



For your information

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Final Guidance Issued on Summary of Benefits and Coverage

The Departments of Labor, the Treasury and Health and Human Services issued final regulations related to the summary of benefits and coverage (SBC) required under PPACA. The SBC must be provided for open enrollment periods that begin on or after September 23, 2012. The final regulations largely follow the proposed regulations issued last year and will be very problematic for large employer plans.

Background

The Patient Protection and Affordable Care Act (PPACA) directed the Departments of Labor, the Treasury, and Health and Human Services (the Agencies) to develop 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.” The primary objective of the SBC is to enable participants to compare coverage options easily and better understand their health benefits.

PPACA also directed the Agencies to develop a uniform glossary of health insurance and medical terms (uniform glossary) to assist consumers in comparing and understanding their health benefits.

The Agencies issued proposed regulations, an SBC template, and a uniform glossary in August 2011 (see our October 19, 2011 [For Your Information](#)). [Final regulations](#), [SBC template](#), and [uniform glossary](#), as well as a [compliance guide](#) were issued on February 14, 2012. Although the Agencies received many comments on the difficulties of applying the requirements in the proposed regulations to group health plans, particularly to large employer plans, the final regulations largely follow the proposed regulations.

This *For Your Information* focuses primarily on the rules that group health plans must follow in providing SBCs to participants and beneficiaries. It does not address the rules that apply to the provision of the SBC by a health insurance issuer to a group health plan, nor does it address the rules for individual health plans.

SBC Requirements

Compliance Date – New September 23, 2012 Milestone

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 final regulations delay this disclosure requirement, but only by six months:

- **Participants who enroll or reenroll through an open enrollment period.** The requirements apply as of the first day of the first open enrollment period that begins on or after September 23, 2012.
- **Participants who enroll other than through an open enrollment period.** The requirements apply as of the first day of the first plan year that begins on or after September 23, 2012. For calendar year plans, that means January 1, 2013.

COMPLIANCE ALERT: The SBC requirements become effective on September 23, 2012.

INSIGHT

The September effective date provides little time for compliance, particularly for plan sponsors with multiple plans and vendors. However, if a plan's open enrollment period starts before September 23, 2012, SBCs will only need to be furnished to new hires and others who first enroll for coverage during the first plan year beginning on or after September 23, 2012. In that case, SBCs will not have to be provided to other participants until the next open enrollment period in 2013.

Plans Subject to the SBC Requirement

All group health plans subject to the PPACA market reform provisions, regardless of grandfathered status, will be required to furnish SBCs to participants and beneficiaries. This includes health reimbursement arrangements (HRAs), although information about an HRA that is integrated with a medical plan can be combined in the SBC for the underlying plan. An SBC does not have to be provided for retiree-only plans and HIPAA-excepted benefit plans (e.g., stand-alone dental and vision plans, most health FSAs). An SBC is also not required for health savings accounts (HSAs), although the SBC for the high-deductible health plan can include the effects of the HSA, for example, how the HSA can offset a portion of the deductible.

COMPLIANCE ALERT: Retiree health plans are generally subject to all the same PPACA requirements as health plans covering active employees, including the SBC requirement, unless the retiree plans are treated as “retiree-only” plans. Compliance with the SBC requirements may present unique challenges for some retiree plans.

The following rules will apply to plans subject to the SBC requirements:

- **Insured plans.** The issuer must provide the SBC to the group health plan. *Both* the issuer (insurer) and the plan administrator must provide the SBC to participants and beneficiaries. However, the regulations permit the obligation to be satisfied for both entities if *either* the issuer or the plan administrator timely provides the SBC.
- **Self-insured plans.** The plan administrator must provide the SBC to participants and beneficiaries.

INSIGHT

A plan sponsor cannot simply delegate this responsibility. In the case of an insured plan, the plan sponsor will have to confirm that the insurer is furnishing SBCs in a timely manner and take action if it is not. In the case of a self-funded plan, the plan administrator, which is typically the plan sponsor, is ultimately responsible. Although the plan sponsor may contract with a third party, such as a claims administrator, to prepare and furnish SBCs, the plan sponsor remains legally liable. Preparation of the SBC may be difficult for plans in which coverage for services such as prescription drugs or mental health benefits has been carved out with a specialty vendor. In those cases, the plan sponsor may need to prepare the SBC, incorporating the needed added details.

Who Must Receive the SBC

An SBC must be provided to all "participants and beneficiaries." Participants include employees or retirees who are, or may become, eligible for a benefit under the plan; beneficiaries include the participant's dependents who may be entitled to coverage under the plan. The final regulations provide that furnishing an SBC to the participant and any beneficiaries at the participant's last known address will satisfy the obligation for all family members. However, separate SBCs must be furnished to a beneficiary known to reside at a different address.

When the SBC Must Be Furnished

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 newly eligible (e.g., new hires, qualifying status changes) must be included in 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. The regulations provide that 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.** Generally, an SBC for the benefit package option in which a special enrollee enrolls must be provided no later than 90 days after enrollment (the same time frame for providing an SPD). However, individuals who have not yet enrolled may request an SBC for any benefit package option at any time. These SBCs must be furnished as described below.
- **On request.** An SBC must be provided as soon as practical (but no more than seven business days) after a request.

INSIGHT

Plan sponsors will need to coordinate the distribution of the SBCs with their upcoming open enrollment material. It is important to note that with respect to a participant already enrolled in the plan, an SBC must only be provided for the option in which the participant is enrolled. Whether “passive” enrollments (where employees are not required to make an election) satisfy the requirements for automatic reenrollment is not clear. Inclusion of the SBCs in SPDs and open enrollment guides should be considered now, in order to meet the requirements most efficiently.

What Must Be in the SBC

An SBC must include all of the following:

- A description of the coverage, including cost sharing for designated categories of benefits
- Exceptions, reductions, and limitations on coverage
- Cost-sharing provisions, including deductibles, coinsurance, and copayments
- Renewability and continuation-of-coverage provisions
- Coverage examples that illustrate benefits provided under the plan (see below)
- 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
- 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
- An Internet address or contact information for obtaining a list of network providers
- An Internet address or contact information for obtaining information on prescription drug coverage
- An Internet address for obtaining the uniform glossary (see below) and a disclosure that paper copies are available through a contact phone number.

The proposed regulations would have required that the SBC specify the premium charged by the insurer or, for self-insured plans, the cost of coverage and a statement that participants should contact their employers with respect to employer contributions. The final regulations do not retain this requirement.

INSIGHT

The elimination of the requirement to include premiums and employee contributions in the SBC is welcome news for employers. However, employers with plans in which deductibles, out-of-pocket limits, or other design features vary by coverage tier, salary, employee position, or other factors may have to prepare employee-specific SBCs to capture the unique features in the SBC and the coverage examples (discussed below). This is a significant semi-personalized communication requirement.

Coverage Examples

PPACA requires that the SBC contain a “coverage facts label” that provides examples of common benefit scenarios, including pregnancy and serious or chronic medical conditions, and related cost sharing. The intent is to provide a standard basis for consumers to easily review and compare their plan choices. The final regulations use the term “coverage examples” for ease of reference.

The coverage examples are intended to show how a plan would process claims for specific benefits so that a participant can see an estimate of cost sharing and payment for comparing plans. The final regulations contain two coverage examples: the normal delivery of a baby and the management of diabetes. Additional coverage examples will be included in the future. HHS has provided specific assumptions (including type, date and cost of services) and instructions for completing the examples to ensure consistency among SBCs. These assumptions will be updated annually. Under the final regulations, the coverage examples must be updated for SBCs that are provided 90 days after HHS revises its specific assumptions.

INSIGHT

Although the Agencies requested comments on other approaches that could be used to provide coverage examples, such as an Internet portal where plan-specific information could be input to produce the coverage examples, the final regulations did not change the proposed requirements. Depending on the plan design, coverage examples may have to be made specific to each participant, for example, if plan design features vary by position or salary.

How the SBC Must Appear and Be Presented

The layout of the SBC template must be followed exactly and, unless printed in grayscale, must use the same colors provided in the template. The SBC must be written in a uniform manner using the model SBC, with no more than four double-sided pages (eight in total) and at least a 12-point font.

Plans with multiple benefit options must prepare a separate SBC for each option. Separate SBCs may be required for each coverage tier – for example, employee only and family coverage – if the tiers have different deductibles, out-of-pocket maximums, etc. To the extent that a plan's terms cannot be reasonably described in a manner consistent with the SBC template and instructions, the plan or issuer must use its best efforts to provide an accurate description consistent with the SBC requirements. The guidance cites as examples instances in which an individual's out-of-pocket costs may be affected by different network structures, participation in wellness programs, or the availability of a related HRA or FSA.

INSIGHT

Although this additional flexibility is welcome, preparing the SBC will require further coordination with the issuer or claims administrator. This flexibility may provide a “good faith” compliance approach for reflecting plan features that vary by coverage tier, salary, position, or other factors.

The SBC must be presented “in a culturally and linguistically appropriate manner.” The final regulations follow the rules applicable to the claims procedures of nongrandfathered plans. (See our August 4, 2011 [For Your Information](#).) Thus, on request, an SBC must be provided in a non-English language to individuals who reside in counties that have been identified by the Census Bureau as having 10% or more of their population literate only in the same non-English language. The current required languages are:

- Chinese (required for residents of San Francisco County, California)
- Tagalog (required for residents of two counties in Alaska)
- Navajo (required for residents of Apache County, Arizona; McKinley County, New Mexico; and San Juan County, Utah)

- Spanish (required for residents of counties of 22 states and Puerto Rico)

Customer service must also be available in the relevant language. An SBC furnished to residents of those specified counties may have to include a statement in the applicable non-English language advising participants of the availability of the language service.

INSIGHT

The Agencies indicated that standard SBCs will be provided in these four languages. However, providing customer service in other languages is the obligation of the plan sponsor or issuer.

The proposed regulations required that the SBC be a stand-alone document. The final regulations provide additional flexibility by allowing the SBC to be combined with other materials, such as an SPD, as long as it satisfies the content and timing requirements and is displayed prominently. The guidance provides an example of including the SBC in an SPD after the table of contents.

How the SBC Must Be Distributed

PPACA specifically provides that an SBC may be provided either in “paper or electronic form.” The final regulations provide very helpful changes related to electronic distribution of the SBCs:

- **For individuals already covered under the plan.** The SBC can be provided electronically, as long as the Department of Labor (DOL) requirements for electronic delivery are satisfied. As mentioned above, an SBC is only required for the benefit option in which the individual is enrolled.
- **For individuals who are eligible for a plan but not yet enrolled.** The SBC can be provided electronically as long as it is readily accessible. If the electronic form is an Internet posting, the plan must advise the individuals in paper form (such as a postcard) or by email about how to access the SBC or obtain a paper copy.

In both instances, a paper copy of the SBC must be available without charge on request and meet the seven-business-day requirement.

INSIGHT

The ability to distribute the SBC in electronic form is welcome, especially with respect to those who are not yet enrolled, where the DOL requirements would not apply. Some employers may wish to revise their SPDs simultaneously, incorporating the SBC with other needed updates and thereby reducing multiple distributions. Others may wish to incorporate the SBC with the open enrollment materials.

COMPLIANCE ALERT: DOL regulations allow plan sponsors to utilize electronic media to distribute SPDs and other ERISA-required notices to participants who have “work-site access” – which means that they have access to the employer’s electronic information system (i.e., the organization’s intranet) as an integral part of their work duties. For participants who do not have this type of worksite access (such as manufacturing employees or retirees) or who want to use non-company networks or other electronic media (such as the Internet or CD-ROMs mailed to homes), additional requirements must be met.

Uniform Glossary

The guidance provides a uniform glossary that must be made available with no changes. The uniform glossary must be provided to participants and beneficiaries within seven business days of request. This may be done by providing the Internet address of a site where the participant or beneficiary may review and obtain the uniform glossary. The Internet address may be the plan sponsor’s, HHS’s or DOL’s Internet address. A paper copy must be made available on request.

INSIGHT

Because the standard uniform glossary must be made available to participants, the only action a plan sponsor must take is to make it available. This will be a standard document for all plans and will be available broadly.

Notice of Modification

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 if the modification occurs other than during open enrollment. A modification is considered material if an average plan participant would consider it to be an important change in covered benefits or other terms of coverage. The guidance also notes that a material modification for this purpose could be either benefit enhancements or reductions.

INSIGHT

The notice of modification to an SBC must be provided sooner than the summary of material modifications (SMM) required by ERISA, which may be provided after the date the modification or change is adopted. The Agencies note that a plan that provides a timely notice of a material modification to an SBC will also satisfy the requirement to provide an SMM under ERISA with respect to that modification.

COMPLIANCE ALERT: Because of the different deadlines, provision of an SMM under ERISA may not satisfy the requirement to provide a notice of material modification to an SBC.

Penalties for Failure to Provide SBCs

A group health plan or issuer that willfully fails to provide the SBC or other required information is subject to a fine of up to \$1,000 for each failure. The final regulations specify that a failure for each individual constitutes a separate offense. The excise tax under Section 4980D of the Internal Revenue Code may also apply.

Conclusion

The SBC requirements represent a significant change for plan sponsors. With the SBC effective date for most plans in September, there is very little time to prepare the required information. It is important for self-insured plans to note that although the claims administrator may assist the plan sponsor in complying with these requirements, the requirements fall on the plan sponsor. Plans with carved-out benefits, benefit provisions that vary by employee, and special programs such as wellness programs and HRAs will require special coordination.

Buck Can Help

- Identify the active and retiree plans subject to the SBC requirements
- Develop a compliance and communication approach to describing benefit provisions and the timing and packaging of the SBCs with other communication activities for annual enrollment and new hires
- Coordinate the preparation of SBCs with insurers and TPAs
- Prepare SBCs and, if desired, update SPDs
- Prepare claim examples
- Distribute the SBCs