supreme Court has already upheld a very similar rule in New York.

The Michigan fee does not apply to the following:

- Any claims in excess of \$1 million per year for an individual
- Co-pays and deductibles that are the responsibility of the covered individual
- Section 125 health FSA reimbursements
- HSA distributions
- Reimbursements from a health reimbursement arrangement (HRA)
- Plans providing specified accident coverage or accident-only plans
- Long-term care coverage
- Workers' compensation claims

Employers are not directly responsible to pay the fee - the law requires health insurance companies and TPAs (in the case of a self-funded plan) to calculate and pay the fee on a quarterly basis.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES LAUNCHES A HIPAA AUDIT PROGRAM

#### Overview

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a portion of The American Recovery and Reinvestment Act of 2009 (ARRA) requires HHS to provide for periodic audits to ensure covered entities and business associates are complying with the HIPAA Privacy and Security Rules and Breach Notification standards. To implement this requirement mandate, The HHS Office for Civil Rights (OCR) is piloting a program to perform up to 150 audits of covered entities to assess privacy and security compliance. OCR is the agency charged with HIPAA privacy and security compliance. Audits during the pilot phase will begin November 2011 and conclude by December 2012. It is anticipated that additional audits will continue after the initial pilot program.

OCR will use the audit program to assess HIPAA compliance efforts by a range of covered entities. Audits present a new opportunity to examine mechanisms for compliance, identify best practices and discover risks and vulnerabilities that may not have come to light through OCR's ongoing compliance investigations and compliance reviews. OCR plans to share information gleaned through the audit process and issue guidance targeted to observed compliance challenges.

#### Who Will Be Audited?

Every covered entity and business associate is eligible for an audit. OCR will audit as wide a range of types and sizes of covered entities as possible; covered individual and organizational providers of health services, health plans of all sizes and functions, and health care clearinghouses may all be considered for an audit. Business Associates will not be included in the initial audit pilot program but will be included in future audits.

#### How Will the Audit Program Work?

Entities selected for an audit will be informed by OCR of their selection and asked to provide documentation of their privacy and security compliance efforts. In this pilot phase, every audit will include a site visit and result in an audit report. During site visits, auditors will interview key personnel and observe processes and operations to help determine compliance. Following the site visit, auditors will develop and share with the entity a draft report; audit reports generally describe how the audit was conducted, what the findings were and what actions the covered entity is taking in response to those findings.



Prior to finalizing the report, the covered entity will have the opportunity to discuss concerns and describe corrective actions implemented to address these concerns. The final report submitted to OCR will incorporate the steps the entity has taken to resolve any compliance issues identified by the audit, as well as describe any best practices of the entity.

#### What is the General Timeline for an Audit?

OCR expects to notify selected covered entities between 30 and 90 days prior to the anticipated onsite visit. Onsite visits may take between 3 and 10 business days depending upon the complexity of the organization and the auditor's need to access materials and staff. After fieldwork is completed, the auditor will provide the covered entity with a draft final report; a covered entity will have 10 business days to review and provide written comments back to the auditor. Should an audit report indicate a serious compliance issue, OCR may initiate a compliance review to address the problem. OCR will not post a listing of audited entities or the findings of an individual audit which clearly identifies the audited entity.

#### Summary

It is expected that the majority of covered entities selected for the pilot audit program will be medical providers and insurance companies. However, based on the description of the audit process provided by HHS, it is likely that a number of employer's will be included in the program relative to the health plans offered to their employees. Now would be a good time for employers who sponsor plans subject to the HIPAA privacy and security rules to review their existing HIPAA policies and procedures.

#### BLUE SHIELD CREDITS

During 2011, Blue Shield of California returned a percentage of their profits to their customers. This credit was given in

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the summer and represented profits for the 2010 plan year. The credit was also given in December 2011 for the 2011 plan year. To the extent that policy credits are being paid to group health plans that are subject to regulation under the Employee Retirement Income Security Act of 1974, as amended (ERISA), employers will need to exercise care. Based on long-standing Department of Labor (DOL) guidance, a portion of aggregate policy credits could constitute "plan assets," which are subject to the ERISA fiduciary requirements. Based on prior Department of Labor treatment of policies, refunds or credits it is recommended that employers determine their obligation with respect to policy credits by taking the following action:

1. Review plan documents to determine if there is a manner for allocating credits,
2. Calculate the premium amount for the period attributable to the profit that BCBS returned;
3. Determine the percentage of the premium amount attributable to employee contributions;
4. Take one of the following two options:
  - a. Give a premium holiday to employees for a few months that is equivalent to the amount of employee contributions attributable to the amount of returned profits; or
  - b. Refund employees the portion of employee contributions attributable to the profit.

Blue Shield of California also encourages employers to return a portion of the credit money to employees if there were participant contributions to the plan.

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#### About Jennifer

*Jennifer is Vice President, Compliance Officer in the Benefits practice at Woodruff-Sawyer & Co. She consults directly with our Employee Benefits clients on all matters of compliance and leads both internal and external trainings. She has also conducted numerous trainings on ERISA, COBRA and HIPAA to Department of Labor employees, the Department of Justice and to employers that sponsor ERISA-covered plans. A published expert on ERISA, COBRA and HIPAA rules and regulations, Jennifer has investigated a broad spectrum of company employee benefit plans and has extensive experience negotiating with industry fiduciaries and service providers.*

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