EMPLOYEE BENEFITS

PPACA UPDATE: SUMMARY OF BENEFITS AND COVERAGE

by Cynthia A. Moore
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Group health plans have a new addition to their arsenal of acronyms - the summary of benefits and coverage ("SBC"). The summary of benefits and coverage, a/k/a the uniform explanation of coverage, is a new disclosure requirement added by the Patient Protection and Affordable Care Act ("PPACA") and applies to grandfathered and non-grandfathered group health plans. It is intended to provide a user-friendly basis on which participants can make an "apples to apples" comparison of different health benefit plans.

As background, Section 2715 of the Public Health Service Act, added by PPACA and incorporated by reference into ERISA and the Internal Revenue Code, requires that every group health plan and every health insurance insurer offering group or individual health insurance coverage must provide applicants and enrollees with a 4-page uniform explanation of benefits and coverage. The statute contained a long list of information required to be included in the SBC and directed the Secretaries of Health and Human Services ("HHS"), Treasury and Labor to work with the National Association of Insurance Commissioners ("NAIC") to develop the required form. The initial guidance was to be issued by March 23, 2011, and plans and issuers were required to distribute SBCs beginning on March 23, 2012.

The NAIC convened a working group of a diverse group of stakeholders and, after meeting for a little over a year, submitted its recommended template for the SBC and a uniform glossary of health insurance and medical terms to the Departments on July 29, 2011. The Departments adopted the NAIC's recommendations with one minor change.

The Departments of HHS, Treasury and Labor published proposed regulations and the proposed template with instructions for the SBC on August 22, 2011. The proposed regulations provide guidance on who will provide the SBC; who will receive the SBC; when the SBC will be provided; and how it will be provided.

Who Must Provide the SBC to Participants?

- In the case of an insured plan, the SBC can be issued by the health insurer or by the plan administrator. Although both entities are responsible, the requirement is satisfied if one entity distributes the SBC, if the SBC is timely and complete. The Departments anticipate that the plan sponsor and the insurer will contractually agree as to which entity will distribute the SBC to participants.

- In the case of a self-insured plan, the plan administrator is responsible for distributing the SBC to participants.

Who is Entitled to Receive the SBC?

- In the case of a group health plan, the plan must provide the SBC to each participant or beneficiary of the plan. If the participant and beneficiaries live at the same address, a single SBC delivered to that address will satisfy the delivery requirement. If a beneficiary is known to reside at a different address, an SBC must be delivered to the beneficiary at that address.

When Must the SBC Be Provided?

- *Initial Enrollment*. The SBC must be provided as part of any written application materials that the plan distributes in connection with enrollment (i.e., new hire enrollment kit). If the plan does not use written application materials, the plan or issuer must distribute the SBC no later than the date on which the participant is first eligible to enroll in the plan. If any information changes before the first date of coverage, an updated SBC must be provided to the participant no later than the first day of coverage.

- *Special Enrollment*. If a participant seeks to exercise a special enrollment right, the plan or issuer must provide the SBC within 7 days after a request for special enrollment.

- *Coverage Renewal*. When coverage is renewed, typically at the beginning of each plan year, the SBC must be provided as follows:

  (1) as part of the open enrollment materials, if written application is required (in paper or electronic form); or

  (2) if renewal is automatic, 30 days before the beginning of the new coverage period.

- *Upon Request*. An SBC must be provided to a participant or beneficiary as soon as practicable after request, and in no event later than 7 days following the request.

What is Distributed if a Participant is Eligible for Multiple Benefit Packages?

- *Initial Enrollment*. If a participant is eligible for multiple benefit packages (i.e., a PPO or a high deductible health plan), an SBC must be distributed for each benefit package for which the participant is eligible.

- *Coverage Renewal*. Upon renewal, a plan is required to furnish an SBC only for the benefit package in which the participant is enrolled. However, the plan must promptly furnish an SBC for

other benefit packages upon request. The purpose of this rule is to avoid duplication of information; however, during the open enrollment process, it may be preferable to give participants copies of SBCs for all benefit packages for which they are eligible.

How Must the SBC be Provided?

- The SBC provided by a plan to participants and beneficiaries can be provided in paper form or electronic form, if the DOL's rules on electronic delivery are satisfied.

What is the Content of the SBC?

The SBC must be provided in a uniform format and include a long list of items, including:

- A description of the coverage;
- Cost-sharing provisions;
- Exceptions, reductions and limitations of coverage; and
- Coverage examples.

The SBC can't be longer than 4 pages (double-sided) in 12-point font type. The proposed template for the SBC can be viewed at: www.dol.gov/ebsa/pdf/sbctemplate.pdf.

Can the SBC be Provided as Part of a Summary Plan Description?

The proposed regulations require that the SBC be provided as a standalone document. However, the Departments asked for comments as to whether the SBC could be provided as part of an SPD, if the SBC was intact, prominently displayed at the beginning of the SPD and if the timing requirements for providing the SBC are satisfied.

Is the SBC Template Appropriate for Use With All Types of Plans?

The NAIC developed the template primarily for use by health insurance issuers. Accordingly, it does not reflect features of a self-funded plan (for example, "employee contribution" vs. "premium"). The Departments also note in the preamble that changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs.

May the Plan or Issuer Charge a Participant Who Requests a Copy of the SBC?

No. The SBC must be provided to participants and beneficiaries free of charge.

What is the Uniform Glossary?

A plan or issuer must also make available a uniform glossary of health-coverage-related terms and medical terms. The glossary includes definitions for approximately 40 terms, including balance billing; co-insurance; durable medical equipment; medically necessary; and out-of-pocket limit. The proposed uniform glossary can be viewed at: www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf. The plan or issuer must make the uniform glossary available upon request, in either paper or electronic form (as requested) within 7 days of the request. According to the preamble to the proposed regulations, electronic delivery can be satisfied by providing the individual with an internet address where he or she can access the glossary. This could be the plan's or issuer's website, or the website of the DOL or HHS. A paper copy of the glossary must be provided upon request.

What if Changes are Made to the Content of the SBC?

If the plan or issuer makes any material modification to the health plan that affect the content of the SBC, other than in connection with a renewal of coverage, the plan or issuer must notify participants of the modifications at least 60 days prior to the effective date of the modification. The Departments interpret a material modification as any change that would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage under the plan. A material modification would be an enhancement of covered benefits; a material reduction in covered services or benefits; or a more stringent requirement for the receipt of benefits.

Is There a Penalty for Failing to Provide the SBC, the Uniform Glossary or a Notice of Material Modifications?

Yes. A group health plan or health insurance issuer that willfully fails to provide the SBC, the uniform glossary or a notice of material modifications to a participant or beneficiary is subject to a fine of up to $1,000 for each failure. A failure to deliver to multiple participants is a separate offense as to each such participant.

What is the Effective Date of These Rules?

Consistent with the statute, the proposed regulations are effective on March 23, 2012. However, the Departments requested comments regarding factors that may affect the feasibility of implementation within this time frame, so it is possible that the effective date could be delayed.

What is a Plan Sponsor's Next Steps?

These rules are in proposed form and could change before the effective date. Preliminary action steps include:

- Contact the insurer/TPA to determine if that entity will prepare the SBC or assist in the preparation of the SBC. If the plan is insured, discuss whether the insurer will deliver the SBC on behalf of the plan.

- Monitor the effective date.

- Be prepared to include the SBC in new hire and open enrollment materials.
- Be aware of the 60-day advance notice of material modifications and modify processes if necessary.

If you have questions about the SBC rules or other aspects of PPACA, please feel free to contact:

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