Proskauer

Health Care Reform: Guidance Released on Uniform Summary of Benefits and Coverage

August 23, 2011

On August 18, 2011, the Departments of Labor, Health and Human Services, and the Treasury released proposed regulations that provide standards for use by group health plans and health insurance carriers in compiling and providing a summary of benefits and coverage (SBC) and a uniform glossary of commonly used health insurance and medical terms, as required by the Affordable Care Act. The Departments also released templates, instructions, and related materials to assist with development of the SBC and disclosure of the uniform glossary. The proposed regulations were published yesterday in the August 22, 2011 *Federal Register*.

As described below, the Affordable Care Act directs group health plans (including grandfathered plans) and health insurance carriers to comply with the SBC and uniform glossary requirements starting March 23, 2012.

These new rules and standards are designed to enable plan participants to "easily understand their health coverage and determine the best health insurance options for themselves and their families." To that end, the SBC must be presented as a stand-alone document, 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. The SBC is accompanied by the four page uniform glossary of health insurance and medical terms, which also will be available on the government websites www.healthcare.gov and www.dol.gov/ebsa/healthreform/.

For fully insured plans, health insurance carriers are responsible for developing the SBC. For self-insured plans, the plan sponsor (or designated administrator) is responsible for developing the SBC. Although the SBC requirement applies jointly to group health plans and health insurance carriers, to avoid duplication of efforts both parties will satisfy the requirement if either party provides a timely and otherwise compliant SBC.

Failure to comply with the SBC requirement can result in significant penalties: a group health plan or health insurance carrier that willfully fails to provide an SBC is subject to a fine of not more than $1,000 per offense; however, each failure with respect to a participant or beneficiary constitutes a separate offense. Additional excise tax penalties and reporting obligations (i.e., Form 8928) may also apply.

PROVIDING THE SBC (CARRIER TO PLAN SPONSOR)

Effective March 23, 2012, health insurance carriers are required to provide an SBC to the plan sponsor upon application or request for information. The SBC must be provided as soon as practicable following the request, but in no event later than seven days. A carrier also must provide a new SBC to the plan sponsor each year when the policy is renewed (if renewal is automatic, the SBC must be provided at least 30 days prior to renewal). The Departments seek comments on whether, in the event that the only change to the SBC is a final premium quote, premium information can be provided in another way that is easily understandable and useful to plan sponsors and individuals, other than by sending a new, full SBC.

The proposed regulations also contemplate that changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the recommended disclosures. Plan sponsors of self-funded plans also may need to modify the template, as the preamble to the regulations indicates that the SBC template and related documents were drafted primarily for use by health insurance carriers.

PROVIDING THE SBC (PLAN TO PARTICIPANTS)

Effective March 23, 2012, an SBC must be provided by the plan or carrier at the following times and under the following circumstances:

- A group health plan or health insurance carrier must provide an SBC to:
    - participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request;
    - special enrollees within seven days of a request for enrollment pursuant to a special enrollment right under HIPAA; and

- a participant or beneficiary with respect to each benefit option for which the participant or beneficiary is eligible no later than the first date the participant is eligible to enroll (or with any written application materials distributed prior to enrollment).

  However, upon renewal, an SBC need only be provided for the benefit option in which a participant is enrolled (unless SBCs for other options are requested). If there is any change to the information required to be in the SBC before the first day of coverage, the plan or carrier must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

- A group health plan or health insurance carrier also must provide participants with a new SBC each year when the policy is renewed (if renewal is automatic, the SBC must be provided at least 30 days prior to renewal).

The SBC requirement is satisfied if a single SBC is provided to a participant and beneficiary known to reside at the same address. The SBC requirement may be satisfied electronically, provided the distribution complies with ERISA's electronic disclosure rules.

If a material modification is made to the terms of the plan (other than in connection with a renewal of coverage – e.g., mid-year) that would affect the content of the SBC, and such modification is not reflected in the most recently provided SBC, then the plan or carrier must provide notice of the modification to enrollees not later than 60 days prior to the date on which such modification will become effective. This means that plan sponsors will not be required to distribute a new SBC 60 days in advance of changes made in connection with the renewal (although SBCs must continue to be provided as described above).

CULTURALLY AND LINGUISTICALLY APPROPRIATE

The Affordable Care Act requires that the SBC be presented in a culturally and linguistically appropriate manner and utilize terminology understandable by the average plan enrollee. Under this requirement, a plan must provide the SBC in a non-English language upon request if, with respect to the participant's home address, ten percent or more of the population residing in the county is literate only in the same non-English language, as determined by guidance published by the Departments. We note that this standard is different from, and will be more difficult to administer than, the standard applicable to summary plan descriptions and other ERISA documents.

English language versions of the SBC must include a statement prominently displayed in an applicable non-English language clearly indicating how to access any language services provided by the plan or carrier.

CONTENT OF THE SBC

The SBC must include the following:

> (A) 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;
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> (B) A description of the coverage, including cost-sharing, for each category of benefits identified by the Departments in the guidance;
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> (C) The exceptions, reductions, and limitations of the coverage;
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> (D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
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> (E) The renewability and continuation of coverage provisions;
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> (F) Coverage examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost-sharing based on recognized clinical practice guidelines;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides “minimum essential coverage” and whether the plan’s share of the total allowed costs of benefits provided under the plan meets applicable requirements;

(H) 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;

(I) Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance);

(J) For plans and carriers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(K) For plans and carriers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage;

(L) An Internet address for obtaining the uniform glossary; and

(M) Premiums (or in the case of a self-funded group health plan, cost of coverage).

The SBC must include coverage examples that illustrate benefits provided under the plan for common benefits scenarios (including pregnancy and serious or chronic medical conditions). The Departments may identify up to six coverage examples that may be required in an SBC.

The examples will be hypothetical situations, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines. Future guidance will specify the types of services, dates of service, applicable billing codes, and allowed charges for each claim in the benefits scenario.

NEXT STEPS

Sponsors of fully insured group health plans should check with their insurance carriers and prepare to begin distributing SBCs in accordance with the requirements described above starting March 23, 2012 (note that an immediate complete distribution of SBCs is not required). Also, because an insurance carrier generally satisfies its obligations by providing the form to the plan sponsor, sponsors should confirm with the carrier whether it is delivering the notice directly to participants.

Sponsors of self-funded group health plans should consult with benefits counsel and their plan administrators to develop an SBC that meets the content requirements described above. Also, considering that the SBC was designed primarily for use by health insurance carriers, plan sponsors may need to modify the template to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the recommended disclosures.

To view the proposed template for the summary of benefits and coverage, visit www.healthcare.gov/news/factsheets/labels08172011b.pdf.

Please contact your Proskauer attorney or any member of our Health Care Reform Task Force should you have questions regarding this or any other aspect of health care reform.