EMPLOYEE BENEFITS

PPACA UPDATE: SUMMARY OF BENEFITS AND COVERAGE FOR A GROUP HEALTH PLAN

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One of the new compliance burdens added by the Patient Protection and Affordable Care Act ("PPACA") is the obligation to furnish participants in a group health plan with a Summary of Benefits and Coverage or "SBC." The Summary of Benefits and Coverage is a 4-page summary of material provisions of a health plan in a uniform format, accompanied by a glossary of health coverage and medical terms.

On February 14, 2012, the Departments of Labor ("DOL"), Treasury and Health and Human Services issued joint final regulations on the obligation to distribute the Summary of Benefits and Coverage and specific guidance on preparing the SBC, including a template and required disclosure language. On March 19, 2012, the Departments also issued a set of frequently asked questions ("FAQs"), further clarifying the SBC rules.

The initial SBC must be distributed to participants and beneficiaries who enroll or re-enroll during an open enrollment period that begins on or after **September 23, 2012**. For newly hired employees and special enrollees who enroll in coverage other than during an open enrollment period, the SBC must be distributed on the first day of the plan year that begins on or after September 23, 2012 (January 1, 2013 for a calendar year plan).

What Types of Plans Must Distribute a Summary of Benefits and Coverage?

The obligation to furnish an SBC applies to a group health plan (whether insured or self-insured) and a health insurance issuer offering group health coverage.

A plan that offers "excepted benefits" is not required to distribute an SBC. This would generally include a standalone dental or vision plan and most health flexible spending arrangements (health FSAs).

The following rules apply to "account" type health plans:

- Disclosures for a health FSA that is not an excepted benefit depend on whether it is integrated with other major medical coverage. If the health FSA is integrated with other major medical coverage, features of the health FSA can be included in the SBC for the major medical coverage. If the health FSA is not integrated with major medical coverage, then it is required to furnish an SBC.
- A health reimbursement account (HRA) is a group health plan and must furnish an SBC.
- A health savings account (HSA) is not a group health plan and is not required to furnish an SBC. However, an SBC for a high deductible health plan can mention the effects of any employer contributions to an HSA that can be used for deductibles, copayments, coinsurance or other services not covered by the high deductible health plan.

When Must a Health Insurance Issuer Provide a Summary of Benefits and Coverage to a Group Health Plan?

A health insurance issuer that offers group health insurance must provide an SBC to the plan or plan sponsor as follows:

- Within 7 business days after receipt of an application for health coverage;
- By the first day of coverage, if there are any changes in the initial SBC;
- If written application for renewal is required, no later than the date the written application materials are distributed;
- If renewal is automatic, at least 30 days before the beginning of the new plan or policy year; and
- Within 7 business days after receipt of a written request from the plan or plan sponsor.

When Must a Health Insurance Issuer or Plan Administrator Distribute a Summary of Benefits and Coverage to Participants and Beneficiaries?

The plan administrator or health insurance issuer must provide an SBC to a participant or beneficiary (including a COBRA qualified beneficiary) with respect to each benefit package for which the participant or beneficiary is eligible as follows:

- As part of the written application or enrollment materials (i.e., new hire enrollment packet). If the plan does not distribute written enrollment materials, the SBC must be distributed no later than the first date on which the participant is eligible to enroll for coverage;
- By the first day of coverage, if there are any changes to the initial SBC;
- Within 90 days from enrollment for any special enrollee. A special enrollee is generally an employee who enrolls mid-year upon the occurrence of a special enrollment event, such as marriage, birth of a child, or loss of other coverage;

- If a participant must actively elect to maintain coverage, or has the opportunity to change coverage options during an annual open enrollment period, an SBC must be distributed as part of the open enrollment materials;
- If renewal of coverage is automatic (i.e., a participant's coverage election is "evergreen"), an SBC must be distributed no later than 30 days before the beginning of the plan or policy year; and
- Within 7 business days after receipt of request by the participant or beneficiary.

Who is Responsible to Provide the Summary of Benefits and Coverage for an Insured Health Plan?

Both the health insurance issuer and the plan administrator of a group health plan are required to furnish an SBC to plan participants. However, this obligation is satisfied if one party furnishes the SBC to participants, as long as it is timely and complete. In any insured arrangement, the parties should specify by contract who will prepare and distribute the SBCs. Further, the non-distributing party should review the form and content of the SBC to make sure that it is accurate; periodically monitor whether SBCs are being timely distributed; and correct any failures as soon as practicable.

Is the Plan or Issuer Required to Send a Separate Notice to Family Members or Other Plan Beneficiaries?

The requirement to provide an SBC to participants and beneficiaries is met if the plan or issuer provides an SBC to the participant's last known address. However, if the plan administrator knows that a beneficiary has an address that is different from the participant's address, an SBC must be sent to the beneficiary's last known address. This delivery requirement is similar to the method of delivery of the COBRA general notice.

What is Distributed if the Group Health Plan Offers Multiple Benefit Packages?

Assume a group health plan offers participants a choice of a High, Medium and Low Option. At the time of initial enrollment in the plan, the employee must be given an SBC for all three options. Let's say that the employee enrolls in the Medium Option. During the open enrollment period, only the SBC for the Medium Option must be furnished to the participant. If the participant wants information on the Low and High Options, he or she can request copies and the plan or issuer must furnish them within 7 business days. This rule is designed to prevent unnecessary duplication, but it may lead to many requests for information since the open enrollment period is a time when participants evaluate the medical plan options and decide whether to switch. Therefore, a plan administrator may wish to furnish copies of all three SBCs during the open enrollment period, and/or make them available electronically to all participants.

What Types of Information Must be Included in the Summary of Benefits and Coverage?

The SBC must disclose a long list of information, including:

- A description of the coverage;
- Exceptions, reductions and limitations of the coverage;
- Cost-sharing provisions;
- Renewability and continuation of coverage provisions;
- Coverage examples (currently, two examples are required, illustrating plan coverage of a pregnancy and of a person with well-controlled type 2 diabetes);
- A statement that the SBC is only a summary;
- Contact information for questions and obtaining a copy of the plan document or policy;
- An Internet address for obtaining a list of network providers and information on the prescription drug formulary; and
- An Internet address for obtaining the glossary of health coverage and medical terms.

Premium information is not required to be disclosed, but it can be added at the end of the SBC form. A plan can also voluntarily indicate if it is a grandfathered plan by adding language at the end of the SBC.

The SBC content will be modified as of January 1, 2014 to also require disclosure of whether the plan provides minimum essential coverage and whether the plan's share of the cost of benefits meets the minimum value requirement.

Is the Summary of Benefits and Coverage Required to be Provided in a Uniform Format?

Yes. The SBC must be provided in the form issued by the Departments using prescribed language. The information must be presented in the order shown in the SBC template, must be in 12-point font and cannot exceed four pages (double-sided). The template, instructions, the information necessary for the coverage examples, the uniform glossary, and a sample completed SBC are available at:

http://www.dol.gov/ebsa/healthreform
or
http://cciio.cms.gov/resources/other

The final forms have been revised from the proposed versions so that they can be used for self-insured as well as insured plans. If the plan terms cannot reasonably be described in a manner consistent with the template and instructions, the plan terms must be accurately described in a manner as consistent with the template and instructions as possible. Thus, an insurer or plan administrator is provided some latitude to conform the template to the plan terms, but any significant variations are not allowed.

How Can the Summary of Benefits and Coverage be Delivered?

A health insurance issuer can deliver the SBC to the plan sponsor in paper form or electronically.

The plan administrator or the health insurance issuer can deliver the SBC to participants and beneficiaries in paper form. The SBC can be delivered in electronic form to participants who are *covered* by the plan if the DOL's existing rules on electronic delivery are met. These rules include a requirement that the participant use a computer as part of his or her integral job duties.

The SBC can be delivered in electronic form to participants who are *eligible but not enrolled* for coverage if:

- The format is readily accessible;
- The SBC is provided in paper form free of charge upon request; and
- If the SBC is posted on an Internet site, the plan or issuer notifies the individual in paper form (such as by postcard) or email that the documents are available on the Internet, provides the Internet address, and notifies the individual that the documents are available in paper form upon request. Model language for this e-card or postcard is available in the FAQs (Part VIII, Q&A 12; accessible at www.dol.gov/ebsa/faqs/faq-aca8.html).

Does the SBC Need to be Provided in a Language Other Than English?

The SBC must be provided in a culturally and linguistically appropriate manner. Under the Departments' current interpretation of this requirement, if the SBC is sent to an address in a county where 10% or more of the population is literate only in a non-English language, the SBC must include a statement notifying the recipient how to access oral language services and must provide a non-English version of the SBC upon request. The list of counties where this rule currently applies can be accessed at: www.cciio.cms.gov/resources/factsheets/clas-data.html.

Can the SBC Disclosures Be Coordinated with the SPD for the Group Health Plan?

A group health plan must provide the SBC even if it furnishes participants with a comprehensive summary plan description (SPD). The SBC cannot substitute a reference to the SPD for any content requirement of the SBC. For example, when listing exclusions or limitations, the SBC cannot state "refer to the SPD." The SBC may include a reference to the SPD in the SBC footer and/or it can refer participants to particular pages or portions of the SPD. For example, the SBC could list 3 limitations or exclusions that apply to outpatient mental health services and then state "for further information, refer to page ___ of the SPD."

The SBC can be furnished as part of an SPD if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents) and in accordance with the timing requirements for providing an SBC.

Are There Any Disclosure Requirements if the Content of the SBC Changes?

Yes. If there is any material modification in the content of the SBC (whether a benefit enhancement or a benefit detriment), which occurs other than in connection with a renewal or reissuance of coverage, the plan or health insurance issuer must provide notice of the modification to enrollees at least 60 days prior to the effective date of the change.

What are the Sanctions for Failing to Deliver the SBC or Give Notice of Modification?

A group health plan or health insurance issuer who *willfully* fails to provide the SBC, or notify participants of a modification, is subject to a fine of up to $1,000 for each failure. A failure with respect to each participant or beneficiary is a separate offense. In addition, a group health plan could be subject to a separate excise tax of $100 per day for a failure to comply with the SBC rules. The Departments of Labor and Treasury intend to issue separate regulations on these penalties and how they will be coordinated.

In the FAQs, the Departments indicated that they intend to emphasize assisting plans with compliance rather than assessing penalties during the first year of applicability for any plan or issuer that is working diligently and in good faith to comply with the SBC rules.

What Action Steps Should Plan Sponsors Take to Ensure Compliance?

If the open enrollment period for the group health plan is anticipated to begin on or after September 23, 2012, an SBC will be required, so it is not too soon to begin considering how to comply with the SBC rules.

If the plan is insured, the insurer will likely prepare the SBC because it is responsible, along with the plan, to prepare and distribute the SBC. The plan sponsor should discuss and agree contractually with the insurer as to which party will assume this responsibility. If the insurer assumes this responsibility, the plan sponsor should monitor compliance and correct any violations as soon as possible.

If the plan is self-insured, the plan sponsor should check with its third party administrator (TPA) to determine whether the TPA will prepare, assist in preparing, review, disseminate and/or assist in disseminating the SBC to participants.

In addition to preparing the SBC and ensuring that it is accurate, the plan sponsor should consider:

- the type of delivery (paper or electronic);
- whether the SBC should be part of the SPD; and
- what processes need to be implemented to ensure compliance with the timing rules applicable to the distribution of the SBCs.

Any inaccuracies in the SBC could lead to lawsuits by participants and the potential for the assessment of fines and excise taxes. Therefore, careful review of the SBC, including by leagl counsel, is important to ensure that the SBC is complete and consistent with the terms of the plan or policy.

FOR MORE INFORMATION CONTACT:

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