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Agencies Issue Final Rule Regarding Summary of Benefits and Coverage

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The Departments of Health and Human Services, Labor, and the Treasury have issued final regulations under the Patient Protection and Affordable Care Act (the "Affordable Care Act") to implement the requirement that group health plans and health insurance issuers provide consumers with a summary of benefits and coverage (SBC).[1] This final rule makes some notable changes to the proposed regulations which are intended to help consumers better understand their health care coverage and choices while reducing the burden on health plans and issuers.

Background

The Affordable Care Act requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide 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 final rule includes details on the content and format of the SBC as well as details about the notice of modifications that must be sent to enrollees and policyholders informing them of any significant changes in coverage that will occur in the middle of a plan year. In conjunction with the final rule, the agencies have issued a template for the SBC instructions, sample SBC language, examples of calculations, and a glossary of terms commonly used in health care coverage.

Delivery of the SBC

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. An SBC need not be provided for plans, policies, or benefit packages that constitute HIPAA excepted benefits, such as stand-alone dental or vision plans or certain health Flexible Spending Arrangements (FSAs). The preamble to the final rule explains that Health Savings Accounts (HSAs) generally are not group health plans and thus generally are not subject to the SBC requirements. Nevertheless, an SBC prepared for a high-deductible health plan associated with an HSA may mention the effects of employer contributions to HSAs on the SBC which will show the deductibles, copayments, coinsurance, and benefits otherwise not covered by the high-deductible health plan.

In the case of a self-insured group health plan, the plan administrator is responsible for providing

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the SBC to participants and beneficiaries. For insured group health plans, either the group health plan or the issuer may deliver the SBC to enrollees. To avoid unnecessary duplication with respect to group health plans, 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. As in the proposed rule, the final rule allows 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 than 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.
- Special Enrollment: The proposed rule would have required a plan or issuer to provide the SBC to a HIPAA special enrollee within seven days of a request for enrollment. Under the final regulations, special enrollees must be provided the SBC no later than when a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.
- Renewal: If written application is required for renewal (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. However, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier. 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. The final rule extends the time to provide the SBC from within seven calendar days of the request to seven business days.
- Upon Request: The plan or issuer must also provide the SBC within seven *business*, instead of calendar, days of a request by a participant or beneficiary for the summary.

The final rule describes a group health insurance issuer's obligation to provide an SBC to a 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 business 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. However, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.
- Upon Request: The issuer must provide the SBC to the plan within seven business days of a request.

Expatriate Plans

The final rule includes a special provision that provides that 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) to allow participants to obtain information about benefits and coverage provided outside of the U.S. To the extent the plan or policy provides coverage available within the United States, however, the plan or issuer is required to provide an SBC for coverage offered within the U.S.

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Content

Generally, the SBCs will be required to summarize, in plain language, key features of the plan or coverage, including covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

The final rule follows the requirements set forth in the statute, which states that an SBC must include all of the following information:

- 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.
- A contact number to call with questions and an Internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

The final rule also includes three additional elements for the SBC: (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 as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available. Unlike the proposed rule, the final rule *does not* require the SBC to include premium or cost of coverage information. As stated in the preamble, "the Departments believe that premium information can be more efficiently and effectively provided by means other than the SBC."

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 final rule requires only two, instead of three, coverage examples in the first year of applicability. These coverage examples will set forth the degree of coverage and costs associated with having a baby (normal delivery) and managing Type II diabetes. Additional coverage examples will be added in later years. The Departments explain that reducing the number of coverage examples in the first year should lessen the administrative burden on the regulated community.

Appearance and Format

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

Unlike in the proposed regulations, the final rule does not mandate that the SBC for a group health plan be a standalone document. Although plans or issuers may provide the SBC as a separate document, they are permitted under the rule to provide it in combination with other summary materials, such as a summary plan description (SPD), so long as the SBC information is "intact and prominently displayed at the beginning of the materials," such as after the table of contents in an SPD. SBCs issued pursuant to a plan in the individual market, however,

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must be provided as a standalone document. Details about the form, content, sample language, uniform glossary, and related items are set forth in the guidance document published along with the final rule.

To facilitate faster and less burdensome disclosure of the SBC, the final regulations set forth rules to facilitate electronic transmittal of the SBC. Specifically, an SBC provided by a plan or issuer to a participant or beneficiary may be provided in paper form. As an alternative to providing the SBC in paper form, the SBC may be provided electronically to participants and beneficiaries if the requirements of the Department of Labor's electronic disclosure safe harbor are met. With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if: (1) the format is readily accessible; (2) the SBC is provided in paper form free of charge upon request; and (3) in a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provides the Internet address, and notifies the individual that the documents are available in paper form upon request.

Language

The SBC must be presented in a "culturally and linguistically appropriate manner." The final 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 Affordable Care Act internal appeals process.

Prior Notice of Mid-Year Material Modifications

Plan modifications may result in a requirement for an employer to issue an off-cycle SBC. If a group health plan, or health insurance issuer offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. 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.

The preamble to the proposed rule stated that the notice of mid-year material modifications could be satisfied either by a separate notice describing the material modification or by providing an updated SBC. The final rule retains this flexibility allowing plans and issuers to either provide an updated SBC reflecting the modifications or provide a separate notice describing the material modifications.

Template and Uniform Glossary of Terms

Group health plans and issuers must make a uniform glossary of health coverage related terms available to participants and beneficiaries upon request within seven business 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 Affordable Care Act 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 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 coinsurance; 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.

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.

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Effective Date

The Affordable Care Act mandated that plans and issuers comply with the SBC requirement 24 months after enactment of the Act – March 23, 2012. The final rule provides for a delayed effective date described below.

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 requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012.

Even with a delayed effective date, plans and issuers are left with little time to comply with the SBC requirements in accord with the final rule. Compliance with these disclosure requirements will impose new administrative burdens and costs on plans and issuers. The materials and information in the guidance document are to be used for the first year of applicability only. The agencies state that they will issue updated materials next year. Therefore, plans and issuers should recognize that these requirements are likely to evolve over time as the regulations, guidance and templates change.

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[1] 77 Fed. Reg. 8668 (Feb. 14, 2012).

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