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For your information

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Departments Issue FAQs Simplifying Summary of Benefits and Coverage Requirement

The Departments of Labor, the Treasury and Health and Human Services have issued new FAQs that provide additional guidance related to the summary of benefits and coverage (SBC) required under PPACA. The FAQs provide relief in several areas. However, the timing, content and distribution requirements in the final regulations still generally apply.

Background

The Patient Protection and Affordable Care Act (PPACA) directed the Departments of Labor, the Treasury, and Health and Human Services (the Departments) to develop standards for a summary of benefits and coverage (SBC) and a uniform glossary of health insurance and medical terms that group health plans and health insurance issuers must provide to participants and beneficiaries. The primary purpose of the SBC is to enable participants to compare coverage options easily and to help them better understand their health benefits.

On February 14, 2012, the Departments issued final regulations, an SBC template, and a uniform glossary (see our March 1, 2012 For Your Information). On March 19, 2012, the Departments released Frequently Asked Questions that address some issues raised by the final regulations.

The FAQs do not change the SBC compliance dates. The requirements are generally effective with open enrollment periods that begin on or after September 23, 2012. The FAQs also emphasize that the focus of the Departments is on assisting plans and issuers (insurers) in compliance, rather than imposing penalties. Therefore, "the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final 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.

Number of SBCs Required

The FAQs provide useful guidance that may enable plan sponsors to reduce the number of required SBCs by permitting information to be combined as long as the content and coverage examples are understandable.

- **Separate SBCs are not required for different coverage tiers.** Information for different coverage tiers (e.g., self-only, employee-plus-one, family) can be combined on one SBC. If information for multiple tiers is included on one SBC then the coverage example should be for self-only coverage and clearly indicate the applicable tier.
- **Different levels of cost-sharing such as deductibles, copayments and coinsurance can be combined in a single SBC**. If a participant is able to select the level of cost-sharing within a benefit package, that information can be combined in a single SBC. For example, the SBC could list the deductible or out-of-pocket maximums applicable to in-network versus out-of-network benefits.
- **The impact of HRAs, HSAs, FSAs and wellness programs can be reflected in a single SBC.** The effects of these program features can be included in the appropriate section of the SBC.

INSIGHT

Taking advantage of this permitted flexibility will require customization of the plan sponsor's SBCs. The FAQs do not directly address plans that vary deductibles, out-of-pocket limits, or other design features by salary, employee position or other factors other than coverage tier. However, this permitted flexibility may provide a viable approach for a plan sponsor to distribute a single or limited number of SBCs, as long as the content is presented in an understandable manner.

Language Requirements

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. Thus, on request, an SBC must be provided in a non-English language in counties having 10% or more of their population literate only in the same non-English language. The current four languages are Spanish, Chinese, Tagalog and Navajo.

The FAQs confirm that an SBC sent to an address in these counties must include a sentence in the applicable language advising participants of the availability of language assistance services in that language. The FAQs state that sample language for this statement is available on the model notice of adverse benefit determination at Language Service Availability.

INSIGHT

The FAQs confirm that the SBC can include the statements in non-English languages even in counties that do not meet the 10% threshold. Since it may be difficult to prepare and distribute county-specific SBCs, plan sponsors may want to include the model language in all four languages in all SBCs.

COMPLIANCE ALERT: The counties where the 10% threshold applies are based on data published by the United States Census Bureau. This data is published annually, and an updated list of counties for 2012 was recently published.

SBC Format

The final regulations were very prescriptive in many areas on the SBC format. The FAQs provide some flexibility concerning page breaks, row and column sizes, and the order of some information.

Furnishing the SBC

The FAQs confirm that group health plans and issuers must provide SBCs at the following times:

- **Initial enrollment.** An SBC for each benefit package option for which the participant is newly eligible (e.g., new hires or HIPAA special enrollees) 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. An updated SBC must be provided by the first day of coverage if there is any change to the information in the SBC.
- **Open enrollment.** During open enrollment, only an SBC for the benefit package option in which the participant is currently enrolled must be provided. If the participant must make an active election for coverage for the next plan year, or is provided an opportunity to change coverage options during open enrollment, the SBC must be provided at the same time as open enrollment materials.
- **Automatic enrollment.** If the participant does not have to enroll and has no opportunity to change coverage, the SBC must be provided no later than 30 days prior to the first day of the new plan year.
- **HIPAA special enrollment.** Generally, an SBC for the benefit package option that a special enrollee selects 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. The FAQs clarify that "provided" means when the SBC was sent and not when it is received by the participant.

INSIGHT

The FAQs clarify that plan sponsors with "passive" enrollments, where the participant election automatically renews, must still distribute SBCs during open enrollment if the participant can change coverage options.

COBRA Qualified Beneficiaries

The FAQs confirm that SBCs must be furnished to COBRA qualified beneficiaries. Although a COBRA qualifying event will not trigger the need to distribute an SBC, COBRA beneficiaries must be provided the same opportunity to change coverage during open enrollment periods as similarly situated non-COBRA beneficiaries. In addition, SBCs may have to be provided to a qualified beneficiary who is entitled to change to different coverage following the qualifying event.

INSIGHT

The requirement to provide SBCs to participants like COBRA beneficiaries and retirees who are not active employees, may require different distribution methods than those used for active employees.

Carve-out Arrangements

Many large employer plans have "carve-out arrangements" for providing coverage for prescription drugs and managed behavioral health services that complicate the preparation of the SBC. The FAQs don't modify the rules regarding SBC content requirements, but provide limited enforcement relief for plans with carve-out arrangements. Under that enforcement relief, a plan that enters into a binding contract with a third party to complete or assist in the completion of an SBC, or to deliver an SBC, will not subject a plan to any enforcement action for failing to provide a complete and timely SBC if:

- The plan monitors performance under the contract
- The plan corrects any violation as soon as practicable if it can do so
- If the plan knows of a violation but doesn't have the information to correct it, it communicates with participants and beneficiaries and takes significant steps to avoid future violations

INSIGHT

Plan sponsors with self-funded or insured plans with carve-out arrangements will still need to coordinate the consolidation of the plan information into a single SBC.

Electronic Distribution

The FAQs do not make any changes to the requirements for electronic distribution of the SBCs but set out the rules more succinctly:

- **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 SBC is posted on the Internet, the plan must advise the individuals in paper form (such as a postcard) or by email how to access the SBC or obtain a paper copy.

Conclusion

While the FAQs provide helpful relief and additional guidance in many key areas, the basic SBC requirements, including the effective date, are largely unchanged from the final regulations. For self-insured plans, complying with the SBC requirements falls on the plan sponsor. For insured plans, while the issuer is generally responsible for providing the SBC, the plan sponsor is also responsible for the distribution of the SBCs.

Buck has prepared a Health Care Reform Timeline and Health Care Reform Comparison in Brief that provide an overview of the health care reform requirements, reflecting current guidance.

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