MILLENNIUM BENEFITS CONSULTING

Millennium Update

September 20, 2011

In This Issue

How Are We Doing?

For many, the busy season of Open Enrollment is coming up and before that time we'd like to ask, "How are we doing?" We're looking for candid feedback about your experiences with MBC and your assessment of our services. We will be sending out some questions via email in the next few weeks and request that you take a few minutes to give us your feedback. We'll take this information and use it to enhance our performance in areas that add the most value to your organization. We look forward to hearing what you have to say.

Important Reminder About Employee Incentives

As wellness programs continue to rise in popularity, you may be considering various forms of incentives and rewards for your employees. It's important to remember how the IRS treats these "fringe benefits," including gift cards. Because they have a finite and easily accountable dollar value, gift cards are considered to be taxable income under the IRS code, and therefore must be reported on an employee's Form W-2. Essentially, gift cards are treated exactly the same as cash. So if you give a $20 gift card, the employee will owe tax and end up with less than the intended gift amount.

Read more about taxes and Fringe Benefits in IRS Publication 15b.
http://www.irs.gov/publications/p15b/ar02.html#en_US_2011_publink1000193805

Instead of gift cards, consider other options that are more tax-efficient. The IRS does not tax items that can be considered *"de minimis,"* meaning they are of an undeterminable or relatively low value. Instead of giving a gift card for Amazon.com, buy them a book. A $20 gift card can be taxed, but a $20 book cannot.

The next time you need an employee incentive, consider these de minimus benefits:

- Holiday gifts, other than cash, with a low fair market value
- Meals or food such as refreshments (coffee, soft drinks and light snacks), a party or a picnic
- Tickets for theater or sporting events

See the IRS tax code for more information about de minimis fringe benefits.
http://www.irs.gov/govt/fslg/article/0,,id=184791,00.html

As you navigate your way through determining which fringe benefits to offer, please contact us with any questions or concerns you may have. We're here to help!

PPACA Updates

#1 New Preventive Care Guidelines For Women's Services

On August 1, 2011, the Department of Health and Human Services (HHS) released **new guidelines** outlining required preventive care services for women. These guidelines **add** services to the existing list of preventive care services that were implemented this year under the requirements of the Patient Protection and Affordable Care Act (PPACA).

As an employer, this impacts you because it adds to the list of services that must be included in your medical benefit plans offered to employees.

QUICK LOOK:
Women's Preventive Care Guidelines

When is the effective date?
Plan years beginning on or after August 1, 2012

What do the guidelines require?
Healthcare plans must include coverage for specific preventive care services for women at 100%. This means there cannot be a copayment, deductible or coinsurance to receive these benefits.

Who must comply?
Nongrandfathered health plans (including ASO plans).

What action must I take now?
While these regulations don't take effect until 2012, you can offer your comments about the new regulations to HHS. The comment period for these guidelines ends **September 30, 2011**. In commenting, please refer to file code CMS-9992-IFC2. To submit comments:

1. Go online to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. Written comments may be mailed to:
   Centers for Medicare & Medicaid Services,
   Department of Health and Human Services
   Attention: CMS-9992-IFC2
   P.O. Box 8010
   Baltimore, MD 21244-8010

For A CLOSER LOOK at the new guidelines for Women's Preventive Care services, click here.

A CLOSER LOOK:
Women's Preventive Care Guidelines

The guidelines state that the following services must be offered without cost sharing:

- Well-woman visits
- Screening for gestational diabetes for all pregnant women
- Human papillomavirus DNA testing for all women 30 years and older
- Annual sexually transmitted infection counseling for all sexually active women
- Annual counseling and screening for HIV for all sexually active women
- FDA-approved contraception methods, sterilization procedures and contraceptive counseling
- Breastfeeding support, supplies, and counseling, including costs for renting breastfeeding equipment
- Domestic violence screening and counseling

Some additional fine-print details:

- Plans may include cost sharing for branded drugs if a generic version is available and just as effective and safe. For example, you may include a provision in your plans that an employee must pay the difference between the brand-name and the generic drug, if they choose to receive the more expensive brand-name Rx.
- An interim final rule was released with these guidelines to give religious organizations the choice of buying or sponsoring group health insurance that does not cover contraception if that is inconsistent with their tenets. This proposal is modeled on the most common exemption available in the 28 states that already require insurance companies to cover contraception.

We will continue to monitor this requirement and will keep you posted to any changes that result from the comment period.

For more detail on the amendment and the additional preventive care services for women, visit:

www.hrsa.gov/womensguidelines/

For more information on the existing PPACA preventive care guidelines, visit:

http://www.healthcare.gov/center/regulations/prevention/taskforce.html

#2 Uniform Benefit Summaries Required

On August 17, the Department of Health and Human Services (HHS) released some additional information about the previously released requirement to provide Uniform Benefit Summaries to all enrollees. The information released in August provides more specifics of how to comply with this regulation.

As an employer, this impacts you because it requires you to distribute a clear and understandable Summary of Benefits and Coverage to all employees in a timely manner.

QUICK LOOK:
Uniform Benefit Summaries Required

When is the effective date?
Enrollment in plans on or after March 23, 2012

What do the guidelines require?
Insurers and self-insured employers must provide a Summary of Benefits and Coverage (also referred to as an 'SBC') to individuals who apply for and enroll in medical plans. The Summary of Benefits and Coverage is a required document that must be provided in a standard format that has already been determined. Insurers and employers will simply "fill-in" their benefit and other information to the standard format, similar to using a template.

Timing of Distribution:
Open Enrollment - The guidelines require that employees must receive the SBC 30 days before the effective date of the new plan year. So, if this document is included in your Open Enrollment packets, it must be received at least 30 days prior to day 1 of your new plan year.

During the Plan Year: If you make any "significant changes" to your plan during the plan year, employees must receive the SBC that reflects these changes at least 60 days prior to the effective date of the change.

Who must comply?
Individual and employer-sponsored medical plans, regardless of grandfathered status or funding. It does not apply to retiree-only plans or to standalone dental and vision plans.

What action must I take now?
While these regulations don't take effect until 2012, you can offer your comments about the new regulations to HHS. Specifically, they are asking for comment on:

- How the Summary of Benefits and Coverage and the uniform glossary can be provided to individuals while minimizing undue cost and burden on employers and health insurance issuers.
- Different methods of providing the uniform glossary and the Coverage Examples,
- Making the implementation of these requirements as workable, efficient and user-friendly as possible.

The comment period for these guidelines ends **October 15**.

To submit a comment:

1. Go online to http://www.regulations.gov/#!documentDetail;D=EBSA-2011-0023-0001.
2. Click on "Submit a Comment"

For A CLOSER LOOK at the new guidelines for providing a Summary of Benefits and Coverage and a Uniform Glossary to your enrollees, click here.

A CLOSER LOOK:
Uniform Benefit Summaries

The intent of this regulation is to provide your employees with understandable benefit information that allows them to review medical plans, compare insurers and make decisions about which medical plan to choose. In order to achieve this goal, the regulation states that the Summary of Benefits and Coverage must have a standard format with four components:

1. A four-page Benefit Summary (double sided)
2. Medical Scenarios called "Coverage Examples". They estimate customer costs based on the specific plan's benefits for three medical scenarios – Maternity, Breast Cancer Treatment and Managing Diabetes
3. A standard glossary of medical and insurance terms
4. A phone number and website where individuals can get additional information including documents such as Certificates, Summary Plan Descriptions (SPDs) and policies

The National Association of Insurance Commissioners (NAIC) was asked to propose a format of the four components of the SBC. A link to their sample documents is below:

http://www.naic.org/committees_b_consumer_information.htm

- The format of the SBC is exact – meaning that the wording and the layout must be maintained. Insurers and employers will simply insert their specific benefit information into the template.
- The SBC must be a freestanding document and may not be combined or included with any other documents.
- The plan fiduciary holds the responsibility for creating and distributing the SBC. So, for fully insured plans, the insurer must produce and distribute the summaries. For self-insured plans, the responsibility may lie with the employer. We are currently checking with the carriers to determine their interpretation, action plan and timing. We will keep you posted as to what we learn.

Distribution and Timing

- The SBC may be delivered via paper or electronic format.
- The Summaries must be provided:
  - when an employee requests information, applies for, or enrolls in a plan;
  - At least 30 days before the effective date of the new plan year;
  - At least 60 days prior to the effective date but only when there are changes to the plan that become effective outside of the renewal period.

We will continue to monitor this requirement and will keep you posted with any changes that result from the comment period.

To view the proposed template for the Summary of Benefits and Coverage, visit:

http://www.healthcare.gov/news/factsheets/labels08172011b.pdf