Employment, Labor & Benefits Alert

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Summary of Benefits and Coverage: Final Rules Issued, Requirement Effective Beginning September 23, 2012

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The Affordable Care Act (Act) creates a new disclosure requirement for group health plans and issuers: the summary of benefits and coverage (SBC). On February 14, 2012, the Departments of Labor, Treasury, and Health and Human Services (the Departments) published final regulations[1] setting forth the required content, timing, and appearance of the SBC.

Background

Section 2715 of the Public Health Service Act (PHSA), added by the Act, sets forth the SBC requirement and directs the Departments to develop standards for SBCs, including standard definitions. The goal of the SBC is to standardize health insurance information in a way that allows consumers to make informed and efficient decisions.

Which Plans Must Provide the SBC?

The SBC must be distributed by group health plans and health insurance issuers offering group or individual health insurance coverage. With respect to group health plans, the plan administrator is held responsible for providing the SBC. There is no exemption for large or self-insured plans.

The SBC need not be provided for excepted benefits, such as stand-alone dental and vision plans and most employee-funded health care flexible spending accounts (FSAs). FSAs that are not excepted benefits as well as health reimbursement accounts (HRAs) must issue an SBC; however, an HRA that is integrated with other major medical coverage need not issue a separate SBC. Rather, information about the HRS should be incorporated into the SBC of the other major medical coverage. Health Savings Accounts (HSAs) need not provide an SBC; however, a high deductible health plan associated with an HSA can mention the effects of employer contributions to HSAs on its SBC.

To whom must the SBC be provided?

To participants and beneficiaries, by plans and issuers, with respect to each benefit package.

- Application. The SBC must be provided as part of any written application materials distributed or, if the plan does not distribute written application materials for enrollment, the first date the participant is eligible to enroll in coverage. In addition, if there is any change to the SBC information before the first day of coverage, the plan must update and provide a current SBC no later than the first day of coverage.
- Special enrollment. Special enrollees are also entitled to an SBC no later than when a

summary plan description is required to be provided (i.e., 90 days from enrollment).

- Renewal. If renewal or reissuance of coverage is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. If the SBC cannot be provided within this timeframe, the SBC must be provided as soon as practicable, but in no event later than seven business days after the issuance of the policy or the receipt of written confirmation of intent to renew, whichever is earlier. If a written application is required, the SBC must be provided no later than the date the written application materials are distributed.
- Upon Request. The SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.
- Special rules:
  - The requirement to provide an SBC generally will be considered satisfied for all entities if it is provided by any entity, so long as all timing and content requirements are satisfied.
  - A single SBC may be provided to a participant and any beneficiaries at the participant's last known address. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.
  - SBCs are not required to be provided automatically upon renewal for benefit packages in which the participant or beneficiary is not enrolled, but a participant or beneficiary may request the SBC for any package for which he/she is eligible. In this case, the plan has up to seven business days to respond to the request.

To group health plans, by issuers.

- Application. When a group health plan applies with an issuer for coverage, the issuer must provide an SBC to the plan as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. In addition, if there is any change to the SBC information before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the first day of coverage.
- If renewal or reissuance of coverage is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. If the SBC cannot be provided within this timeframe, the SBC must be provided as soon as practicable, but in no event later than seven business days after the issuance of the policy or the receipt of written confirmation of intent to renew, whichever is earlier. If a written application is required, the SBC must be provided no later than the date the written application materials are distributed.
- Upon Request. The SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

To individuals and dependents in the individual market, by issuers.

In this instance, the rules are similar to those provided with respect to group health plans and the group market, with some minor adjustments to reflect the differences among the markets.

Notice of Modification

A special notice must be provided whenever a material modification to the underlying coverage is made which affects the content of the SBC, other than a change made in accordance with a renewal or reissuance of coverage. This notice must be provided no later than 60 days prior to the date on which such change will become effective. "Material Modification" includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in

the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other terms of coverage under the plan or policy. A material modification includes material reductions of *and enhancements to* benefits, as well as changes or modifications that reduce or eliminate benefits, increase cost-sharing, or impose a new referral requirement.

With respect to the form of the notice, plans and issuers may provide either a new SBC reflecting the modifications or a separate notice describing the material modifications. A compliant SBC notice of modification will satisfy ERISA's "Summary of Material Modification" requirements.

Contents

The regulations set forth 12 required content elements, as follows:

1. *Uniform definitions* of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage (as described in more detail below);
2. A description of the coverage, including cost sharing, for each category of benefits identified by the Departments;
3. The exceptions, reductions, and limitations on coverage;
4. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
5. The renewability and continuation of coverage provisions;
6. Coverage examples specified in guidance by the Departments. To date, the Departments have created two coverage examples ("Having a Baby" and "Managing Type 2 Diabetes") that must be included in the SBC; [2]
7. 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 or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;
8. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;
9. Contact information for questions and details about where a copy of the plan document or insurance policy can be obtained;
10. For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;
11. For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and
12. An Internet address for obtaining the *uniform glossary* (as described in more detail below), as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

Uniform Definitions/Glossary

With respect to the uniform definitions required by the statute, the Departments have created a uniform glossary for use with the SBC.[3] A plan must make the uniform glossary available upon request within seven business days. The SBC must include an Internet address where an individual may review and obtain the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available upon request. The glossary must be provided in the form prepared by the Departments.

The glossary contains the following terms required by statute: co-insurance, copayment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network co-payments, out-of-pocket limit, preferred provider, premium, UCR (usual, customary, and reasonable) fees, durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services, and skilled nursing care.

The glossary also contains the following terms recommended by the NAIC: allowed amount, balance billing, complications of pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network co-insurance, in-network co-payment, medically necessary, network, out-of-network co-insurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist, and urgent care.

Permitted Variation

If a plan's terms cannot reasonably be described within the parameters of the SBC template, the plan or issuer is directed to use its best efforts to do so in a manner that is still consistent with the instructions and template format as reasonably possible.

Expat Plans

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) for obtaining information about benefits and coverage provided outside the United States (however, an SBC is still required with respect to coverage available within the United States).

Format

The SBC must be presented in a uniform format, cannot exceed four double-sided pages in length, must not include print smaller than 12-point font, must use terminology understandable to the average enrollee, and may be provided in either color or grayscale.

Coordination with the SPD

For group health plans, SBCs may be provided in connection with other summary materials (for example, an Employee Retirement Income Security Act [ERISA] summary plan description), if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in a summary plan description [SPD]) and in accordance with the timing requirements for providing an SBC. For health insurance coverage offered in the individual market, the SBC must be provided as a stand-alone document, but may be included in the same mailing as other plan materials.

Means of Distribution

With respect to group health plans, the SBC must be provided free of charge, and may be provided on paper. In addition, the final regulation provides rules for electronic distribution. With respect to the SBC notices provided to covered group health plan beneficiaries and participants, the SBC may be provided electronically pursuant to the requirements of the Department of Labor's electronic disclosure safe harbor.[4]

Language

The SBC must be provided in a culturally and linguistically appropriate manner, according to the rules promulgated with respect to claims-related notices. These rules provide that, if a notice is provided in a county where at least 10% of the population is literate only in a non-English language, (1) language services must be provided in that non-English language, (2) a statement must be provided on the English notice, in the non-English language, indicating how to access the language services, and (3)

the notice must be provided in the non-English language upon request.

Effective Date

The requirements to provide an SBC, notice of modification, and uniform glossary apply for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), these final regulations apply beginning on the first day of the first plan year that begins on or after September 23, 2012. For disclosures to plans, and to individuals and dependents in the individual market, these requirements are applicable to health insurance issuers beginning on September 23, 2012.

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Endnotes

1 *See* 77 FR 8668. Proposed regulations, as well as an accompanying document of related materials, were published on August 22, 2011, (see 76 FR 52442 and 76 FR 52475, respectively).

2 Additional guidance published on February 14, 2012 provides additional guidance with respect to the coverage examples, and indicates that additional coverage examples will be provided by the Departments in the future. *See* 77 FR 8706.

3 *See* http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

4 29 CFR 2520.104b-1