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NAVIGATING HEALTH CARE REFORM

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Four-Page Benefit Summary Requirement for Group Health Plans Arrives in 2012

by Greg Gautam and Nancy Campbell

Section 2715 of the Public Health Service Act, which was added by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") expands ERISA's disclosure requirements by requiring group health plans to provide a four-page summary of benefits and coverage (the "SBC") to applicants and enrollees before enrollment or re-enrollment. All group health plans, including grandfathered plans,[1] will be required to furnish SBCs effective March 23, 2012. Retiree-only and HIPAA-excepted plans, such as stand-alone dental and vision plans, are not subject to this new requirement.

On August 22, 2011, the Departments of Health and Human Services, Labor, and Treasury (the "Departments") jointly issued proposed regulations (the "Regulations") and a proposed SBC template and uniform glossary. The proposed SBC template can be found here. The proposed uniform glossary can be found here.

Appearance and Language Requirements for the SBC

The Act provides that the SBC must be presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font. The Regulations, however, provide that the SBC cannot exceed four, double-sided pages (resulting in eight pages).

The SBC must be provided in a culturally and linguistically appropriate manner similar to the rules regarding the group health plan claims and appeals notices.

In general, those rules provide that, in specified counties of the United States, plans must provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages. In addition, in such counties, English versions of the SBC must disclose the availability of language services in the relevant language. This must be done in counties in which at least 10 percent of the population residing in the county is literate only in the same non-English language. The current list of counties in which the 10 percent threshold is met is included here (See Table 2).

Contents of the SBC

The Regulations provide that the SBC must include the following information:

1. Uniform glossary of insurance and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
2. A description of coverage, including cost sharing for each category of benefits identified by the Departments;
3. Exceptions, reductions and limitations on coverage;
4. Cost-sharing provisions of coverage, including deductibles, coinsurance and co-payment obligations;
5. The renewability and continuation of coverage provisions;
6. A “coverage facts label” that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost-sharing based on recognized clinical practice guidelines;
7. For coverage beginning on or after January 1, 2014, a statement of whether the plan provides minimum essential coverage and whether the plan pays at least 60 percent of the total cost of benefits;
8. A statement that the SBC is only a summary and that the plan document, policy or certificate of coverage should be consulted to determine the governing contractual provisions of coverage;
9. Contact information for questions and for obtaining a copy of the plan document or insurance policy, certificate or contract of insurance;
10. For plans that maintain one or more provider networks, an internet address for obtaining a list of network providers;
11. For plans that use a prescription drug formulary, an internet address for obtaining information on prescription drug coverage;
12. An internet address for obtaining the uniform glossary; and
13. Information on premiums for insured coverage or the cost of coverage for

self-funded coverage.

Who Must Receive the SBC and When Must the SBC Be Distributed?

The Regulations generally provide that the SBC, for each benefit package offered for which the participant or beneficiary is eligible, must be distributed upon initial enrollment, open enrollment, HIPAA special enrollment, and as soon as practicable upon request, but in no event later than seven (7) days following the request. Accordingly, while open enrollment for calendar year plans will not be impacted by the March 23, 2012 effective date, plan administrators will need to be ready to distribute the SBC for all initial enrollments, special enrollments and requests for SBCs that occur on or after March 23, 2012. The SBC must be provided to all applicants, enrollees and policyholders or certificate holders. The Regulations clarify that if enrollees live at the same address (i.e., a participant and his or her spouse), only one SBC needs to be delivered to that address.

SBCs can be delivered to participants and beneficiaries in paper or electronic form if the requirements of the Department of Labor's electronic disclosure safe harbor are met.

60-Day Advance Notice of Changes

The Regulations provide that a group health plan must provide 60 days *advance* notice of material modifications that affect the content of the current SBC. A material modification for this purpose includes benefit enhancements or reductions. This notice requirement may be satisfied by an independent notice describing the modification or by providing an updated SBC reflecting the change. The Regulations provide that if a timely notice is delivered pursuant to the Regulations, the ERISA summary of material modification requirement is also satisfied.

Glossary Requirement

The Regulations also provide guidance on the uniform glossary requirements of Section 2715(g) of the Act which requires the Departments to develop a glossary of standard terms used in health insurance coverage. The proposed uniform glossary must define the 43 words identified in the Regulations and may not be modified from the appearance (i.e., format) authorized in the Regulations. The glossary must be provided to participants and beneficiaries in either paper or electronic form within seven (7) days of request. The preamble to the Regulations acknowledges that the generic definitions in the glossary may not necessarily help consumers understand what terms mean in the context of their own plan because the definitions in the glossary are not plan specific. Accordingly, plan sponsors will need to be especially careful in coordinating definitions in their plan document, summary plan description and uniform glossary. Alternatively, plan sponsors that do not intend to conform the definitions in their plan document and summary plan description to the uniform glossary should be sure to adequately notify participants and beneficiaries of

such decision.

Penalties for Noncompliance

Section 2715(f) of the Act provides that a group health plan or issuer that willfully fails to provide the SBC to a participant or beneficiary is subject to a fine of up to $1,000 for each failure. The Regulations clarify that a failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this penalty. In other words, a plan sponsor who fails to distribute the SBC to 10 enrollees could be fined up to $10,000. The Regulations also state that a failure to provide the SBC may also result in an excise tax of $100 per day for each individual affected by the failure.

What Should Plan Sponsors Do Now?

While we expect insurers to be very involved in preparing the SBC, the Regulations clarify that, for insured plans, the plan administrator *or* insurer bears the responsibility for providing the SBC. For self-insured plans, the plan sponsor or plan administrator must provide the SBC. Plan sponsors and plan administrators should start working with their third-party administrators and/or insurance providers to allocate responsibility for preparing and distributing the SBC.

Action Items

- ☐ Assess which group health plans are subject to the SBC requirement and prepare an SBC for each benefit package.
- ☐ Allocate responsibility for preparing and distributing the SBC. This could require changes to service provider agreements.
- ☐ Determine if foreign language requirements apply.
- ☐ Consider whether to revise plans and SPDs to coordinate with the uniform glossary to prevent confusion.
- ☐ March 23, 2012 start distributing SBCs for initial enrollments, special enrollments and upon request.
- ☐ Be sure to distribute the SBC for open enrollments occurring on or after March 23, 2012. For calendar year plans, this will be the open enrollment for the plan year starting January 1, 2013.
- ☐ Prepare 60-day advance notice of any changes to benefits that affect the content of the current SBC.

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Notes:

[1] A grandfathered plan is any group health plan or individual coverage that was in effect on March 23, 2010, the date of the Act's enactment. A plan or coverage can lose its grandfathered status if significant changes are made to the plan or coverage that reduce benefits or increase costs to participants. [back]

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