EPSTEINBECKERGREEN

IMPLEMENTING HEALTH AND INSURANCE REFORM:
Opportunities & Challenges for Your Organization

HEALTH CARE & LIFE SCIENCES

Thought Leaders in Health Law®

February 29, 2012

Paying Attention to the Fine Print: The Summary of Benefits and Coverage Final Rule and Its Impact on Consumers and the Health Insurance Market

RESOURCE LINKS

Final Rule and Associated Guidance
http://cciio.cms.gov/resources/regulations/index.html#sbc

Instructions for Completing the SBC and Examples of SBCs
http://cciio.cms.gov/resources/other/index.html#sbcug

IMPORTANT DATES

Statutory effective date of Section 2715
March 23, 2012

New effective date
September 23, 2012

On February 14, 2012, the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (collectively referred to as the "Departments") published the Summary of Benefits and Coverage ("SBC") Final Rule (the "Final Rule")[1] implementing Section 2715 of the Public Health Service Act ("PHSA"), as added by the Patient Protection and Affordable Care Act ("PPACA"). This section of PPACA required the Departments to develop standards for use by group health plans and health insurance issuers offering group or individual health coverage in providing SBCs. Accordingly, the Final Rule details how the Departments envision an SBC that "accurately describes the benefits and coverage under the applicable plan or coverage."[2] Additionally, the Final Rule sets forth a list of key definitions ("uniform glossary") meant to help explain insurance terms.

Taken together, these two forms, the SBC and the uniform glossary, are intended to ease the process for consumers to evaluate and purchase insurance coverage and to render the system more accessible to consumers by increasing their understanding of coverage options. Although increasing consumer understanding is a worthy goal, the SBC requirements pose a significant burden and new risk to group health plans and issuers that will have to collect the applicable information, assemble it into the specific format discussed below, and distribute it as delineated in detail in the Final Rule. Moreover, even though the Final Rule extends the time period within which group health plans and issuers have to come into compliance with these federal requirements, there is still work to be done in a short time. Additionally, it is premature to know whether consumers will take advantage of these forms as intended and, even if they do, how useful the forms may be when making decisions regarding their coverage options.

---

[1] 77 Fed. Reg. 8,668 (Feb. 14, 2012).
[2] *Id.*

SUMMARY OF THE FINAL RULE

Specific Scenarios Under Which SBCs Must Be Provided

The Final Rule sets forth three scenarios under which SBCs must be provided. Specifically, SBCs must be provided: (1) by a group health insurance issuer to a group health plan; (2) by a group health insurance issuer and a group health plan to participants and beneficiaries; and (3) by a health insurance issuer to individuals and dependents in the individual market.

1. SBC Provided by a Group Health Insurance Issuer to a Group Health Plan

When the SBC is provided by a group health insurance issuer to a group health plan upon application for health insurance, it must be provided as soon as practicable upon receipt of the application, but no later than seven business days following receipt of the application. A new SBC must be provided by the first day of coverage if there is a change in the information in the SBC following provision of the original SBC. Upon renewal of coverage, if a written application is required for renewal, the SBC must be provided by the date that the application materials are distributed. If renewal is automatic, the SBC must be provided at least 30 days prior to the first date of coverage. However, if the coverage has not been renewed prior to the 30-day period before the first date of coverage, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the new coverage or the receipt of written confirmation of intent to renew, whichever is sooner. Finally, an SBC must be provided upon request by a group health plan for such information as soon as practicable, but no later than seven business days following receipt of the request.

2. SBC Provided by a Group Health Insurance Issuer and a Group Health Plan to a Plan Participant or Beneficiary

An SBC must be provided by a group health insurance issuer and a group health plan to a plan participant or beneficiary for each benefit package for which the participant or beneficiary is eligible. The SBC must be provided as part of any written application materials distributed by the issuer or plan. If the issuer or plan does not distribute written applications for enrollment, the SBC must be provided no later than the first date on which the participant is eligible to enroll. A new SBC must be provided by the first day of coverage if there is a change in the information in the SBC following provision of the previous SBC. Upon renewal of coverage, if a written application is required for renewal, the SBC must be provided by the date that the application materials are distributed. If renewal is automatic, the SBC must be provided at least 30 days prior to the first date of coverage. However, if the coverage has not been renewed prior to the 30-day period before the first date of coverage, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the new coverage or the receipt of written confirmation of intent to renew, whichever is sooner. An SBC must be provided upon request as soon as practicable, but no later than seven business days following receipt of the request. A group health insurance issuer or a group health plan satisfies the requirement to provide an SBC to a plan participant or beneficiary if another party provides the SBC, but only to the extent that it is timely and complete in accordance with the SBC requirements (*e.g.,* a group health plan funded through an insurance policy satisfies its obligations if the insurance issuer provides a timely and complete SBC to the required plan participants and beneficiaries). Finally, unless the group health plan or group health insurance issuer is aware that a beneficiary lives at a different address than the applicable plan participant, the

obligation to provide an SBC to plan participants and beneficiaries is satisfied by sending the SBC to the plan participant's address.

3. SBC Provided by a Health Insurance Issuer to an Individual

An SBC must be provided by a health insurance issuer to an individual covered under the policy (including a dependent) upon receiving an application for any health insurance policy as soon as practicable upon receipt of the application, but no later than seven business days following receipt of the application. A new SBC must be provided by the first day of coverage if there is a change in the information in the SBC following provision of the previous SBC. Upon renewal of coverage, if a written application is required for renewal, the SBC must be provided by the date that the application materials are distributed. If renewal is automatic, the SBC must be provided at least 30 days prior to the first date of coverage. However, if the coverage has not been renewed prior to the 30-day period before the first date of coverage, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the new coverage or the receipt of written confirmation of intent to renew, whichever is sooner. Additionally, an SBC must be provided upon request as soon as practicable, but no later than seven business days following receipt of the request. Finally, unless the health insurance issuer is aware that a dependent lives at a different address than the individual applying for coverage, the obligation to provide an SBC to the dependent is satisfied by sending the SBC to the applicant's address.

Content of the SBC

In general, the SBC must include the following content in a document that follows the instructions provided by the Departments in sub-regulatory guidance, does not exceed four double-sided pages, and appears in a font no smaller than 12-point:

1. Uniform definitions of standard insurance terms and medical terms, as specified by the Departments;

2. A description of the coverage, including cost-sharing, for each category of benefits identified by the Departments in sub-regulatory guidance;

3. The exceptions, reductions, and limitations of the coverage;

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

5. The renewability and continuation of coverage provisions;

6. Coverage examples;

7. With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage and whether the plan's share of the total allowed costs of benefits provided under the plan meets applicable requirements;

8. A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

9. Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance;

10. An Internet address for obtaining a list of network providers;

11. An Internet address for obtaining information on prescription drug formulary information; and

12. An Internet address for obtaining the uniform glossary of health-coverage-related terms and medical terms as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

    a. If the uniform glossary is requested, it must be provided within seven business days of the request.

In a departure from the SBC Proposed Rule,[3] the Departments no longer require the inclusion of premium or cost of coverage information in the SBC on the basis that it would be administratively burdensome. For instance, in the group health insurance market, the group health insurance issuer may not have information regarding the employee's contribution to the cost of health insurance and, therefore, would not be able to include this information in the SBC.

Examples of Coverage

During the first year of applicability of the SBC requirements, the Departments are requiring that the SBC includes two coverage examples: having a baby (normal delivery) and managing Type 2 diabetes (routine maintenance of a well-controlled condition). The coverage examples depict a sample treatment plan during a specific time period and illustrate the benefits provided under the plan and an estimate of what an individual may expect to pay under that plan. In future years, the Departments may require up to six coverage examples to be included in the SBC.

Material Modification to Terms of Plan or Coverage

In all instances, if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide at least 60 days' prior notice of the modification to affected plan participants or individuals.

Format, Culturally and Linguistically Appropriate Content, and Penalties

The SBC may be provided either in hardcopy or, if certain requirements are met, in an electronic format. The SBC must be provided in a culturally and linguistically appropriate manner; this requirement is met if the group health plan or health insurance issuer meets the culturally and linguistically appropriate standards set forth in the internal and external claims and appeals regulations at 45 C.F.R. § 147.136(e), as applied to the SBC. Finally, the failure by the group health plan or health insurance issuer to provide the SBC in accordance with the Final Rule subjects the applicable group health plan or health insurance issuer to a fine not to exceed $1,000 for each such failure, and a failure with respect to each affected individual constitutes a separate offense.

[3] 76 Fed. Reg. 52,442 (Aug. 22, 2011).

Applicability to Certain Account-Type Arrangements

SBCs are not required for plans, policies, or benefit packages that constitute excepted benefits.[4] Thus, the Departments clarified in the preamble to the Final Rule whether the SBC requirements would apply to certain account-type arrangements that may sometimes qualify as excepted benefits, such as flexible spending arrangements ("FSAs"), health reimbursement arrangements ("HRAs"), and health savings accounts ("HSAs"). For instance, if an FSA qualifies as an excepted benefit, then it would not be required to issue SBCs. However, stand-alone FSAs and those combined with major medical coverage products that do not qualify as excepted benefits must somehow meet the SBC requirements. First, stand-alone FSAs must independently satisfy the SBC requirements, whereas FSAs integrated into other major medical coverage can satisfy the SBC requirements by providing the relevant information for the SBC prepared by the other major medical coverage issuer. Second, HRAs are considered group health plans, and, thus, are generally subject to the SBC requirements. However, similar to the approach to integrated FSAs, HRAs combined with major medical coverage are not required to separately meet the SBC requirements. Finally, HSAs are generally not considered to be group health plans and are not subject to the SBC requirements. That being said, the preamble to the Final Rule notes that SBCs prepared by high-deductible health plans associated with HSAs may make mention of the effects of employer contributions to HSAs on their SBCs.

IMPACT AND CONCLUSION

In the preamble to the Final Rule, the Departments acknowledge that group health plans and health insurance issuers will incur substantial costs in compiling and distributing the SBCs and uniform glossaries as required. However, the Departments seem to discount these costs in the face of the anticipated benefit of having a more informed consumer making coverage decisions with the aid of these new SBCs and the uniform glossary. The Departments then conclude that such improvements will result "in a more efficient, competitive market."[5] Whether the Final Rule may improve consumer understanding of the health insurance market has yet to be determined. It remains unclear what impact, if any, the SBC requirements will have on the efficiency and competiveness of the health insurance market. Given the costs of implementing the Final Rule's requirements, and the impossibility of gauging consumer utilization[6] and interest at this point, much uncertainty remains.

Although an extension from the statutory effective date of March 23, 2012 has been granted in the Final Rule, group health plans and health insurance issuers in the individual and group health markets will be required to take a number of steps in order to ensure compliance with the SBC requirements by September 23, 2012.

*   *   *

.

[4] *See* 26 C.F.R. § 54.9831-1(c), 29 C.F.R. § 2590.732(c), 45 C.F.R. § 146.145(c).

[5] 77 Fed. Reg. at 8,669.

[6] Consumer testing was performed on the model forms to try to measure their impact on the ability of such consumers to better understand their coverage options on behalf of the National Association of Insurance Commissioners. However, it remains to be seen how widespread consumer use and understanding of these forms will be and whether such increased understanding will translate into a more efficient and competitive health insurance market nationwide.

For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

Shawn M. Gilman
Associate
EpsteinBeckerGreen
WASHINGTON
202/861-1878
sgilman@ebglaw.com

Julia E. Loyd
Associate
EpsteinBeckerGreen
WASHINGTON
202/861-1896
jloyd@ebglaw.com

Information published in IMPLEMENTING HEALTH AND INSURANCE REFORM is not intended to be, nor should it be considered, legal advice. Readers should consult an attorney to discuss specific situations in further detail.

EPSTEIN BECKER GREEN

IMPLEMENTING HEALTH AND INSURANCE REFORM:
Opportunities & Challenges for Your Organization

HEALTH CARE & LIFE SCIENCES

Thought Leaders in Health Law®

Information published in IMPLEMENTING HEALTH AND INSURANCE REFORM is not intended to be, nor should it be considered, legal advice. Please consult your attorneys in connection with any fact-specific situation under federal law and the applicable state or local laws that may impose additional obligation on you and your company.

www.ebglaw.com
© 2012
Epstein Becker & Green, P.C.
Attorney advertising.

If you would like to be added to our mailing list,
please click here, complete the form below or contact:

Kristi Swanson
Practice Development Manager
National Health Care & Life Sciences Practice
Epstein Becker & Green. P.C.
1227 25th St., NW, Suite 700
Washington, D.C. 20037
phone 202/861-4186 -- fax 202/861-3086
kswanson@ebglaw.com

Name:______________________________ Title:____________________

Company/Firm/Organization:____________________________________

Street Address:____

City:___________________________ State:________ Zip Code:_______

Phone No.:____________________ Fax No.:______________________

E-mail Address:____

ATLANTA
Robert N. Berg
Michael Coleman
J. Andrew Lemons
Kenneth Menendez
Marisa Pins
Bradley Skidmore
Evan Rosen
Alan B. Wynne

BOSTON
Barry A. Guryan

CHICAGO
Amy Dow
Lisa J. Matyas
Griffin W. Mulcahey
Kevin Ryan

HOUSTON
Mark S. Armstrong
Daniel E. Gospin
Patricia D. Tyner

INDIANAPOLIS
Leah R. Kendall
Bradley Merrill Thompson

LOS ANGELES
Dale E. Bonner
Ted Gehring
Susan Graham

NEW YORK
Nicholas Allison
Eric Altman
Jeffrey H. Becker
Michelle Capezza
Aime Dempsey
Kenneth DiGia
Alice Dong
Scott M. Drago
Jerrold I. Ehrlich
Hylan Fenster
James S. Frank
Arthur J. Fried
Paul Friedman
Philip M. Gassel
Jay E. Gerzog
Sarah K. Giesting
John F. Gleason
Robert D. Goldstein
Wendy C. Goldstein
Robert S. Groban, Jr.
Gretchen Harders
Jennifer M. Horowitz
Kenneth J. Kelly
Joseph J. Kempf, Jr.
Jane L. Kuesel
Purvi Badiani Maniar
Wendy Marcari
Eileen Millett
Cynthia Mitchell
Leah Roffman
Tamar Rosenberg
William A. Ruskin
Jackie Selby
Catherine F. Silie
Victoria Sloan
Steven M. Swirsky
Natasha Thoren

NEWARK
Joan A. Disler
James P. Flynn
Daniel R. Levy
Philip D. Mitchell
Maxine Neuhauser
Kerry M. Parker
Michael J. Slocum

WASHINGTON, DC
Mujadala Abdul-Majid
Kirsten M. Backstrom
Emily E. Bajcsi
Clifford E. Barnes
James Boiani
George B. Breen
M. Jason Brooke
Lee Calligaro
Jesse M. Caplan
Jason B. Caron
Jason E. Christ
Eric Conn
Tanya Cramer
O. Benton Curtis, III
Anjali N.C. Downs
Steven B. Epstein
Gregory Epstein
Ross K. Friedberg
Stuart M. Gerson
Shawn M. Gilman
Jennifer K. Goodwin
Daniel G. Gottlieb
Douglas A. Hastings
Robert J. Hudock
William G. Kopit
Jennie B. Krasner
Jay P. Krupin
Amy F. Lerman
Katherine R. Lofft
Julia E. Loyd
Mark E. Lutes
Kara M. Maciel
Benjamin S. Martin
David E. Matyas
Colin McCulloch
Frank C. Morris, Jr.
Leslie V. Norwalk
Jonah D. Retzinger*
Joel C. Rush
Kathleen A. Peterson
Rene Y. Quashie
Robert D. Reif
Serra J. Schlanger
Deepa B. Selvam
Alaap B. Shah
Lynn Shapiro Snyder
Adam C. Solander
David B. Tatge
Daly D.E. Temchine
Carrie Valiant
Dale C. Van Demark
Patricia M. Wagner
Robert E. Wanerman
Dawn R. Welch
Constance A. Wilkinson
Kathleen M. Williams
Lesley R. Yeung

*Not Admitted to the Practice of Law