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On August 22, 2011, the Department of Health and Human Services (HHS) along with the Departments of Labor and Treasury published a proposed rule setting forth the requirements of the Summary of Benefits and Coverage (SBC) disclosure that health insurers and group health plans must provide to consumers under the Patient Protection and Affordable Care Act (PPACA).

# Agencies Issue Proposed Rule Outlining PPACA Requirements for Summary of Benefits and Coverage

By Ilyse Schuman and Steven Friedman

On August 22, 2011, the Department of Health and Human Services (HHS) along with the Departments of Labor and Treasury published a proposed rule (Proposed Rule) setting forth the requirements of the Summary of Benefits and Coverage (SBC) disclosure that health insurers and group health plans must provide to consumers under the Patient Protection and Affordable Care Act (PPACA). To help consumers understand and evaluate their health insurance choices, consumers will also receive a uniform glossary of terms commonly used in health insurance coverage.

Employers should take note of this rule which will soon require them to make yet another disclosure under the PPACA to their employees.

## Background

The PPACA mandates that group health plans and health insurance issuers offering group or individual health insurance coverage provide to enrollees a summary of benefits and coverage explanation that accurately describes a plan's benefits and coverage. The SBC requirement applies to both grandfathered and non-grandfathered health plans.

The law mandated that the Departments develop standards governing the summary by March 23, 2011, 12 months after the PPACA's enactment, and directed HHS to consult with the National Association of Insurance Commissioners (NAIC) regarding the content of the summary. The statute provides that plans and issuers must comply with the disclosure requirement 24 months after enactment, or March 23, 2012. Comments on the Proposed Rule are due October 21, 2011.

## The Proposed Rule

The Proposed Rule outlines the standards that will govern who provides an SBC, who receives an SBC, when the SBC will be provided, and how it will be provided. In conjunction with the proposal, the agencies are issuing a proposed template for the SBC, instructions, sample language, a guide for coverage examples calculations to be used in completing the template, and a uniform glossary that would satisfy the law's disclosure requirements.

### *Delivery of the SBC by a Group Health Plan and Group Health Insurance Issuer to Participants and Beneficiaries*

The plan or issuer must provide an SBC free of charge to participants and beneficiaries with respect to each benefit package for which the participant and beneficiary is eligible. In the case of a self-insured group health plan, the Proposed Rule would make the plan administrator responsible for providing the SBC to participants and beneficiaries. For insured group health plans, either the group health plan or the issuer can deliver the SBC to enrollees. To avoid unnecessary duplication with respect to group health plans, the Proposed Rule states that the plan's obligation to deliver the SBC will be satisfied if the issuer properly delivers the SBC to the plan's participants and beneficiaries. Specifically, the rules permit the plan or issuer to send a single SBC to the same address where participants and beneficiaries are known to reside. However, the plan or issuer must send a separate SBC to a beneficiary if their last known address is different from that of the participant.

- Enrollment: The plan or issuer must include the SBC with any written application materials the plan distributes for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later that the first date the participant is eligible to enroll in coverage. The plan or issuer must update and provide a current SBC no later than the first day of coverage if there is any change to the SBC. The plan or issuer must also provide the SBC to a Health Insurance Portability and Accountability Act (HIPAA) special enrollee within seven days of a request for enrollment.
- Renewal: In addition, if a written application is required for renewal, the plan or issuer must provide the SBC to participants and beneficiaries no later than the date renewal materials are distributed. If renewal is automatic, the plan or issuer must provide the SBC no later than 30 days prior to the first day of coverage in the new plan year. The plan and issuer only need to automatically provide a new SBC for the benefit package in which a participant or beneficiary is enrolled. However, the plan or issuer must provide the SBC of another benefit package for which the participant or beneficiary is eligible but not enrolled upon request.
- Upon Request: The plan or issuer must also provide the SBC within seven days of a request by a participant or beneficiary for the summary.

Therefore, if enrollment is on a calendar year basis, employers may first need to make this disclosure to new enrollees who join the plan on or after Mach 23, 2012, and to those who request the SBC on or after this date. With respect to all other participants, it is likely the first disclosure with enrollment materials will be made for the 2013 plan year.

### *Delivery of the SBC by a Group Health Insurance Issuer to a Group Health Plan*

The Proposed Rule describes group health insurance issuer's obligation to provide an SBC to the group health plan.

- Enrollment: The issuer must provide the SBC to the plan, or its sponsor, upon application or request for information about health coverage within seven days following the request. If the plan subsequently applies [?] for health coverage, the issuer must send a second SBC only if there has been a change. The issuer must update and provide a current SBC to the plan no later than the date of the offer or first day of coverage if there is any change to the SBC.
- Renewal: The issuer must also provide a new SBC to the plan upon renewal or reissuance of the policy. If a written application is required for renewal, the issuer must provide the SBC to the plan no later than the date materials are distributed. If renewal is automatic, the issuer must provide the SBC no later than 30 days prior to the first day of coverage in the new plan year.
- Upon Request: The issuer must provide the SBC to the plan within seven days of a request.

### *Prior Notice of Mid-Year Material Modifications*

Plan modifications may result in a requirement for an employer to issue an off-cycle SBC. The rules provide that if a plan or issuer makes any material modification in any of the terms or conditions of coverage that would affect the content of the SBC other than in connection with renewal, the plan or issuer must provide notice of the modification to enrollees at least 60 days before the modification becomes effective. A *material modification* is defined under the Employee Retirement Income Security Act (ERISA) section 102, and the Departments note that the term 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 to be an important change in covered benefits or other terms of coverage under the plan or policy. The preamble to the Proposed Rule states that this notice could be satisfied either by a separate notice describing the material modification or by providing an updated SBC.

Significantly, for ERISA-covered group health plans, this notice is in advance of the timing required for the provision of a summary of material modification (SMM), which is generally not later than 210 days after the close of the plan year in which the modification or change was adopted, or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change. In situations where a complete notice is provided in a timely manner under the new PPACA notice requirement, the preamble to the Proposed Rule states that an ERISA-covered plan will also satisfy the requirement to provide an SMM under Part 1 of ERISA. The Departments invite comments on this expedited notice requirement, including whether there are any circumstances where 60-day advance notice might be difficult.

***Content***

Generally, under the Proposed Rule, the SBC will summarize the key features of the plan or coverage, including the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. In order to help consumers compare plans, the SBC will also include *Coverage Examples*, a standardized health plan comparison tool akin to nutrition label information. The Coverage Examples would illustrate what proportion of care expenses a health insurance policy or plan would cover for three common benefits scenarios—having a baby, treating breast cancer, and managing diabetes. Plans and issuers would also have to illustrate how claims would be processed under each scenario. The proposed template document includes specific instructions and details about an HHS website that can assist with this simulation. According to the HHS, additional scenarios – but no more than six in total – may be required in future SBCs.

Overall, the Proposed Rule follows the requirements set forth in the statute, which states that an SBC must include:

- 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;
- A description of the coverage, including cost sharing, for each category of benefits identified by the Departments;
- The exceptions, reductions, and limitations on coverage;
- The cost-sharing provisions of the coverage, including deductible, coinsurance, and co-payment obligations;
- The renewability and continuation of coverage provisions;
- 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;
- For coverage beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code), 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;
- 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; and
- A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

The Proposed Rule also includes four additional elements for the SBC consistent with NAIC's recommendations: (1) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers; (2) for plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage; (3) an Internet address where an individual may review and obtain the uniform glossary; and (4) premiums (or cost of coverage for self-insured group health plans).

The proposal notes that the insurance exchanges are set to be operational in 2014. Therefore, because the statutory SBC elements include the information in the minimum essential coverage statement, the Departments invite comments on how employers might provide this information to employees and the Exchanges in a manner that minimizes duplication and burden. The agencies also acknowledge that some of the plan level information that is required to be provided in the SBC is already required to be provided under the Internal

Revenue Code, and therefore, government agencies are coordinating their efforts to determine how and whether the same data can be used for multiple purposes.

The agencies also request comment as to whether it would be feasible or desirable to permit plans and issuers to input plan- or policy-specific information into a central Internet portal, such as the federal health care reform website (www.healthcare.gov), that would use the information to generate the coverage examples for each plan or policy.

***Appearance and Format***

The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

Under the Proposed Rule, a group health plan or a health insurance issuer will provide the SBC as a stand-alone document. The agencies acknowledged concerns about the potential redundancies and additional costs of the new SBC requirement for those plans and issuers that already provide a Summary Plan Description. The agencies have invited comments on whether and how the SBC might best be coordinated with the Summary Plan Description and other group health plan disclosure materials. For example, the agencies ask whether they should allow the SBC to be provided immediately after the cover page and table of contents of the Summary Plan Description.

To facilitate faster and less burdensome disclosure of the SBC, the proposed regulations set forth rules to facilitate electronic transmittal of the SBC, where appropriate. Specifically, an SBC provided by a plan or issuer to a participant or beneficiary may be provided in paper form. Alternatively, for plans and issuers subject to ERISA or the Internal Revenue Code, the SBC may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor are met. An issuer may provide the SBC to the group health plan in paper or electronically if: (1) the format is readily accessible by the plan; (2) the SBC is provided in paper form free of charge upon request; and (3) for internet postings, the plan is notified by paper or e-mail that the documents are available on the web if the web address is given.

***Language***

The SBC must be presented in a "culturally and linguistically appropriate manner." The Proposed Rule explains that a plan or issuer is considered to satisfy this requirement if the SBC meets the thresholds and standards for a "culturally and linguistically appropriate manner" that apply to the PPACA internal appeals process.

***Template and Uniform Glossary of Terms***

Group health plans and issuers must make the uniform glossary of health coverage related terms available to participants and beneficiaries upon request within seven days either in paper form or electronically. As to the definitions to be included in the uniform glossary, the new section to the Public Health Service (PHS) Act added by the PPACA directs agencies to develop standards and definitions for a number of insurance- and medical-related terms. In addition to the ones listed in the statute, the Proposed Rule includes standards and definitions for the following terms: 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 coinsurance; plan; preauthorization; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; specialist; and urgent care.

The agencies are seeking comments on the uniform glossary, including the content of the definitions and whether there are additional terms that are important to include in the uniform glossary so that individuals and employers may understand and compare the terms of coverage and the extent of medical benefits (or exceptions to those benefits).

With respect to the sample template, the agencies seek comment on the following issues:

- The SBC template is intended to be used by all types of plan or coverage designs. The agencies seek input on issues that may arise from the use of this template for different types of plan or coverage designs.
- Comments are sought regarding any modifications needed for use by group health plans.

- The agencies ask whether the content of the SBC should require inclusion of additional information that might be important for individuals to know about their coverage.
- The fourth page of the SBC template includes a list of services that plans and issuers must indicate as either excluded or covered in the "Excluded Services & Other Covered Services" chart. The agencies are asking whether services should be added or removed from this list, as well as whether the disclosure stating that the list is not complete is adequate.
- The SBC template includes a disclosure on the first page indicating to consumers that the SBC is not the actual policy and does not include all of the coverage details found in the actual policy. The agencies seek comment on the sufficiency of this disclosure.

***Penalties***

A group health plan or health insurance issuer that willfully fails to provide the SBC to a participant or beneficiary as required is subject to a fine of not more than $1,000 for each failure. A separate fine may be imposed for each participant and beneficiary to whom the failure relates.

## Effective Date

Although the rule has not been finalized, plans and issuers should begin preparing now for its implementation. The Proposed Rule comes five months after the statutory deadline for the Departments to issue standards has passed, leaving plans and issuers with little time to familiarize themselves with the new standards and draft the necessary documents before the SBC requirement is slated to become effective on March 23, 2012. The agencies have delayed the effective dates for several other PPACA provisions. However, the effective date for the SBC provision has not been changed even though the Departments missed the deadline for issuing standards. The agencies have invited comment on the feasibility of the March 23, 2012 deadline.

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