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Alert

Final Rule on Summary of Benefits and Coverage

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Earlier this year, the Departments of Treasury, Labor and Health and Human Services ("HHS") (collectively, the "Departments") issued a final rule regarding the implementation and content requirements of the Summary of Benefits and Coverage ("SBC"), a standardized document that group health plans and health insurance issuers must provide under the Patient Protection and Affordable Care Act ("PPACA") to summarize the benefits and terms of coverage for plan participants and beneficiaries. A separate SBC (and summary plan description) must be prepared for each benefit package offered by the plan or issuer.

Effective Date
For participants and beneficiaries who enroll or re-enroll in coverage through open enrollment, the plan administrator of a self-insured group health plan (or the health insurance issuer for a fully-insured group health plan) must provide the SBC on the first day of the open enrollment period that begins on or after Sept. 23, 2012. For participants and beneficiaries who do not enroll in coverage through open-enrollment (i.e., individuals who enroll during HIPAA special enrollment periods), the SBC must be provided on the first day of the first plan year beginning after Sept. 23, 2012 (Jan. 1, 2013 for calendar year plans).

Background
As a response to the Departments' growing concern that health plan participants and beneficiaries do not understand the terms or value of their health coverage and are unable to compare their coverage options, PPACA requires group health plans and health insurance issuers to provide plan participants and beneficiaries with an easy-to-understand summary of the benefits and coverage offered under their plan, free of charge and in a uniform format. The SBC must be distributed in a timely fashion so that participants and beneficiaries are aware of their coverage options before making a year-long health care commitment.

Form and Content of the SBC
The final rule clarifies exactly what information must be included in the SBC, and in what form. Concurrent with issuing the final rule, the Departments issued materials, including an SBC template complete with instructions and examples and a uniform glossary that defines standard medical and insurance terms, that group health plans and health insurance issuers must use for coverage beginning before Jan. 1, 2014. Because of market reforms that take effect in 2014 and beyond (e.g., the requirement to provide minimum essential coverage and the prohibition of any annual limit), the Departments expect to issue updated materials that take these provisions into consideration in the coming years. If a plan's terms cannot be described in a manner consistent with the template, the plan or issuer must use its best efforts to describe the terms in a manner as consistent as possible with the template's instructions. The SBC cannot exceed four double-sided pages and must be written in at least 12-point font.

For coverage in the individual market, the final rule retains the proposed regulations' requirement that the SBC must be provided as a stand-alone document, though it can be included in a mailing with other plan documents. However, for group health plan coverage, the final rule states that the SBC can be provided as a

stand-alone document or along with other summary materials (for example, a summary plan description) if the SBC is positioned at the beginning of the materials (i.e., right after the SPD's table of contents).

Generally, the SBC must include:

- Uniform definitions of standard insurance and medical terms so that participants and beneficiaries can better understand and compare their health care options. The Departments have prepared a uniform glossary of the relevant terms for this purpose, which includes common terms such as "co-insurance," "deductible," "preferred provider," "hospital outpatient care," "physician services" and "prescription drug coverage." Group health plans and health insurance issuers must provide the uniform glossary within seven (7) business days of a participant's or beneficiary's request, distributed in either paper or electronic form pursuant to the same requirements for distributing the SBC itself.
- A description of the coverage offered under the plan, including any exceptions, reductions or limitations on coverage. This description must also include certain cost-sharing requirements, including deductibles, co-payments and co-insurance. In an answer to a set of Frequently Asked Questions posted on the DOL website, the Departments clarified that group health plans and health insurance issuers are not required to provide a separate SBC for each tier of coverage. Instead, information for different tiers of coverage can be consolidated into one SBC as long as the SBC's appearance is understandable. If the SBC includes information on multiple tiers of coverage, the SBC's coverage examples should be completed using only the cost-sharing information for employee-only coverage, and the SBC should note this assumption.
- A description of the terms governing renewal and continuation of coverage.
- Examples of common benefits scenarios. Pursuant to the template, one example must illustrate normal childbirth and one must illustrate how to manage type II diabetes. Both examples must include the expected cost-sharing for both scenarios.
- An Internet address or other contact information where participants can obtain a list of network providers and/or more information about the plan's or issuer's prescription drug coverage must be provided if the plan or issuer maintains one or more networks of providers and/or a prescription drug formulary.

These content requirements differ slightly from the content requirements of the proposed regulations. For example, the proposed regulations required the SBC to include premium or cost-of-coverage information. After receiving several comments opposing this requirement, the Departments decided that it would be administratively infeasible to require this kind of information when premiums and costs-of-coverage differ based on many factors, including family size and, for multiemployer plans, employer contributions. In addition, the proposed regulations required the SBC to include three coverage examples, but the final rule requires only the two examples described above. Additional information, including other examples, may be required in future SBCs.

Form and Timing of Distribution

Generally, the SBC must be provided upon:

- *An Application for Coverage (and Before Initial Enrollment):* A health insurance issuer must provide an SBC to a group health plan (or individual in the individual market) as soon as practicable following the health insurance issuer's receipt of the group health plan's (or individual's) application for coverage, but in no event later than seven (7) business days after receipt of the application. Similarly, the SBC must be provided along with any written open enrollment materials. If no materials are distributed for open enrollment, the SBC must be provided no later than the first date on which the participant or beneficiary is eligible to enroll in coverage.

  If a change occurs in the information required to be included in the SBC between the time the SBC was first provided and the first day of coverage, the health insurance issuer must provide a revised SBC no later than the first day of coverage.
- *A Participant's, Beneficiary's or Employer's Request:* A health insurance issuer or group health plan must provide an SBC to a participant, beneficiary or employer as soon as practicable, but in no event

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later than seven (7) business days, after receiving the participant's, beneficiary's or employer's request for the document.

- *Renewal or Reissuance:* A health insurance issuer or group health plan must provide a group health plan or individual with an SBC upon renewal or reissuance of the policy or coverage. If written application is required for renewal, the SBC must be provided no later than the date on which the materials for application are distributed. If renewal is automatic, the SBC must be provided no later than 30 days before the first day of the new policy or plan year.

  The final rule contains an exception for fully-insured plans whose terms of coverage are finalized within 30 days of the new policy year. For these plans, because the SBC cannot be provided within the required timeframe, the SBC must be provided as soon as practicable, but in no event later than seven (7) business days after the earlier of the date policy is issued or the date the issuer receives written confirmation of the plan's or individual's intent to renew.

- *Special Enrollment:* Special enrollees must receive an SBC within 90 days from their date of enrollment. Plan administrators will note that this is the same timing requirement that applies to distribution of summary plan descriptions to special enrollees.

The SBC can be provided as a hard copy or electronically, though the form of electronic delivery will depend on whether the participant or beneficiary is already covered under a group health plan or is merely eligible for, but not yet enrolled in, coverage.

Participants and beneficiaries already covered under a group health plan can receive the SBC electronically if the requirements of the Department of Labor's safe harbor for electronic distribution of plan materials are met (e.g., if the plan or issuer takes appropriate measures (i.e., return-receipt) to ensure that participants and beneficiaries actually receive the SBC). These participants and beneficiaries also have the right to request a paper copy of the SBC free of charge.

For participants and beneficiaries who are not yet covered under a group health plan, but are eligible for such coverage, the SBC can still be provided electronically if the electronic form is "readily accessible" (i.e., posted on an internal website) and a paper copy is provided free of charge upon the participant's or beneficiary's request. If the SBC is posted on a website, the health insurance issuer or group health plan must timely notify participants and beneficiaries, in writing (either paper or email), that the documents are available on the website. This writing must also include the address of the website and inform participants and beneficiaries that they can request a paper copy of the SBC free of charge.

Risk of Duplication

For fully-insured group health plans, PPACA requires both the health insurance issuer and the plan to provide an SBC to a participant or beneficiary. Similarly, because PPACA requires each participant and beneficiary to receive a copy of the SBC, participants and beneficiaries residing at the same address covered by the same health plan could receive multiple copies of the same SBC.

The final rule clarifies who must provide the SBC to prevent unnecessary duplication of information. Generally, if either the health insurance issuer or group health plan timely provides the SBC to plan participants and beneficiaries, both the issuer and the health plan will have fulfilled their obligation. The Departments expect plans and issuers to coordinate who will be responsible for providing the SBC. Similarly, one SBC may be provided to a participant and any beneficiary residing at the same address unless the beneficiary's last known address differs from the participant's last known address. In this case, the health insurance issuer or group health plan would be required to provide separate SBCs to both the participant and the beneficiary.

Notice of Modification

Group health plans and health insurance issuers must provide notice of any material modifications made to the terms of coverage if the modifications are not reflected in the most recent SBC. For this purpose, the final rule clarifies that a "material modification": (1) is any change that would affect the information provided in the SBC; (2) is not reflected in the most recent SBC; and (3) occurs independently of a renewal or reissuance of coverage. If a material modification occurs, the notice of modification must be provided to enrolled individuals no later than 60 days before the date on which the change becomes effective.

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Plan administrators will note that this timing requirement differs from ERISA's requirement that a summary of material modifications ("SMM") must generally be provided within 210 days of the close of the plan year in which the change is adopted. To avoid unnecessary duplication, the preamble to the final rule clarifies that if an ERISA-covered plan provides a complete notice of material modification, as required by PPACA, within the 60-day period preceding the effective date of the modification, the plan will be treated as having satisfied its requirement under ERISA to provide a SMM and no additional SMM will be necessary.

Exceptions to the Rule
Though the final rule emphasizes that there is no exception from the SBC requirement for large or self-insured group health plans, SBCs do not have to be provided for stand-alone dental or vision plans. Similarly, an SBC does not have to be provided for health flexible spending accounts ("FSAs") if the benefits offered under the health FSA constitute excepted benefits (i.e., accident-only or disability income coverage). If the benefits offered under a health FSA are not excepted benefits but the health FSA is integrated with other major medical coverage, the final rule clarifies that an SBC can be prepared only for the major medical coverage and the benefits and coverage offered under the health FSA can be noted in the appropriate areas of the major medical SBC.

Penalties
In an answer to a set of Frequently Asked Questions posted on the DOL website, the Departments clarified that they will not impose penalties on group health plans and health insurance issuers during the first year of applicability if the plan or issuer is working "diligently and in good faith" to timely provide the SBC in the form required by the final rule.

After the first year of applicability, if an entity required to provide the SBC (i.e., the plan sponsor or other designated administrator of a group health plan or health insurance issuer) willfully fails to provide the SBC, under PPACA the entity will be subject to a fine not to exceed $1,000 per failure. A separate fine may be imposed on the entity for each individual or employer who does not receive the appropriate SBC.

The Department of Labor expects to issue regulations in the future that provide for civil penalties should a plan or issuer fail to comply with the SBC requirements. In addition, under Section 4980D of the Internal Revenue Code, an excise tax will be imposed on any group health plan that fails to comply with the SBC requirements. The amount of the excise tax is $100 per day per individual for each day that the plan fails to comply with the SBC requirements, though there are exceptions that reduce the amount of the excise tax (for example, if the failure is due to reasonable cause and not willful neglect).

How to Prepare
In order to avoid potentially steep penalties and ensure timely compliance with the SBC requirement, plan administrators of self-insured group health plans should begin to compile the information that must be included in the SBC and begin to consider how they will distribute the SBC to plan participants and beneficiaries. Plan administrators of fully-insured group health plans should revisit their third party administrator agreements with their health insurance issuers and revise as necessary to ensure that the appropriate entity will be providing the SBC.

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If you have questions about the SBC requirement or need help preparing the SBC (or any other plan or participant communication materials) or reviewing and revising a third party administrator agreement, please contact your attorney at Schulte Roth & Zabel or one of the authors.

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