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Health Care Reform Update: Employer Sponsored Group Health Plans Must Provide New Summary of Benefits and Coverage

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On August 22, the Departments of the Treasury, Labor, and Health and Human Services (the "Agencies") published long-awaited proposed regulations on the new Summary of Benefits and Coverage ("SBC") that all group health plans (including grandfathered plans) will be required to distribute, effective March 23, 2012. Plan administrators must deliver this four-page (front and back) SBC to plan participants in addition to already-required disclosures such as the summary plan description. These proposed regulations provide standards that will govern the SBC, including who provides and receives the SBC, when the SBC must be provided, and how the SBC must be formatted and distributed. This client alert summarizes the proposed requirements for sponsors of group health plans. Plan administrators and insurance providers of group health plans should review these requirements now to prepare for timely provision of the SBC.

The Patient Protection and Affordable Care Act of 2010 ("PPACA") requires that all group health plans (and their insurance providers) must distribute an SBC to applicants, participants, and beneficiaries that accurately describes the benefits and coverage available under the plan. This mandate is in alignment with the current administration's goal of making healthcare choices easier for consumers by providing better access to information comparing the most important features of available healthcare options. The proposed regulations develop the standards for how, when, and to whom the SBC will be provided.[1] In addi-

[1] To view the proposed regulations see http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf.

tion, the Agencies simultaneously published an SBC draft template and sample language, instructions for completing the SBC, and the uniform glossary of terms that must be made available with the SBC.[2]

The SBC requirement is statutorily effective March 23, 2012. Unless this effective date is extended in the final regulations, the SBC requirement will apply to all enrollments (including annual and special enrollments) and requests for the SBC that occur as of March 23, 2012.

Summary of SBC Requirements[3]

Who must provide the SBC?

- **Insured Plans:** Both the plan administrator and the insurance provider have the obligation to provide the SBC. However, if one of the parties timely provides the SBC, the other party may rely on that distribution as satisfying its own obligation to provide the SBC. Plan administrators should coordinate with their insurance providers on distributing the SBC because: (1) the plan administrator may not avoid liability by agreeing, in writing, that the insurance provider will timely provide the SBC, and (2) the insurance provider may not have all of the information needed to timely provide the SBC to all appropriate individuals.

- **Self-Insured Plans:** The plan administrator has the sole obligation to provide the SBC.

What information must be covered in the SBC?

An SBC must be prepared and provided to eligible individuals for each "benefit package" offer by the plan (i.e., each coverage arrangement offered by the plan with different benefits or cost-sharing obligations). Every SBC must include the following:

- 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 Agencies;

- The exceptions, reductions and limitations on coverage;

- The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

- The renewability and continuation of coverage provisions;

- 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 the applicable requirements (Note: this information is not required until on or after January 1, 2014);

[2] To view the SBC template, uniform glossary and related materials see http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21192.pdf. Note, the draft template, uniform glossary, and related materials were prepared by the National Association of Insurance Commissioners and proposed by the Agencies without change. Accordingly, these materials were drafted primarily for use by insured health plans. The Agencies have requested comments on how to modify these materials for other types of health plans, such as self-insured plans.

[3] The SBC requirements also apply to insurance providers providing group and individual health coverage, however, this client alert focuses on the SBC requirements as they apply to plan administrators of group health plans.

- 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;
- Premiums (or the cost of coverage for self-insured group health plans);
- A contact number to call with questions; and
- Internet addresses for obtaining the following:
  - a copy of the group certificate of coverage;
  - a list of network providers (for plans and insurance providers that maintain one or more networks of providers);
  - information about the prescription drug coverage under the plan or coverage (for plans and insurance providers that maintain a prescription drug formulary); and
  - the uniform glossary.[4]

In addition, the SBC must include "coverage examples" for up to six common benefit scenarios that are adopted by the Department of Health and Human Services. The coverage examples are meant to estimate the proportion of expenses for the adopted benefit scenarios that would be covered by a particular health plan or policy. The proposed regulations currently require that the plan provide these coverage examples for the following scenarios: a normal childbirth, breast cancer treatment, and diabetes management. The template SBC includes a template for providing the coverage examples.

What are the format requirements for the SBC?

The SBC must be a stand-alone document of no more than four double-sided pages and no less than 12-point font. The SBC may be printed in color or black and white. The Agencies did solicit comments on whether a plan or insurance provider should be permitted to provide the SBC in the summary plan description or with other plan materials. The SBC may be provided in paper form or delivered electronically, if certain requirements are met (see below).

Who must receive the SBC?

The SBC must be provided to all "participants" and "beneficiaries" of a group health plan. Plan administrators should be aware that for purposes of distributing the SBC, the term "participant" includes any individual who is eligible to enroll in the health plan, even if that individual declines to do so.

The proposed regulations note that one SBC may be sent to an address for all individuals to whom the SBC must be sent reside. However, if a beneficiary's address is different than the eligible employee's address, a separate SBC must be provided to the beneficiary at his or her last known address.

[4] The uniform glossary was prepared by the National Association of Insurance Commissioners and was published with the supplemental materials. It includes "consumer-friendly" definitions for widely used healthcare terminology and it cannot be modified by the group health plan. Plans must make the glossary available to individuals upon request.

When must the SBC be provided to participants and beneficiaries?

In general, the SBC must be provided to a participant or a beneficiary of a group health plan as follows:

Upon Enrollment:

- **Initial Enrollment:** Individuals who first become eligible to enroll in the plan on or after March 23, 2012, must receive the SBC along with any written enrollment materials that are distributed as part of the initial enrollment process. If enrollment materials are not generally distributed, the SBC must be distributed by the first day the individual is eligible to enroll in the plan. In addition, the SBC for each benefit package that the individual is eligible to enroll in must be provided.

- **Special Enrollment:** Individuals who enroll in a plan mid-year under a special enrollment must receive the SBC within 7 days of requesting to enroll in the plan. Again, the SBC for each benefit package the individual is eligible to enroll in must be provided.

- **Annual Enrollment/Renewal:** The SBC must be provided to each plan participant as part of the annual enrollment process. If plan participants must affirmatively enroll in the plan each year, the SBC must be provided with the annual enrollment materials. If participants are automatically enrolled each year based on their current-year elections (i.e., passive enrollment), the SBC for their current benefit package only must be provided no later than 30 days before the start of the new plan year (SBCs for other benefit packages must be provided upon request).

Upon Request: The SBC must be provided to an eligible individual no later than 7 days following a request for that SBC.

Material Modifications: If the terms of the plan are modified other than in connection with the annual renewal process, and such change would impact the information that was provided on the most recently distributed SBC, notice of the modification must be provided at least 60 days **before** the effective date of the change. This can take the form of a separate notice describing the specific modification or an updated SBC.

Note: The requirement to provide an updated SBC is different than a plan's requirement to provide participants with a Summary of Material Modification ("SMM") under ERISA. An SMM only needs to be provided within 210 days after the close of the plan year in which the change is adopted and may include notification of changes to plan terms that are not described in the SBC. This means that while not all changes to a plan will require an updated SBC, for those that do, an updated SBC must be provided to participants in advance of the effective date of the change.

How can the SBC be delivered?

Electronic Delivery. The SBC may be provided to a participant or beneficiary in paper form. Alternatively, the SBC may be provided to a participant or beneficiary in electronic form, provided certain requirements are met. The SBC may be delivered electronically only if the delivery complies with the Department of Labor's electronic disclosure safe harbor rules under 29 C.F.R. Section 2520.104b-1(c). Nonfederal government plans may comply with either the safe harbor rules or the electronic delivery requirements under the proposed regulations for individual coverage.

Non-English Language Versions. The SBC must be provided in a "culturally and linguistically appropriate manner." The proposed regulations provide that this requirement is met if the general claims and appeals rules under PPACA for when communications must be provided in a language other than English

are followed. In general this means that a statement about the availability of interpretive services and written translations must be included in certain non-English languages for SBCs provided to participants and beneficiaries in counties identified by the U.S. Census Bureau as having a particular threshold of non-English speakers.

What is the penalty for failing to provide the SBC?

Willful failure to comply with the SBC requirements can subject the health plan or insurance provider to a fine of up to $1,000 for each failure to distribute an SBC. Under the proposed regulations, each failure to distribute the SBC to a participant or beneficiary of the plan is considered a separate offense. The Department of Labor has indicated it will issue separate regulations regarding the penalty for noncompliance with the SBC requirements. Each failure to distribute the SBC is also subject to an excise tax of $100 per day under the Internal Revenue Code Section 4980D reporting requirements for group health plans (other than governmental plans).

Request for Comments by October 21, 2011

The Agencies have requested comments on the proposed regulations, draft SBC template, and related materials by October 21, 2011.

In particular, the Agencies have requested comments on the factors that may impact the feasibility of the current statutory effective date for providing the SBC by March 23, 2012. In light of the Agencies' delay in publishing the proposed regulations and the request for comments before the regulations will be finalized, there may not be much time between the release of final regulations and the effective date of the regulations, unless the effective date is extended. If the effective date remains March 23, 2012, the SBC requirements will apply to all enrollments (including annual and special enrollments) and requests for the SBC that occur as of that date. The requirements set forth in the proposed regulations will likely have a significant impact on a plan's enrollment materials and their distribution. Insurance providers and sponsors of group health plans should begin reviewing these requirements now.

If you have any questions about the content of this publication, please contact the Pillsbury attorney with whom you regularly work or the Executive Compensation & Benefits group.

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