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Health Care Reform: Additional Guidance on the Summary of Benefits and Coverage

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The Departments of Labor, Health and Human Services and Treasury (the "Departments") recently released the ninth in their series of answers to frequently asked questions on implementation issues associated with the Affordable Care Act. The recent FAQ provides clarification on the summary of benefits and coverage ("SBC"), which is required to be provided by group health plans and health insurers starting with the first open enrollment or plan year beginning on or after September 23, 2012.

The Affordable Care Act's SBC rules are generally designed to create a standardized written description of health insurance policies and coverage so that participants and consumers can better understand their health coverage and evaluate it in comparison to other health insurance options in the market. To this end, the SBC must be provided in a consistent four-double-sided-page format with 12-point font. It must also be written in a "culturally and linguistically" appropriate manner and use language that is understandable to the average plan participant and beneficiary. The SBC must address a total of 12 specific required content elements (e.g., descriptions of coverage, cost sharing, limitations or restrictions of coverage, renewability and continuation of coverage provisions, a coverage facts label that includes examples of coverage and related cost sharing, a disclosure statement regarding whether the plan provides minimum essential coverage, etc.) and be provided free of charge.

What plans are subject to the SBC requirement?

The SBC rules apply to all fully insured and self-insured health plans including certain health flexible spending arrangements (FSAs) and stand alone health reimbursement arrangements (HRAs), regardless of grandfathered status. The SBC rules do not apply to health savings accounts (HSAs) or HIPAA-excepted benefits, which include "retiree-only" plans, stand-alone dental or vision plans, and most FSAs.[1] If an HRA is integrated with other major medical coverage, then it does not have to separately satisfy the SBC rules; the effects of employer allocations to an HRA account can be denoted in the SBC for the other major medical plan. Although an HSA is not subject to the SBC rules, an SBC prepared for a high deductible health plan associated with an HSA can mention the effects of the employer contributions to such an HSA.

When are the SBC rules effective?

For participants and beneficiaries who enroll (or re-enroll) at open enrollment, the SBC requirement is effective starting with the first day of open enrollment beginning on or after September 23, 2012. For participants who enroll other than through open enrollment (including newly eligible participants or those subject to a special enrollment opportunity), the requirement to provide an SBC starts on the first day of the plan year beginning on or after September 23, 2012.

Which participants in a group health plan must receive an SBC?

An SBC must be provided to each participant or beneficiary who is enrolled in a group health plan. However, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form), unless the plan or insurer has knowledge of a separate address for a beneficiary (e.g., a spouse or adult dependent).

May the SBC be delivered electronically?

Yes, the rules permit plans to electronically deliver the SBC to participants and beneficiaries in accordance with ERISA's electronic disclosure requirements with one modification. In this regard, a distinction is made between a participant or beneficiary who is already covered under the group health plan, and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan. With regard to the latter group, plans may send a paper postcard electronically or through regular mail to provide instructions for assessing the SBC online, provided the format is readily accessible through an internet posting and a paper copy is provided free of charge upon request.

The FAQs add an additional safe harbor, under which SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. Note that these rules differ from ERISA's electronic disclosure requirements, so consideration should be given if the SBC is intended to suffice as a summary of material modification (SMM) under ERISA. In other words, if a plan chooses to communicate material modifications via the SBC, their distribution must comply with ERISA's electronic disclosure requirements or a separate SMM may be required.

As noted above, plans may provide the SBC to an employee on behalf of a beneficiary, and may do so electronically, unless the plan has knowledge of a separate address for the beneficiary.

When must an SBC be provided to participants in a group health plan?

- **Upon application**. If a plan distributes an enrollment application, the SBC must be provided as part of those materials. If the plan does not distribute an enrollment application, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage.
- **Within 90 days of a "special enrollment"**. An SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided, which is 90 days from enrollment.
- **Upon renewal**. If a plan requires participants to affirmatively elect to maintain coverage during open enrollment, or provides them with the opportunity to change coverage options during open enrollment, the plan must provide the SBC at the same time it distributes open enrollment material. If elections automatically renew

and there is no opportunity to change coverage options, the SBC must be provided no later than 30 days prior to the first day of the new plan year (or, if coverage has not yet been renewed, as soon as practicable but in no event later than seven business days after issuance of the new insurance contract, or upon confirmation of intent to renew, whichever is earlier).

- **Upon request**. The SBC must be provided as soon as practicable to participants and beneficiaries upon their request, and in no event later than seven business days from the date of such request.

Who is responsible for developing the SBC?

For fully insured plans, health insurers are responsible for developing the SBC. For self-insured plans, the plan sponsor (or designated administrator) is responsible for developing the SBC. A plan administrator that uses two or more insurers or service providers with respect to a single group health plan may synthesize the information into a single SBC, or may contract with one of its insurers or service providers to perform that function.

What is the penalty for failure to provide an SBC?

A group health plan or insurer that willfully fails to provide an SBC is subject to a fine of not more than $1,000 per enrollee (or beneficiary if they reside at a known address that is different than the participant) per failure.

The FAQs clarify that the Departments' basic approach to implementation of the Affordable Care Act is to assist (rather than impose penalties on) plans that are working diligently and in good faith to understand and come into compliance with the new law. Accordingly, during this first year of applicability, the Departments will not impose penalties on plans that are working diligently and in good faith to comply. Informal discussions with the Department of Labor have confirmed this approach.

Must plans provide advance notice of changes?

Plans must notify participants no later than 60 days prior to the effective date of any material modification that would affect the content of the most recently provided SBC, unless the change is made in connection with a renewal or reissuance of coverage. This is a change from the rules under ERISA, which provide that notice of a material reduction in group health plan benefits must be communicated to participants within 60 days of being adopted by the plan, and that a material modification (other than a reduction) be communicated within 210 days after the end of the plan year in which the change is adopted.

Must the SBC be provided on a stand-alone basis?

The SBC may be provided as either a stand-alone document or in combination with other documents, as long as the SBC is prominently displayed at the beginning of such other documents.

How should the SBC be drafted if the plan design does not fit the SBC template?

The SBC instructions provide that to the extent a required SBC element cannot be reasonably described consistent with the template and the instructions, the plan is required to accurately describe the plan's terms while using its best efforts in a manner that is still consistent with the instructions and template.

What is the foreign language requirement?

Plans must include, in the English versions of SBCs sent to an address in a county in which 10% or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or insurer. Sample language is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc. Current county-by-county data can be accessed at http://www.cciio.cms.gov/resources/factsheets/clas-data.html. A plan can voluntarily include the statement in the SBC for use in counties that do not meet the 10% non-English language threshold.

Are group health plans primarily for expatriates required to provide an SBC?

Yes, although in lieu of providing an SBC, a plan may provide an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. The Departments will not take any enforcement action against a plan for failing to provide an SBC with respect to expatriate coverage during the first year that the rules apply. Note that to the extent coverage or benefits are available within the United States, the plan is still required to provide a compliant SBC.

Next Steps

Sponsors of fully insured group health plans should check with their insurance carriers and prepare to begin distributing SBC's in accordance with the requirements described above starting with the first open enrollment or plan year beginning on or after September 23, 2012. Also, since 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 with ample time to distribute it by the applicable compliance deadline. Also, considering that 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.

The templates and related materials are accessible via hyperlink from www.dol.gov/ebsa/healthreform. The Departments posted versions of the SBC template and sample completed SBC that were updated as of May 11, 2012, which replace the prior versions issued contemporaneously with the final regulations that were released in February 2012.

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

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[1] HIPAA-excepted benefits include, but are not limited to, certain limited-scope dental or vision benefits, coverage for on-site medical clinics, certain benefits for long-term care and certain accident benefits. In addition, benefits provided under a health flexible spending account (FSA) are HIPAA-excepted benefits to the extent that: (i) the maximum benefit payable for the employee under the health FSA for a plan year does not exceed two times the employee's salary reduction election (or, if greater, the amount of the employee's salary reduction election, plus $500); (ii) the employee has other coverage available under a group health plan of the employer for the year; and (iii) the other coverage is not limited to benefits that are excepted benefits. A "retiree-only" health plan is HIPAA-excepted if it has less than 2 participants who are current employees on the first day of the plan year.