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Departments Issue Summary of Benefits and Coverage Proposed Regulations

The Departments of Labor, the Treasury, and Health and Human Services issued proposed regulations related to the summary of benefits and coverage required under PPACA. In addition, the Departments released a proposed summary of benefits and coverage template and the uniform glossary of health insurance and medical terms. Unless delayed by final guidance, the summary of benefits and coverage generally must be provided for enrollments and reenrollments on and after March 23, 2012. The application of many of the requirements to group health plans is unclear, and additional guidance will be required.

Background

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, (collectively, PPACA) directed the Departments of Labor, the Treasury, and Health and Human Services (the Departments) to develop, in consultation with the National Association of Insurance Commissioners, standards for group health plans and health insurance issuers to provide a summary of benefits and coverage (SBC) to participants and beneficiaries. The SBC must "accurately describe the benefits and coverage under the applicable plan." PPACA also directed the Departments to develop a uniform glossary of health insurance and medical terms (uniform glossary) to assist consumers in comparing and understanding their health benefits. The Departments issued proposed regulations and a proposed SBC template and uniform glossary on August 22, 2011.

SBC Requirements: PPACA and Proposed Regulations

Who Must Furnish the SBC

All group health plans that are subject to the PPACA market reform provisions, including grandfathered plans, will be required to furnish SBCs to participants and beneficiaries. However, retiree-only and HIPAA-excepted benefit plans (e.g., stand-alone dental and vision plans) are not subject to PPACA, and they do not need to provide the SBC.

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For plans that must provide SBCs, the following rules will apply:

- **Insured plans.** Generally, both the insurer and the plan administrator of a group health plan must provide the SBC. However, the proposed regulations would permit the obligation to be satisfied for both entities if *either* the insurer or the plan administrator timely provides the SBC.
- **Self-insured plans.** PPACA provides that either the plan sponsor or the plan administrator must provide the SBC. The proposed regulations clarify that this is the plan administrator's responsibility.

BUCK COMMENT. *Plan administrators of insured group health plans will need to confirm that the insurer will furnish SBCs in a timely manner. Plan administrators of self-funded plans could contract with their third party administrator (TPA) to furnish SBCs, but they too will have to confirm that the TPA can satisfy the requirements for distribution.*

Who Must Receive the SBC

Generally, PPACA requires that an SBC be provided to all "applicants and enrollees." The proposed regulations interpret this to mean that an SBC must be provided to all participants and beneficiaries. However, under the proposed regulations, if a participant and beneficiaries reside at the same address, a plan administrator may send a single SBC to that address.

BUCK COMMENT. *Requiring an SBC to be provided to a beneficiary seems overly burdensome because most plans only allow the participant to elect the type and level of coverage.*

When the SBC Must be Furnished

The proposed regulations provide that group health plans and health insurance issuers are required to provide an SBC to participants and beneficiaries without charge at the following times:

- **Initial Enrollment.** An SBC for each benefit package option for which the participant is eligible must be included with any distribution of enrollment materials. If written enrollment materials are not distributed, the SBC must be furnished no later than the first date the individual is eligible to enroll in coverage.
- **Open Enrollment.** An SBC for the benefit package option in which the participant is enrolled must be included with other open enrollment materials. If reenrollment is automatic, the SBC must be provided no later than 30 days before the beginning of the next plan year.
- **HIPAA Special Enrollment.** An SBC must be provided within 7 days of a request for special enrollment.
- **Upon Request.** An SBC must be provided as soon as practical (but no more than 7 days) after a request.

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What Must Be in the SBC

General Requirements

Similar to PPACA, the proposed regulations provide that an SBC must include the following:

- Uniform definitions of insurance and medical terms;
- A description of the coverage, including cost sharing;
- Exceptions, reductions, and limitations on coverage;
- Cost-sharing provisions, including deductibles, coinsurance, and copayments;
- Renewability and continuation of coverage provisions;
- A "coverage facts label" that includes examples of common benefit scenarios;
- For coverage beginning on and after January 1, 2014, a statement about whether the plan provides minimum essential coverage and that it has a 60 percent actuarial value;
- A statement that the SBC is only a summary and that the plan document, policy, or certificate should be consulted; and
- Contact information for questions, such as a telephone number for customer service, and an Internet address for obtaining a copy of the plan document or policy.

BUCK COMMENT. *It is unclear how group health plans would address some of these items if the SBC must be specific to the coverage of each employee. For example, if a plan's deductibles vary by salary, must the actual deductible for each employee be shown on the SBC? The proposed regulations also do not address issues relating to plans with multiple vendors (for example plans with carve-out prescription drug or mental health benefits).*

In addition to the above items, the proposed regulations also require that the SBC include Internet addresses or contact information for obtaining:

- A list of network providers;
- Information about any prescription drug formulary; and
- The uniform glossary.

Finally, the proposed regulations require that the SBC include the premium charged by the insurer or, for self-insured plans, the cost of coverage. The instructions for the SBC state that an employer must include an addendum to the SBC which defines the premiums for each coverage level. The instructions also require that a statement that participants should contact their employers with respect to employer contributions be included in the SBC.

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BUCK COMMENT. *Because employer-provided coverage generally includes an employer contribution, it would not be useful to a participant in a group health plan to receive the total cost of coverage. The proposed regulations request comments about whether the total cost of coverage should be included in the SBC or the actual cost to the participant. Requiring employee-specific contribution information could be administratively burdensome where participant contributions vary by classification, salary, or other factors.*

Coverage Facts Label

PPACA requires that the SBC contain a coverage facts label that has examples of common benefit scenarios, including pregnancy and serious or chronic medical conditions, and related cost sharing. The scenarios must be based on recognized clinical practice guidelines.

The proposed regulations rename the coverage facts label as "coverage examples." The proposed regulations note that the purpose of the coverage examples is to show how claims for specific benefits would be processed so that a participant can see an estimate of cost sharing and payment. The proposed regulations contain three coverage examples: the normal delivery of a baby, the treatment of breast cancer, and the management of diabetes. Additional examples may be included in the future. The HHS website (http://cciio.cms.gov) sets out specific assumptions (including type, date, and cost of services) and instructions for completing the examples to ensure consistency among SBCs. HHS will update these assumptions annually. Under the proposed regulations, the coverage examples must be updated for SBCs that are provided 90 days after HHS revises its specific assumptions.

BUCK COMMENT. *Plans in which benefit provisions such as deductibles, out-of-pocket limits, or copays vary by factors such as salary, location, or classification may have additional administrative burdens if these coverage examples must be made specific to a participant. The Departments request comments on other approaches that could be used to provide this information, such as an Internet portal where the plan specific information could be input to produce the examples.*

How the SBC Must Appear and Be Presented

PPACA requires that the SBC be written in a uniform manner, no more than four pages, and in at least 12 point font. The proposed regulations interpret PPACA to allow the SBC to be no more than four, double-sided pages (resulting in eight pages).

PPACA also requires that the SBC be presented "in a culturally and linguistically appropriate manner." The proposed regulations interpret this similar to the rules that apply to the PPACA claims appeals requirements. (See our August 4, 2011 *For Your Information*.) The proposed regulations also require that the SBC include a statement that the SBC, upon request, will be provided in the applicable, non-English language (Spanish, Navajo, Tagalog, or Chinese) and that customer service also is available in that language. However, the model SBC does not include a translation of this statement in the applicable non-English languages.

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The proposed regulations provide that the SBC must be a stand-alone document for each plan. Instructions for completing the SBC are very specific, and there is little ability to vary from the instructions. Plans with multiple benefit options must prepare a separate SBC for each option.

PPACA specifically provides that an SBC may either be provided in "paper or electronic form." However, PPACA does not explain how the SBC may be provided in electronic form. The proposed regulations generally require that the Department of Labor's electronic distribution requirements be followed for electronic distribution of SBCs.

Notice of Material Modifications

PPACA requires that a group health plan or issuer must notify participants of any material modification of information contained in the most recent SBC no later than 60 days before the date such modification will become effective. The preamble to the proposed regulations notes that a modification will be considered material if an average plan participant would consider it to be an important change in covered benefits or other terms of coverage. It also notes that a material modification for this purpose could include benefit enhancements or reductions.

BUCK COMMENT. *The notice of material modification required by PPACA is not the same as the summary of material modification (SMM) required by the Employee Retirement Income Security Act (ERISA). Most significantly, the timeframe for providing the notices is different. Although the notice required by PPACA must be provided before the change becomes effective, an SMM does not have to be provided until 210 days following the close of the plan year in which the change was adopted (or no later than 60 days following the adoption of a change that is a material reduction in covered benefits or services). However, the preamble to the proposed regulations notes that a notice of material modification required by PPACA that is furnished in a timely manner could satisfy an ERISA plan's obligation to provide an SMM.*

Uniform Glossary

PPACA requires that the Departments devise a uniform glossary of specific terms. The Departments added an additional 19 terms to the glossary, such as "balance billing" and "medically necessary," and they requested comments on whether additional terms should be added.

PPACA does not specifically require that a group health plan or health insurance issuer provide the uniform glossary to participants and beneficiaries. The propose regulations require that a group health plan or health insurance issuer must provide the uniform glossary to participants and beneficiaries within seven days of request. This may be done by providing an Internet address where the participant or beneficiary may review and obtain the uniform glossary. The Internet address may either be the plan sponsor's, HHS', or DOL's Internet address. A paper copy must be made available upon request.

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BUCK COMMENT. *Because group health plans and health insurance issuers must use the uniform glossary included in the proposed SBC template and the glossary may be made available through a website such as the DOL's or HHS', employers should not have difficulty complying with this requirement. However, the definition of some of the terms may differ from how they are currently being used in SPDs, which could potentially cause confusion for participants.*

Penalties for Failing to Provide SBCs

PPACA specifically provides that a group health plan or issuer that willingly fails to provide the SBC or other required information is subject to a fine of up to $1,000 for each failure. The proposed regulations specify that this amount is for failures for each individual. The excise tax under Section 4980D of the Internal Revenue Code may also apply.

Compliance Date

PPACA directs group health plans and health insurance issuers to comply with the SBC requirements no later than 24 months after the enactment of PPACA, i.e., for enrollments or reenrollments on and after March 23, 2012. The guidance requests comments on the feasibility of implementing the requirements within that timeframe or phasing in the requirements.

BUCK COMMENT. *Unlike some other PPACA provisions, the effective date is not tied to a plan year, or even a calendar year; instead it is a specific date, March 23, 2012. It appears that beginning on that date, SBCs will have to be provided to new enrollees or reenrollees. With the delay in issuing the proposed guidance and the lack of clarity in many areas on how the requirements apply to group health plans, a delay in the effective date should be likely.*

Conclusion

The SBC requirements represent a significant change for plan administrators. With the SBC effective date less than six months away, there is limited time for plan administrators to prepare the required information. The final regulations will likely not be available until very late this year at the earliest. Because of the lack of clarity concerning the application of many of the requirements to employer plans, it will be difficult to prepare the SBCs until final guidance is provided. Plan administrators should discuss these requirements with their insurer or TPA. Buck's consultants are available to assist you with these discussions.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

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