McDermott Will & Emery

Summary of Benefits and Coverage Disclosure Requirements

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Recently issued final regulations and related guidance clarify the requirement under the Patient Protection and Affordable Care Act that group health plans and health insurance issuers provide a summary of benefits and coverage and a uniform glossary. The guidance includes final regulations and sample summaries and instructions.

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA), generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide a summary of benefits and coverage (SBC). On February 14, 2012, the U.S. Departments of Treasury, Labor, and Health and Human Services released final regulations governing the SBC requirement, which are generally applicable beginning September 23, 2012. The final regulations and related guidance clarify and make multiple changes to the proposed regulations issued in August 2011, including the elimination of the requirement that the SBC contain premium information and clarifications to the rules governing the electronic disclosure of SBCs.

Requirement to Provide SBC

The final regulations require plan administrators of group health plans (or health insurance issuers in the case of fully insured plans) to provide an SBC to participants and beneficiaries for each benefit package under the plan. In addition, the health insurance issuer is required to provide an SBC to the group health plan sponsor. The preamble to the final regulations clarifies that an SBC is not required to be provided for plans, policies or benefit packages that are excepted benefits, such as stand-alone dental or vision plans, and certain health flexible spending arrangements. The preamble also clarifies that health reimbursement arrangements (HRAs) generally are not excepted benefits and *are* usually subject to the SBC requirements, while health savings accounts (HSAs) generally are not group health plans and are *not* usually subject to the SBC requirements.

SBC to Plan Sponsors

The health insurance issuer must provide the SBC to the plan sponsor as soon as practical, but no later than seven business days after it receives the plan sponsor's application for health coverage. If any changes in coverage relevant to the SBC are made between the application date and the first day of

coverage, the health insurance issuer must provide an updated SBC to the plan sponsor by the first day of coverage. The health insurance issuer must also provide a new SBC upon request (within seven business days following the request) or upon renewal of the coverage, by either the date the written renewal application materials are distributed to the plan sponsor or, in the case of automatic renewal, no later than thirty days prior to the first day of the new policy year. If the new policy, certificate or contract of insurance has not yet been issued or renewed before this thirty-day period, the issuer must provide the new SBC as soon as practical, but no later than seven business days after the new policy, certificate or contract of insurance is issued, or, if earlier, the date the issuer receives written confirmation of the intent to renew. The final regulations are applicable to health insurance issuers beginning September 23, 2012.

SBC to Participants and Beneficiaries

Either the plan administrator *or* insurer, if applicable, must timely provide an SBC to participants and beneficiaries for each benefit package offered under the group health plan for which the participant or beneficiary is eligible. The SBC must be provided:

- With any written enrollment application materials the plan provides (if no such materials are provided, then no later than the first date the participant is eligible to enroll himself or any beneficiary in coverage)
- No later than the first day of coverage under the plan, if any changes are made to the information in the SBC provided upon enrollment
- To individuals entitled to special enrollment under the Internal Revenue Code, no later than the 90 days from enrollment
- Upon renewal, if applicable, only for those benefit options in which the participant or beneficiary is enrolled, by either the date the written renewal application materials are distributed to the plan sponsor or, in the case of automatic renewal, no later than thirty days prior to the first day of the new policy year (a participant or beneficiary can also request an SBC during renewal for an option in which they are not enrolled). If coverage has not yet been issued or renewed before this thirty-day period, the issuer must provide the new SBC as soon as practical, but no later than seven business days after the coverage is issued, or, if earlier, the date the issuer receives written confirmation of the intent to renew
- Upon request (within seven business days following the request)

The final regulations are applicable to information provided to participants and beneficiaries beginning on the first day of the first open enrollment period that begins on or after September 23, 2012 (the first day of the plan year beginning on or after September 23, 2012, for those participants and beneficiaries who do

not enroll in coverage through an open enrollment period, including individuals who are newly eligible for coverage or who are eligible for special enrollment under the Internal Revenue Code).

A single SBC can be provided to participants and beneficiaries residing at the same last known address. If a beneficiary's last known address differs from the participant's, a separate SBC must be sent to the beneficiary at his or her last known address.

SBC Content and Form

The final regulations include most of the SBC requirements contained in PPACA and the proposed regulations, with some modifications. The guidance issued concurrent with the final regulations, provided here, includes a template SBC and corresponding instructions. The SBC must generally include the following:

- Uniform definitions
- A description of the plan's coverage for each category of benefits, including exceptions, reductions and limitations
- The plan's cost-sharing provisions, such as deductibles, co-pays and coinsurance
- Information about continuation of coverage
- Hypothetical coverage examples selected by the Secretary of Health and Human Services to illustrate the benefits that would be provided for certain common benefits scenarios (these examples are included in the final regulations)
- For coverage beginning on or after January 1, 2014, a statement as to whether the plan provides minimum essential coverage and whether the plan pays at least 60 percent of the total cost of benefit
- An internet address (or similar) for obtaining a list of the network providers
- An internet address where an individual may find more information about the prescription drug coverage under the group health plan or health insurance coverage
- An internet address where an individual may review and obtain the uniform glossary
- A disclosure that paper copies of the uniform glossary are available, and a contact phone number for obtaining a paper copy of the uniform glossary
- Premium information for insured plans or cost of coverage for self-insured plans

- A statement that the SBC is only a summary, and that the plan document, insurance policy, contract or certificate of insurance should be consulted for more information about the coverage provided under the plan
- Contact information for questions or for obtaining a copy of the plan document or the insurance policy, contract or certificate of insurance

Appearance, Form and Manner of an SBC

The final regulations provide that an SBC must be printed in 12-point or larger font and limited to four double-sided pages. The guidance document issued with the final regulations, available here, provides that the SBC can be a stand-alone document or it can be included with other summary materials, such as a summary plan description, as long as the SBC information is intact and displayed prominently at the beginning of the materials, and the SBC is provided in a timely manner.

An SBC may be provided by a group health plan to participants and beneficiaries in paper or electronic form, if, (1) for participants and beneficiaries covered under the group health plan, the group health plan satisfies the Department of Labor's electronic disclosure safe harbor and (2) for participants and beneficiaries who are eligible for, but not enrolled in coverage under the group health plan, the electronic format is readily accessible; the SBC is provided in paper form upon request (with the participant or beneficiary receiving notice that the paper form is available); and, in the case of an Internet posting, the individual receiving the SBC is notified via paper form or e-mail that the SBC is available on the internet, along with the proper internet address. A health insurance issuer may provide an SBC to a plan sponsor in paper form or electronically, provided that any electronic transmittal is readily accessible to the group plan and the SBC is provided in paper form upon request.

The final regulations require that SBCs be provided in a culturally and linguistically appropriate manner similar to the PPACA rules regarding group health plan claims and appeals communications. Generally, group health plans must disclose the availability of language services and provide written translation of an SBC in a non-English language upon request in certain counties that have been identified by the U.S. Census Bureau as having a concentration of non-English speakers.

Notice of Material Modification

The final regulations affirm the requirement in the proposed regulations that if a group health plan or health insurance issuer makes a mid-year material modification to coverage that affects the content of an SBC, the group health plan or health insurance issuer must provide a 60-day *advance* notice of the

modification to enrollees. This is a significant change from current ERISA rules, which require provision of a summary of material modification within 60 days after adoption of a material reduction in group health plan covered services or benefits, or within 210 days after adoption of any other type of material modification or change. The 60-day advance notice rule *does not* apply to modifications made at renewal/annual open enrollment. A "material modification" is the same as a "material modification" under ERISA Section 102 (any change to the coverage offered that independently or in conjunction with other contemporaneous changes would be considered by the average plan participant to be an important change, including changes that enhance or reduce benefits, increase premiums or cost-sharing, or impose new referral requirements).

The advance notice may be provided through a separate notice or an updated SBC. For ERISA plans, the rules regarding the timing of a summary of material modification still apply for modifications that do not affect information provided in an SBC.

Uniform Glossary

The final regulations require group health plans and health insurance issuers to make a uniform glossary of terms available to participant and beneficiaries. The uniform glossary may not be modified and must be provided in either paper or electronic form upon request by a participant or beneficiary within seven business days.

The health coverage-related terms and medical terms that need to appear in the uniform glossary include allowed amount, appeal, balance billing, coinsurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network coinsurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network coinsurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care, as well as other terms the Secretary of Health and Human Services determines important to define, so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits).

Next Steps

Employers sponsoring group health plans should work with insurance providers and third-party administrators to prepare the SBCs, uniform glossary and any material modification notices in compliance with the new September 23, 2012, deadline. In preparing this documentation, plan sponsors should take note of any offered health flexible spending arrangements, HRAs, HSAs or other potential excepted benefits that may be excused from these requirements.

A group health plan or health insurance issuer that willfully fails to provide an SBC will be subject to a fine of up to $1,000 per participant or beneficiary who does not receive the SBC. Excise taxes and self-reporting requirements under Section 4980D of the Internal Revenue Code also apply.

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