HUMAN CAPITAL PRACTICE

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ALERT:
HEALTH CARE REFORM BILL

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SUMMARY OF BENEFITS AND COVERAGE: FINAL REGULATIONS RELEASED

On February 9, 2012, the federal agencies responsible for implementation of the health care reform law (Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury) released final regulations on the summary of benefits and coverage (SBC) that group health plans and health insurance issuers are required to distribute to participants. On March 19, 2012, the DOL released FAQs that help to further clarify several issues relative to the SBC requirement.

The agencies have provided a template for an SBC as well as instructions, sample language and guidance for coverage example calculations to be used in completing the templates. Also included is a uniform glossary of commonly used health insurance and medical terms that group health plans must provide to participants. Links to these materials are provided below:

- **Summary of Benefits and Coverage (SBC) Template,** in **MS Word Format**
- **Sample Completed SBC,** in **MS Word format**
- **Instructions for Completing the SBC – Group Health Plan Coverage**
- **Why This Matters language for "Yes" Answers**
- **Why This Matters language for "No" Answers**
- **HHS Information For Simulating Coverage Examples**
- **Uniform Glossary of Coverage and Medical Terms**

The final regulations can be found **here**. The FAQs can be found **here**.

BACKGROUND

The health care reform law expanded health plans' disclosure obligations, requiring distribution of a uniform four-page "summary of benefits and coverage" – an SBC. The law originally provided that employers and insurers were required to begin distributing the SBC on March 23, 2012. The health care reform law required the agencies responsible for implementing the health care reform law to provide "standards" for creating and providing the summaries by March 23, 2011. The agencies did not meet this deadline. On November 17, 2011, the agencies announced that the requirement would be delayed pending final regulations.

Any employer-sponsored plan – whether insured or self-insured – that provides, pays for or reimburses the cost of health care is a "group health plan" that may be subject to the SBC requirement. And any type of employer (e.g., religious, governmental, for-profit and not-for-profit) may maintain a group health plan that is potentially subject to the SBC requirement. To the extent that a plan consists of "excepted benefits," such as stand-alone dental and vision benefits, the plan is exempt from the SBC requirement. For a detailed explanation of what benefits are considered "excepted benefits," please see Willis' Human Capital Practice *Alert*, July 2011, "**Looking Ahead – Compliance After 2011**."

FINAL REGULATION

The package of final guidance covers a multitude of details regarding SBCs. Highlights are summarized below.

EFFECTIVE DATE

Determining that a requirement for employers and health insurers to comply with the SBC requirement starting March 23, 2012 was not feasible, the agencies have delayed the applicability date by six months. For disclosures made to participants and beneficiaries who enroll or re-enroll through an open enrollment period, employers and insurers must distribute the SBC beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For a group health plan with a plan year that starts on October 1, if the open enrollment is held prior to September 23, 2012, it will not have to worry about distributing the SBC at open enrollment until open enrollment for the October 1, 2013 plan year. For disclosures made to participants and beneficiaries who enroll in coverage other than through an open enrollment (including individuals who are newly eligible for coverage and special enrollees), the employer and insurer must distribute the SBC beginning on the first day of the first plan year that begins on or after September 23, 2012 (January 1, 2013 for a calendar year plan; October 1, 2012 for the October 1 plan year example above).

APPEARANCE

While the health care reform law called for a four-page summary, the regulations interpret the four-page limitation as four *double-sided* pages. This will give employers additional flexibility in providing the required information.

The SBC can be provided as a stand-alone document or in combination with other summary materials (e.g., a summary plan description (SPD)). If providing the SBC with other plan materials, the SBC information must be intact and prominently displayed at the beginning of the materials (such as immediately after the table of contents in an SPD). It also must be presented in a uniform format, use terminology understandable by the average plan enrollee and not include print smaller than 12-point font.

The SBC must be presented in a culturally and linguistically appropriate manner. The regulations reference rules set forth in the guidance issued for claims and appeals (i.e., in certain counties where at least 10% of residents in a given country are only literate in the same language). Generally, to satisfy this requirement the group health plan or health insurer is 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 group health plan or insurer. Additional information about the "culturally and linguistically appropriate manner" requirement can be found in Willis' Human Capital Practice *Alert*, August 2011, "**Internal and External Review/Appeals Process Updated**."

CONTENT

The SBC must contain the following information:

- Uniform definitions of standard insurance and medical terms so that consumers may understand and compare health insurance coverage and exceptions to coverage
- Description of the coverage, including the cost sharing for each category of essential health benefits and other benefits identified by HHS
- Exceptions, reductions and limitations on coverage
- Cost sharing, including deductibles, coinsurance and copayments
- Renewability and continuation of coverage provisions
- Coverage examples that illustrate benefits provided under the plan for pregnancy, serious and chronic medical conditions and for other common benefit scenarios (the agencies are taking a phased approach to implementing the coverage examples and reserve the right to require up to six examples in the future, but in the first year only two coverage examples, a normal childbirth and diabetes management, are required) and related cost-sharing based on recognized clinical practice guidelines

- For coverage beginning on or after January 1, 2014, statements of whether the coverage is minimum essential coverage and has at least 60% actuarial value (for additional information about these requirements, please see Willis' Human Capital Practice *Alert*, July 2011, "**Looking Ahead - Compliance After 2011**")
- Statement that the SBC is a summary and that other documents should be consulted to determine the coverage terms
- Contact information (e.g., phone number, web address, etc.) for questions and obtaining a copy of the plan document or insurance policy
- For plans that maintain one or more networks of providers, an internet address (or similar contact information) for obtaining a list of network providers
- For plans that use a formulary in providing prescription drug coverage, an internet address (or similar contact information) for obtaining information on prescription drug coverage
- An internet address for obtaining the uniform glossary as well as a phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available

Instead of summarizing coverage for items and services provided outside of the United States, the plan or insurer may provide an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the U.S.

DELIVERY

The group health plan or, if applicable, the health insurer is required to provide an SBC to plan participants and beneficiaries (as defined by the Employee Retirement Income Security Act (ERISA), this would include eligible or enrolled employees, dependents, COBRA participants and children covered pursuant to qualified medical child support orders). If the group health plan is self-insured, the plan administrator (employer) has the obligation to provide the SBC to participants and beneficiaries. Presumably, however, the plan could contract with its third-party administrator (TPA) to deliver the SBC. If the plan is fully insured, both the plan and insurer have the obligation. In order to prevent them from duplicating efforts, the regulations provide that a responsible party can satisfy the SBC requirement if a complete SBC is provided by another party on a timely basis.

The SBC may be provided to participants and beneficiaries in paper form (free of charge, upon request). If both the participant and beneficiary are known to reside at the same address, providing one SBC to that address will comply with the requirements. For group health plans subject to ERISA or the Internal Revenue Code, electronic distribution is also permitted in regard to participants and beneficiaries *who are already covered under the group health plan* if the requirements of the DOL's electronic disclosure safe harbor are met (a non-federal governmental plan can deliver the SBC electronically if it meets either the DOL's electronic disclosure rule or the provisions governing electronic disclosure in the individual health insurance market). Many employers may find it difficult to comply with the DOL's electronic disclosure requirements (information about these requirements can be found in, *ERISA Disclosure: An Employer Guide,* available on Willis Essentials), particularly with respect to individuals other than employees with work-related computer access. For participants and beneficiaries *who are eligible but not enrolled in coverage,* the SBC can be provided electronically if the format is readily accessible and a paper copy is provided free of charge upon request. If the electronic form is an internet posting, the plan or health insurer must timely advise the individual in paper form (e.g., a postcard) or email that the documents are available on the internet, provide the internet address, and notify the individual that the documents are available in paper form upon request. The agencies provided a sample postcard in the FAQs.

A group health plan or health insurer must provide plan participants (and beneficiaries) with an SBC for each benefits package offered by the plan or health insurer for which the participant or beneficiary is eligible. Please note that, to the extent the information contained in the SBC varies based on coverage tier (e.g., employee-only, family, etc.), the group health plan or health insurer will not necessarily have to provide a separate SBC for each coverage tier. The FAQs provide that the group health plan or health insurer may combine information for different coverage tiers in one SBC, provided the SBC's appearance is understandable. Similarly, if the participant is able to select the levels of deductible, copayments and coinsurance for a

particular benefits package, group health plans and insurers are not required to provide a separate SBC for every possible combination that a participant may select under the benefits package provided the SBC's appearance is understandable. The FAQs provide that the information can be presented in the form of options, such as deductible options and coinsurance options. The coverage examples, however, should note the assumptions used in creating them (the sample completed SBC provided by the agencies includes an example of how to note assumptions used in creating coverage examples).

If the group health plan offers participants certain "add-ons," such as health flexible spending accounts (FSA), health reimbursement arrangements (HRA), or health savings accounts (HSA), that could affect the participants' cost-sharing and other information contained in the SBC, the plan is permitted, provided the SBC's appearance is understandable, to combine information for all of these add-ons and reflect them in an single SBC. The effects of these additional benefits on the underlying medical benefit can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, etc. The coverage examples should note the assumptions used in creating them (the agencies' sample completed SBC includes an example of how to indicate the effects of a diabetes wellness program).

For those plans that offer multiple benefits package options, the plan is required to provide a new SBC automatically upon renewal only with respect to the benefits package option in which the participant or beneficiary is enrolled. SBCs are not required to be automatically provided with respect to benefits package options in which the participant or beneficiary are not enrolled. However, if the participant or beneficiary requests an SBC with respect to another benefits package option(s) for which the participant or beneficiary is eligible, the SBC(s) must be provided upon request.

In certain situations, discussed in more detail below, health insurers offering group health insurance must provide an SBC to the group health plan (or its plan sponsor). The SBC may be provided to the plan in paper form. The insurer can also provide it in electronic form if:

- The format is readily accessible by the plan
- The SBC is provided in paper form free of charge upon request

If the electronic form is an internet posting, the insurer must notify the plan by paper or via email on a timely basis that documents are available on the internet and provide the web address.

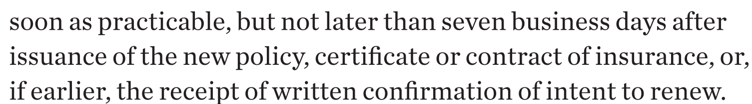
TIMING

The SBC must be distributed from the health insurer to the group health plan at the following times:

- **Upon Application** The SBC must be provided (i.e., sent) upon application or request for information about the health coverage as soon as practicable following the request but in no event later than seven business days following the request. If the insurer provides an SBC upon request for information about health coverage and the group health plan subsequently applies for health coverage, a second SBC is only required if the information in the SBC has changed.

  - If there is any change in the information required to be in an SBC before the coverage is offered, or before the first day of coverage, the insurer must update and provide a current SBC to the plan no later than the date of the offer (or no later than the first day of coverage, if applicable).

- **At Renewal** If the insurer renews or reissues the policy, certificate or contract of insurance, the insurer must provide a new SBC when the policy, certificate or contract is renewed or reissued. If written application is required for renewal, the SBC must be provided no later than the date the materials are distributed. If renewal is automatic the SBC must be provided no later than 30 days prior to the first of the new policy year. If the new policy, certificate or contract of insurance has not been issued or renewed prior to this 30-day period, the insurer must provide the new SBC as



soon as practicable, but not later than seven business days after issuance of the new policy, certificate or contract of insurance, or, if earlier, the receipt of written confirmation of intent to renew.

- **Upon Request** If the group health plan requests an SBC from the insurer, it must be provided as soon as practicable, but in no event later than seven business days following the request.

The SBC must be distributed from the group health plan (or health insurer) to plan participants and beneficiaries at the following times:

- **At Enrollment** The SBC must be provided as part of any written application materials that are distributed by the plan or health insurer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage. 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 there is any change to the information required to be in the SBC before the first day of coverage, the plan or insurer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.
- **At Special Enrollment** The plan or insurer must provide the SBC no later than 90 days from enrollment (the regulations use the same time frame as required under ERSIA for distributing SPDs to new enrollees).
- **At Renewal** If the plan or insurer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or insurer must provide a new SBC when the coverage is renewed. If written application is required for renewal, the SBC must be provided no later than the date the materials are distributed. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan year. If the new policy, certificate or contract of insurance has not been issue or renewed prior to this 30-day period, the plan or insurer must provide the new SBC as soon as practicable, but not later than seven business days after issuance of the new policy, certificate or contract of insurance, or, if earlier, the receipt of written confirmation of intent to renew.
- **Upon Request** The plan or health insurer must provide the SBC to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven business days following the request.

MID-YEAR PLAN DESIGN CHANGES

If the insurer or group health plan makes a *mid-year* material modification to coverage that affects the information in the SBC, the insurer or group health plan must provide notice of the modification to enrollees no later than 60 days prior to the date the modification becomes effective. The 60-day notice requirement does not apply to modifications made at renewal (since plans and insurers must distribute an updated SBC at that time). A material modification is one that affects the information contained in the SBC, including enhancements or reductions of covered services or benefits.

The notice can be sent as a separate notice which describes the material modification or as an updated SBC.

UNIFORM GLOSSARY

Group health plans and insurers must make a glossary available to participants and beneficiaries with uniform definitions on certain health coverage and medical terms. The purpose of the glossary is to help participants to understand the terms of coverage. The glossary cannot be modified by the group health plan or the insurer. The group health plan and insurer must make the glossary available upon request, in either paper or electronic form (as requested) within seven business days of the request. The SBC must disclose the right of an individual to request a copy of the uniform glossary.

PENALTIES

An insurer or group health plan that willfully fails to provide an SBC or glossary will be subject to a fine of up to $1,000 for each failure (a failure with respect to each participant and beneficiary constitutes a separate offense). The DOL, which has enforcement authority over those plans governed by ERISA, will issue separate penalty regulations. A failure to distribute the required materials is also subject to an excise tax (generally $100 per day per individual for each day that the plan fails to comply). It also is subject to the excise tax reporting requirements for group health plans. Additional information about the excise tax can be found in Willis Human Capital Practice *Alert*, Vol. 2, No. 11, "**Stricter Penalties for Group Health Plan Violations**."

The FAQs indicate the agencies' approach to implementation and enforcement of the SBC requirements. Specifically, they provide that, during the first year of applicability, they will not impose penalties on group health plans and insurers "that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations."

CONCLUSION

Regardless of the six-month delay in the effective date, employers have little time to comply with the SBC requirements. The agencies have indicated that the materials and guidance provided are intended only to be used for the first year of applicability. Updated materials will be provided next year. Employers will want to reach out to their insurers and TPAs as soon as possible to address compliance with the requirements.

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