Executive Compensation
& Benefits

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Health Care Reform: Relief for Employers on Summary of Benefits and Coverage

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The Departments of Labor, Health and Human Services and Treasury (the "Departments") have issued administrative guidance giving group health plans a one-year period of relief from enforcement penalties for the failure to provide a complete or timely Summary of Benefits and Coverage ("Summary"). The Departments have also extended temporary relief to group health plans that have delegated the responsibility to provide the Summary to another entity, such as a third-party administrator. In light of this guidance, employers that maintain group health plans are advised to review their vendor contracts to clarify who is responsible for providing information for the Summary, drafting it and distributing it to participants.

On March 19, 2012, the Departments issued a set of 24 frequently asked questions ("FAQs") relating to the obligation of group health plans and health insurance issuers[1] to provide participants with a four-page summary of the benefits available under each of their health care options. The FAQs supplement the final regulations on Summaries issued under the Patient Protection and Affordable Care Act of 2010 ("PPACA") on February 14, 2012.

The FAQs provide that the Departments will not impose penalties on plans that are working diligently and in good faith to provide Summaries with the required content and in an appearance that is consistent with the final regulations. The FAQs also provide that, until further guidance is issued, a plan that has assigned the obligation to provide the Summary to another party will generally not be subject to any enforcement action for failing to provide a timely or complete Summary, if the plan:

- Has entered into a binding contract under which the other party has assumed the responsibility for completing the Summary, providing information to complete the Summary or delivering the Summary;

[1] This advisory focuses on requirements that apply to group health plans. Disclosure requirements that apply to a group health plan effectively apply to that plan's fiduciary. For simplicity, we have assumed in this Alert that the fiduciary is the employer that maintains the plan.

- Monitors performance under the contract;
- Corrects any violation of the regulations, if the plan has knowledge of the violation and information to correct it; and
- Communicates with participants regarding a violation, if the plan does not have the information to correct it, and begins taking significant steps as soon as practicable to avoid future violations.

This relief is significant. But for the relief, employers would be subject to a penalty of $1,000 per participant for any willful failure to provide the required information. In addition, an excise tax of $100 perparticipant per day would apply.

Final Regulations

The final regulations delayed the deadline for providing the initial Summaries to the first open enrollment period that begins on or after September 23, 2012, but otherwise made only limited changes to the proposed regulations. (See our advisory on the proposed regulations, dated September 8, 2011 at http://www.pillsburylaw.com/siteFiles/Publications/ECBAdvisory09082011.pdf.)

Who must provide the Summary?

The final regulations clarified that group health plans will be treated as having satisfied their disclosure obligations if the Summary is provided by a third party, as long as all timing and content requirements are satisfied.

What information must be covered?

Summaries issued in 2012 and 2013 must include the following information:

- A description of coverage for each category of benefits;
- Exceptions, reductions and limitations on coverage;
- Cost-sharing provisions, including deductibles, coinsurance and copayment obligations (but not premiums or cost of coverage);
- Renewability and continuation of coverage;
- Coverage examples for normal childbirth and Type 2 diabetes;
- Contact information and web addresses; and
- A uniform glossary of standard insurance terms.

The purpose of the Summary is to allow employees to compare different options. In the interest of achieving “maximum uniformity” and certainty, the Departments have released a glossary of insurance terms available at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf. and a template Summary available at www.dol.gov/ebsa/pdf/SBCtemplate.pdf, which they have stated is not expected to change significantly when health care reform is fully implemented in 2014. Information for different coverage tiers (such as self-only coverage or family coverage) may be combined on the same Summary. However, if the group health plan’s terms do not reasonably correspond to the template (for example, if a portion of health care costs are covered by a health reimbursement arrangement, health flexible spending account or wellness program), the Summary should be presented in a manner that is as consistent with the instructions as possible. If an employer offers more than one benefit package (for example, an HMO and a PPO), then coverage information for each benefit package must be provided on separate Summaries.

What foreign language requirements apply?

If a Summary is sent to an address in a county in which 10 percent or more of the population is literate only in a non-English language, the plan must provide oral language services in the non-English language, provide the Summary upon request in the non-English language and include in all English versions of the Summary a statement in the non-English language indicating how to access the language services provided by the plan. Current county-by-county literacy data is available at http://www.ciio.cms.gov/resources/factsheets/clas-data.html.

When must the Summary be provided to participants?

Upon enrollment

- **Initial Enrollment**. Employees who become eligible to enroll in a group health plan must receive the Summary as part of any written enrollment materials that are distributed. Otherwise, the Summary must be provided by the first day on which the employee is eligible to enroll in the plan. If there is any change to the information disclosed in the Summary, an updated Summary must be provided by the first day of coverage.

- **Special Enrollment**. Employees who become eligible to enroll in a plan mid-year under a special enrollment right (for example, if the employee loses other health coverage) must be provided the Summary within 90 days after enrollment.

- **Renewal**: If participants must elect to re-enroll in the plan each year, the Summary must be provided no later than the date on which the written enrollment materials are provided. If participants are automatically re-enrolled, the Summary for the participant's benefit package must be provided at least 30 days before the first day of the new plan year (or as soon as practicable, but no later than 7 business days, after issuance of the new insurance policy or confirmation of intent to renew, if the policy was not issued or renewed during the 30-day period).

Upon request. The Summary must be provided within 7 business days following receipt of a request, including a request by a current participant for information on other benefit packages.

Prior to a material modifications. If the terms of the plan are modified, other than in connection with a renewal or reissuance of coverage, and the change would impact the information that was provided on the most recently distributed Summary, notice of the modification must be provided at least 60 days before the effective date of the change.

How may the Summary be delivered?

The final regulations clarified that the Summary may be provided as a stand-alone document or in combination with other materials (for example, a summary plan description), if the information provided in the Summary is "intact" and prominently displayed at the beginning of the other materials.

The Summary must be provided either in paper form or electronically pursuant to the Department of Labor's regulations on electronic distributions. These regulations include a safe harbor for electronic disclosure to employees who have opted to receive electronic delivery or who have the ability to access electronic documents at their place of employment, if access to the employer's electronic information system is an integral part of their duties. If an eligible employee has not enrolled in the group health plan, the final regulations provide that electronic distribution may also be used if the format is readily accessible, the Summary is provided without charge in paper form upon request, and the employee is timely notified (in paper or by email) how to obtain access to the Summary, if it is posted on the Internet.

The Departments have indicated that they will not entertain further requests to extend the deadline for providing Summaries or offer exemptions to particular employers from the duty to comply. For this reason, we recommend that all employers with group health benefits begin compiling the information that will be required to comply with the new requirements in September and review their vendor contracts to determine what contractual obligations their service providers may have to draft and distribute these communications. The new administrative requirements and heightened compliance standards put into place by PPACA make it worthwhile for employers to confirm that their vendor contracts continue to offer them adequate protection.

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