Final Regulations Issued for Summary of Benefit Coverage – Effective Date Delayed

On Thursday, February 9, 2012, the Departments of Labor, Treasury, and Health and Human Services (collectively, the "Departments") issued final regulations providing standards for the new, comprehensive benefits summary and uniform glossary required under the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* (collectively, the "Affordable Care Act").

Section 2715 of the *Public Health Service Act*, enacted under the Affordable Care Act, requires insurers to provide a summary of benefits and coverage ("SBC") to group health plans, plan participants and beneficiaries, and other individuals that request information regarding plan coverage. Group health plans (and their administrators), other than group health plans that provide excepted benefits (such as stand-alone dental and vision coverage, and coverage under most health flexible spending arrangements), are similarly required to provide SBCs to plan participants and beneficiaries.

The regulations set standards for the issuance of an SBC that "accurately describes the benefits and coverage under the applicable plan or coverage." These standards describe who will provide the SBCs, to whom the SBCs will be distributed, and when and in what medium they must be provided. The Departments also simultaneously issued guidance for compliance with the standards, which includes links to an SBC template, instructions for completing the SBC, and related documents. The regulations govern coverage both provided by employers and issued by insurers to individuals. This alert will focus on employer-provided coverage.

Effective Date Delay

The regulations modify in some respects the proposed SBC regulations issued last August. Significantly, the effective date of compliance with the SBC requirements has been delayed for six months to allow time for group health plans and insurers to provide an SBC. For participants and beneficiaries who enroll or re-enroll in group health coverage during open enrollment, the regulations require that group health plans must make an SBC, notice of modification and uniform glossary available beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For all other participants and beneficiaries (e.g., new enrollees or employees who exercise a special enrollment right under HIPAA or CHIPRA), the regulations apply on the first day of the first plan year that begins on or after September 23, 2012. As a practical matter, plans that operate on a calendar year basis will have to start providing an SBC and uniform glossary to these individuals with respect to the plan year that begins on January 1, 2013.

Providing the SBC

Who Must Provide the Notice

The SBC must be provided in writing and free of charge by a health insurance issuer offering health insurance within the United States or, in the case of a self-insured group health plan, the plan sponsor or the designated administrator of the plan. While the regulations make clear that the plan administrator is responsible for providing an SBC to all plan participants and beneficiaries, the regulations contain rules to prevent unnecessary duplication. For instance, they do not require that the plan administrator issue an SBC when, in the case of a fully-insured plan, the health insurer is required to issue the SBC. In addition, the anti-duplication rules allow for a single SBC to be provided to a family unless any beneficiaries are known to reside at a different address. The final regulations also include special rules for group health plans providing coverage outside the United States. Such plans and issuers are not required to provide an SBC with respect to

this coverage, but may instead provide contact information, including an internet address, for obtaining information about these benefits.

When the Notice Must be Provided

The timing of the SBC's distribution varies, depending on the circumstances.

- A group health plan or insurer (if the plan is fully-insured) must provide an SBC to a participant or beneficiary for each benefit package offered for which such individual is eligible. Such SBC must be provided as part of any written application (enrollment) materials or, if no such materials are distributed, prior to the first day of eligibility, upon any change in the information required to be in the SBC between the date of application and the first day of coverage, upon a special enrollment event, and as soon as practicable but no later than seven business days following receipt of a request to provide summary information about the employer's health coverage.
- If the plan requires participants or beneficiaries to renew in order to maintain coverage, the plan must provide a new SBC no later than the date on which the application 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 or policy year. In recognition, however, that the terms of some insured plans may not be finalized until after the first day of coverage, the regulations permit, with respect to an insured plan for which the policy has not been issued or renewed before such 30-day period, the SBC to be provided as soon as practicable but in no event later than seven business days after the issuance of the new policy or receipt of written confirmation of intent to renew, whichever is earlier. If a group health plan offers multiple options, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit plan in which the participant or beneficiary is enrolled. If a participant or beneficiary requests an SBC with respect to any other benefit option offered under the plan, the plan administrator or issuer, as applicable, must provide the SBC upon request as soon as practicable but not later than seven business days following receipt of the request.

The regulations also provide that, with respect to an insured plan, the insurer must provide an SBC to the plan sponsor automatically upon application or request for information, upon renewal or reissuance of the insurance policy, upon any change in the information required to be in the SBC between the date of application and the first day of coverage, or as soon as practicable but no later than seven business days following receipt of a request to provide summary information about a health insurance product. The rules for providing an SBC when an insurer renews or reissues coverage for a plan sponsor are the same as those for re-enrollment by a plan participant or beneficiary.

Material Modifications to Plan Terms

If a group health plan or issuer makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan that would affect the content of the SBC most recently issued, other than in connection with a renewal or reissuance of coverage, the plan must provide a notice of modification to enrollees not later than 60 days prior to the date on which the modification will become effective.

Form of Notice and Electronic/Paper Delivery

The final regulations relax the requirement in the proposed regulations that an SBC provided in connection with group health plan coverage be provided as a stand-alone document. The regulations permit such SBCs to instead be provided in combination with other plan materials, e.g., an SPD, if the SBC information is

intact and prominently displayed at the beginning of the materials. Furthermore, the SBC may be provided either in paper copy or electronically, but the rules differ depending upon the recipient of the SBC. For those individuals already enrolled, the SBC can be provided electronically if the Department of Labor's electronic distribution requirements are met. For those individuals who are eligible but not yet enrolled, the SBC can be provided electronically if the format is readily accessible. In both cases, a paper copy must be available free of charge upon request. The regulations allow a plan sponsor to post the SBC on the internet if the plan or issuer advises individuals by paper or email that the SBC is available online, provides the internet address and notifies individuals that a paper copy is available free of charge upon request.

What Must the SBC Contain

One of the central purposes of the SBC is to enable prospective enrollees and current plan participants and beneficiaries to easily compare the health plan options available to them. Toward that end, the SBC, which must be printed with no smaller than 12-point font and on no more than 4 double-sided pages, must include the following information:

- uniform definitions of standard insurance and medical terms;
- a description of coverage, including cost sharing, for each category of benefits;
- the exceptions, reduction and limitations on coverage;
- cost-sharing provisions of coverage, including deductible, coinsurance and copayment obligations;
- renewability and continuation of coverage provisions;
- coverage examples (the details of which will be determined by the Secretary of Health and Human Services, but which for coverage beginning before January 1, 2014 require only two examples – having a baby (normal delivery) and managing type 2 diabetes);
- with respect to coverage beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage and whether the plan's share of total allowed cost of benefits provided under the plan meet applicable requirements;
- a statement that the SBC is only a summary, and that the plan document, policy or certificate should be consulted to determine governing provisions of coverage;
- contact information for questions and obtaining a copy of plan documents and insurance policies, such as a customer service telephone number and an internet address;
- contact information for obtaining a list of network providers, if applicable;
- for plans that use a formulary in providing prescription drug coverage, contact information for obtaining information about prescription drug coverage;
- an internet address for accessing the uniform glossary online and a contact number to obtain a paper copy of the uniform glossary.

The final regulations delete the requirement in the proposed regulations that plans must provide premium or cost of coverage information. They also eliminate the requirement that the coverage examples include treatment of breast cancer, but they do retain the requirements that an illustration of benefits provided must be included that will generate an estimate of what an individual might expect to pay under the plan.

The Departments also acknowledged that changes to the SBC template may be appropriate if plan types and coverage designs cannot reasonably be described in a manner consistent with the template and instructions provided by the Departments. In such cases, deviation from the template would be appropriate, although plans and issuers are expected to do so in a manner that is as consistent as possible with the provided template and instructions.

The final regulations interpret the requirement that the SBC be provided in a culturally and linguistically appropriate manner to require provision of the SBC in a language other than English when at least 10% of the population residing in the county are literate only in the same non-English language. Based on data available at the time of publication and to facilitate compliance with this requirement, HHS will provide written translations of the SBC template, sample language and uniform glossary in Spanish, Tagalog, Chinese and Navajo.

Failure to Comply

A group health plan or issuer that willfully fails to provide the information required is subject to a fine of not more than $1,000 for each such failure. The regulations state that a failure with respect to each participant or beneficiary constitutes a separate offense.

The Uniform Glossary

The regulations also direct a plan to make a uniform glossary of a wide range of health coverage related terms and medical terms available upon request within seven business days. It is intended to provide simple, general, descriptive definitions designed to help consumers comprehend terms and concepts commonly used when describing health care coverage. The requirement to provide the uniform glossary is satisfied by including on the SBC an internet address where the individual may review and obtain the glossary, a contact phone number to obtain a paper copy of the glossary and a disclosure that paper copies are available upon request. The Departments have issued a standard uniform glossary which complies with all of the requirements set forth in the regulations.

More to Come

Certain standards regarding the appearance and content of the SBC are effective for coverage beginning before January 1, 2014, the period which the preamble to the regulations defines as "the first year of applicability." While there is little expectation that the core of the rules will change once the first year of applicability ends, the Departments intend to issue further guidance with respect to minimum essential coverage and minimum value requirements and to add other coverage examples. They also anticipate changes when the prohibition on annual limits and other market reforms take effect beginning January 1, 2014, and they reserve the right to make other changes.

Resources

The Departments have provided access to a number of documents through the following links:

- Summary of Benefits and Coverage Template, available here.
- Sample Completed SBC, available here.
- Instructions for Completing the SBC - Group Health Plan Coverage, available here.
- Instructions for Completing the SBC - Individual Health Insurance Coverage, available here.

- Why This Matters language for "Yes" Answers, available here.
- Why This Matters language for "No" Answers, available here.
- HHS Information for Simulating Coverage Examples, available here.
- Uniform Glossary of Coverage and Medical Terms, available here.

If you have any questions about the SBC requirements, please contact a member of the Ropes & Gray employee benefits practice or your usual Ropes & Gray advisor. For access to other information about the Affordable Care Act, please visit the Ropes & Gray Health Reform Resource Center.