SUTHERLAND

LEGAL ALERT

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# Final Rules for Summary of Benefits and Coverage for Health Plans

The tri-agency task force[1] has issued several new items of guidance relating to the Summary of Benefits and Coverage (SBC) required for group health plans and health insurance issuers under the Patient Protection and Affordable Care Act (PPACA). The guidance includes:

- Final regulations implementing the SBC requirements;
- A final SBC template, along with new instructions and a sample of a completed SBC;
- Revised "Why this Matters" language for the SBC, with separate versions for Yes and No answers;
- An amended uniform glossary;
- Updated SBC coverage examples and instructions; and
- Compliance guidance for health plans and issuers with additional information on the items listed above.

The new SBC guidance updates the proposed regulations, template and uniform glossary issued in August 2011, which were described in an earlier Sutherland Legal Alert. This Legal Alert highlights key SBC requirements that have been modified by the new guidance, including a welcome delay in the effective date, and it focuses on the rules for employer-sponsored group health plans, though the rules also apply to individual health insurance contracts.

## Background

Section 2715 of the Public Health Services Act (PHSA), as added by PPACA, directs the agencies to work with a National Association of Insurance Commissioners (NAIC) working group to develop standards for compiling a summary of benefits and coverage for enrollees in group and individual health plans. The purpose of the SBC is to provide plans, participants and beneficiaries with a concise, uniform summary of coverage options for comparative purposes. The summary must be no longer than four pages and use a font no smaller than 12 point. Also, it must be presented in a culturally and linguistically appropriate manner that utilizes terminology understandable by the average enrollee. The statute includes specific content standards for the summary, including uniform definitions of insurance and medical terms; detailed cost-sharing information; a description of the plan's exceptions, reductions and limitations on coverage; coverage examples to illustrate common benefits scenarios; and information on whether the plan provides minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986, as amended (Code)). Section 2715 of the PHSA further specifies that the agencies must issue rules implementing the SBC within one year after PPACA was enacted (*i.e.,* March 23, 2011) and that plans and issuers must provide the SBC to participants and beneficiaries no later than 24 months after enactment (*i.e.*, March 23, 2012).

The agencies and the NAIC working group were unable to meet the one-year deadline for developing SBC standards. On August 22, 2011, the tri-agency task force issued a proposed template for, and proposed regulations regarding, the SBC, with an effective date of March 23, 2012, consistent with the

[1] The tri-agency task force consists of the Internal Revenue Service (IRS), the Department of the Treasury, the Employee Benefits Security Administration of the Department of Labor (DOL), and the Department of Health and Human Services (HHS), which are also referred to above as the agencies.

statute. However, on November 17, 2011, the agencies issued FAQs delaying the implementation date of the SBC until final regulations were issued and applicable.

## Final Regulations and Other Guidance

**Effective Date**. Consistent with the November 2011 FAQs, the final regulations provide a delayed effective date for the SBC requirements, which is referred to in the rules as the applicability date. Specifically, the final rules require that SBCs be issued to participants and beneficiaries who enroll or re-enroll in group health coverage during an open enrollment period that begins on or after September 23, 2012. For calendar year health plans that begin open enrollment on September 23 or later, this means that SBCs must be ready for distribution to participants and beneficiaries during the Fall 2012 open enrollment season. Calendar year plans with an open enrollment period that begins prior to September 23 can, presumably, delay the distribution of SBCs until the next open enrollment season (*i.e.,* in 2013 for 2014).

There is a separate implementation date for individuals who enroll outside an open enrollment period, such as newly eligible employees or beneficiaries and special enrollees. These participants and beneficiaries must begin receiving the SBC and related materials no later than the first day of the first plan year that begins on or after September 23, 2012. For calendar year plans, this means that newly eligible participants and special enrollees who join the plan after open enrollment for the 2013 plan year has closed will not receive the SBC until January 1, 2013. In contrast, newly eligible employees and special enrollees who join the plan before or during Fall 2012 open enrollment and who have the opportunity to re-enroll for 2013 at that time would receive SBC materials during open enrollment.

**Plans Subject to the SBC Requirements**. The proposed rules would have required fully insured and self-insured group health plans subject to the PHSA, the Code and/or the Employee Retirement Income Security Act (ERISA) to comply with the SBC rules but would have exempted excepted benefit plans, such as stand-alone vision and dental plans, from the requirement to issue an SBC.

The final regulations retain this general rule. The preamble clarifies that the SBC disclosure for an integrated health flexible spending account (FSA) that is not an excepted benefit can be incorporated in the SBC prepared for the related major medical coverage in connection with the disclosure of deductibles, copays, etc. However, a stand-alone health FSA must satisfy the SBC requirement separately if it is not an excepted benefit. Similarly, stand-alone health reimbursement arrangements (HRAs) must issue a separate SBC, while integrated HRAs can be reflected in the SBC for the employer's major medical coverage. According to the final rules, health savings accounts (HSAs) generally are not required to issue an SBC, but the availability of an HSA can be noted in appropriate places on the SBC for the associated high-deductible health plan. Finally, despite comments suggesting that self-insured health plans should be exempt from the SBC requirements, the final regulations do not include such an exemption.

**Responsibility for Issuing the SBC**. The proposed regulations provided that all group health plans (or the plan administrators of those plans) and the insurers of fully insured plans would be responsible for distributing SBCs to participants and beneficiaries. In anti-duplication rules, the proposed rules would have allowed (1) the plan (or insurer) to satisfy its obligation to deliver the SBC to all participants and related beneficiaries at a given address if the plan (or insurer) knew that they all resided at the same address, and (2) for an insured plan, either the plan or the insurer could rely upon an SBC delivered by the other, as long as the SBC was complete and timely.

The final rules generally retains these rules, but clarifies that a plan will generally satisfy its obligation to provide SBCs to all participants and related beneficiaries if the SBC is delivered to the participant's last known address, unless it is known that a beneficiary does not reside at that address. This change relieves the plan of a seeming obligation to confirm addresses of beneficiaries before delivering SBCs. However,

if a plan administrator knows that a beneficiary resides at a different address, the plan must issue a separate SBC to that beneficiary. The preamble also makes clear that if certain benefits are carved out under an insured plan (for example, there is a third-party pharmacy benefits manager) both the insurer and the plan administrator are responsible for coordinating with the service provider for the carved out feature to ensure that the SBCs delivered to participants reflect all benefits covered under the plan. The final rules do not allow plan administrators of self-insured plans to rely upon an SBC delivered by a service provider; thus, administrators of these plans will want to consider whether indemnification language or other protections are appropriate for contracts with outside entities that assume responsibility for drafting and distributing the SBC to plan participants. Similarly, the administrator of an insured plan may want to contractually obligate the insurer to provide SBCs, since the administrator is only entitled to rely on SBCs delivered by the insurer if they are complete and timely.

**Format and Delivery Requirements**. The proposed regulations would have required that the SBC be a stand-alone document issued pursuant to the uniform SBC template. The agencies requested comments on the potential integration of the SBC with other disclosure documents, such as the summary plan description (SPD). The proposed rules also provided that an electronic SBC delivered to the plan by an insurer would have to be issued in a readily accessible format, with a paper copy provided free of charge on request. The rules would have permitted the SBC to be posted to the Web, if the insurer notified the plan by email or paper of the posting and provided the Internet address. The proposed rules further provided that an SBC sent to participants or beneficiaries of a plan subject to ERISA could be distributed electronically pursuant to the DOL rules for electronic disclosure.

Generally, the format requirements for the SBC and related materials are relaxed under the final regulations. In response to comments, the final rules provide that an SBC may be provided either as a stand-alone document or in combination with other summary materials, such as an SPD, if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the SPD table of contents).[2]

For electronic SBCs, the final rules provide different delivery requirements for covered participants as opposed to eligible (but not enrolled) employees. SBCs delivered to participants covered under the group health plan may be provided electronically in accordance with DOL electronic disclosure rules, including the safe harbor. However, SBCs delivered to employees who are eligible but not yet enrolled in coverage must simply be provided in a readily accessible electronic format. If the SBC is posted to the Internet, the plan or issuer must advise the eligible employee in paper form (such as a postcard) or email that the documents are available on the Internet, provide the Internet address and notify the employee that the documents are available in paper form. The guidance also clarifies that the SBC template may be printed in grayscale or color.

Under the final rules, any eligible employee, participant or beneficiary is entitled to receive a written copy of the SBC free of charge upon request.

**SBC Timing Requirements**. Under the proposed rules, the SBC for each benefit coverage option would have been provided: (1) to new enrollees, upon initial application for coverage, either with any written application materials or on the first day the individual was eligible to enroll, if there were no written application materials; (2) to participants renewing coverage, with written application materials, if any, otherwise at least 30 days prior to the effective date of coverage; (3) before the first day of coverage if the insurer or plan made changes to the SBC before coverage became effective; (4) as soon as practicable

[2] This rule is applicable only for SBCs issued for coverage beginning prior to January 1, 2014, and may be modified for subsequent years.

after receipt of a request for information about health insurance or an application for coverage, but no later than seven days after the request; and (5) within seven days of a special enrollment request. Upon renewal of coverage, the only SBC that would have been required to be provided automatically would be for the benefit option in which the participant or beneficiary was enrolled. However, if the participant or beneficiary requested information regarding a different option, the additional SBC(s) would have to be provided within seven days of the request. The proposed rules included similar provisions that would have required insurers to provide information to a plan or plan sponsor applying for or renewing coverage.

The final rules make two changes to these requirements: the SBC must be provided within seven business days (rather than calendar days) following a request for the SBC by a plan, participant or beneficiary, and the SBC may be provided to special enrollees as late as the date that the SPD is required to be provided to special enrollees (*i.e.*, 90 days following enrollment).

**Notice of Material Modifications**. Plans and participants must be given notice of any material modifications to the SBC. The proposed rules would have required that the notice be provided within 60 days prior to the effective date of any material modification to the terms of the plan or coverage that would affect the content of the SBC if the modification was not reflected in the most recently provided SBC. The proposed rules further mandated that a notice of changes occurring in connection with the renewal or reissuance of coverage would have to be provided within 60 days prior to the effective date of the change.

The final rules clarify that, for purposes of the notice of material modifications, the definition of "material modification" under ERISA section 102 applies, and the notice requirement would be triggered by any modification to the coverage offered under a plan or policy that, independently or in conjunction with other contemporaneous modifications, would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan or policy. The final rules also clarify that changes resulting from changes to the regulatory requirements for SBCs will not trigger a notice of modification, unless specified in the new requirements. The notice may be provided in the form of an updated SBC reflecting the modifications or a separate notice, and a timely notice of modification will also satisfy the requirement for an ERISA-covered plan to provide a summary of material modifications.

**Content Requirements**. The proposed rules, including the template published with the proposed regulations, provided that the SBC must include information on participant costs, including premium costs and participant out-of-pocket limits on coverage (including in-network and out-of-network limits), a description of covered and excluded services, a "Why this Matters" column and a statement that the uniform glossary is available. The rules would have required usage of certain standardized language included in the proposed template. Under the proposed rules, the SBC would also have been required to include coverage examples describing typical treatment costs and coverage for three medical events: normal delivery of a baby, breast cancer and diabetes management. These coverage examples were intended to help participants directly compare the level of coverage offered under available benefit options. In addition, the proposed rules would have required that all SBC materials be written in plain language presented in a culturally and linguistically appropriate manner similar to the external review requirements. Finally, while the statute requires the SBC to include a statement on whether a plan provides minimum essential coverage, the effective date of this requirement was delayed until January 1, 2014, under the proposed rules.

The final rules streamline the content requirements and offer plans greater flexibility in drafting SBCs. Under the final template, premium information is no longer required to be provided in the SBC. Also, if a plan contains complex or detailed terms that cannot be adequately conveyed using the prescribed template, the plan may use its best efforts to describe those terms in the template in a manner as consistent with the instructions and the format of the template as reasonably possible. In addition, if the plan covers expatriates, in lieu of summarizing coverage for items and services provided outside the

United States, a plan or issuer may provide an Internet address (or similar contact information) in the SBC for obtaining information about benefits and coverage provided outside the United States.

The final SBC template includes coverage examples for only two medical events: normal delivery of a baby and type 2 diabetes management. The coverage example for breast cancer was deleted in response to comments suggesting that there is no typical treatment for breast cancer. However, future guidance relating to SBCs for coverage beginning on or after January 1, 2014, will likely include additional coverage examples. Examples suggested in comments included prostate cancer, colorectal cancer, hypertension, heart attack, stroke, major depression and chronic kidney disease. In addition, details of the cost examples have been modified to reflect typical costs more accurately.

The final rules further provide that any changes to the "culturally and linguistically appropriate" requirement will be consistent with changes made to this standard under the external review rules, and future guidance will also include information on the minimum essential coverage and minimum value statements.

**Coordination with State Law Requirements**. The proposed regulations provided that any requirement under state law for insurers to provide a document similar to an SBC is preempted unless the document requires more information to be provided.

The final regulations clarify that states may impose separate, additional disclosure requirements on health insurance issuers; however, states are encouraged to take steps to harmonize existing state requirements with the SBC requirements. If states require health insurance issuers to provide information not contained in the SBC or uniform glossary, the state may require issuers to provide that information only if it is provided in a separate document. The separate document can be provided at the same time as the SBC.

**Uniform Glossary Requirements**. The proposed uniform glossary included general definitions for medical and coverage terms used in the SBC that would apply across all plans and programs to help participants understand common terms. Under the proposed rules, the uniform glossary could be posted on the plan or insurer's website, though the plan or insurer would be required to make a paper copy available within seven days of any request.

Under the final rules, the requirement to provide the uniform glossary is satisfied if the SBC includes an Internet address at which an individual may review and obtain the uniform glossary, a phone number to call to obtain a paper copy and a statement that a paper copy is available upon request. A paper copy must still be made available within seven business days of a request. The Internet address provided can be a plan's or an insurer's website or the DOL or HHS website. If the uniform glossary is posted on a plan's website, it cannot be modified in any manner. If additional explanation regarding a term in the uniform glossary is needed (*e.g.,* because the plan uses a different term or a different meaning for a term), that additional information must be provided in the SBC.

The revised uniform glossary contains disclaimer language stating that the glossary is intended to be educational and that the definitions in the glossary may not be the same as the definitions used by a particular plan. Despite this disclaimer, the potential for conflicting definitions in the SBC and the employer's plan warrants cautious review of the plan's standard definitions. This is particularly true for plans that intend to integrate the SBC into the SPD.

**Enforcement**. Under the statute, a plan or an insurer may incur a penalty of up to $1,000 for each willful failure to provide an SBC to a plan, an individual, or a plan participant or beneficiary. A separate failure occurs for each covered individual, plan participant or beneficiary who does not receive an SBC.

The final regulations provide additional detail on enforcement of the SBC rules, and the inter-agency compliance responsibilities. For health insurers, the final regulations clarify that states may enforce the SBC requirements under the PHSA, using their own enforcement mechanisms, and imposing their own penalties. However, HHS will use its discretion to enforce the rules against insurers if it determines that a state is not adequately addressing willful violations. Also, regardless of state action, HHS may impose the $1,000 penalty against insurers or governmental plans for willful violations and may impose a $100 per day per individual penalty for violations, regardless of intent. According to the final regulations, the DOL will issue separate regulations in the future describing the procedures for assessment of the $100 per day, per participant civil fine for violations by ERISA-covered group health plans. The final rules clarify that the DOL is not authorized to assess fines against insurers.

Group health plans subject to an excise tax for failure to comply with the SBC requirements as included in the Code (up to $100 per day, per person) must report the failure and the amount of the excise tax on IRS Form 8928 until the IRS issues future guidance on enforcement. This reporting is presumably voluntary, unless penalties have been previously assessed by the state, HHS or DOL. The DOL and IRS will coordinate with respect to penalties against plans that are subject to the jurisdiction of both agencies.

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*If you have any questions about this Legal Alert, please feel free to contact any of the attorneys listed below or the Sutherland attorney with whom you regularly work.*


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