Government Strategies Alert: HHS-DOL-Treasury Summary of Benefits and Coverage and Uniform Glossary Final Rule

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Background and Introduction

Section 2715 of the Public Health Service Act (PHS Act), which was enacted as part of the Patient Protection and Affordable Care Act (also referred to as PPACA, the Affordable Care Act, or the ACA), requires health insurers and group health plans offering health care coverage to enrollees and beneficiaries in the plan to provide a "Summary of Benefits and Coverage" (SBC) and Uniform Glossary to insured individuals and plan enrollees. The purpose of the SBC is to ensure that individuals enrolled in these plans are able to receive a simple, easy-to-understand summary of the benefits and coverage available under their plan. The law required the Departments of Health and Human Services, Treasury, and Labor (together, the Departments) to issue standards that would have to be included in the SBC.

On February 8, 2012, the Departments issued the SBC and Uniform Glossary final rule implementing section 2715 of the PHS Act.[1] The Departments also issued a separate corresponding document, Templates, Instructions, and Related Materials; and Guidance for Compliance. Both of these documents will be published in the Federal Register on February 14, 2012. Additional templates, guidance and related instructions for the SBC and uniform glossary are available on the Departments' websites.[2]

Below is a summary of key provisions in the final rule.

Effective Date

Although the law required that the provision be effective two years after the enactment of PPACA (which would have been March 23, 2012), the Departments announced in the final rule that the provision would be effective:

- For insured plans, for participants or beneficiaries who enroll or re-enroll in group health plan coverage through an open enrollment period beginning on the first day of the open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll outside of an open enrollment period, the provision applies on the first day of the first plan year that begins on or after September 23, 2012.

- For insurance sold to individuals and dependents in the individual market, the provision is applicable to health insurance issuers on September 23, 2012.

Main Provisions of the Final Rule

The regulations address the following questions:

- Who must provide an SBC, to whom, and when?
- What are the required content elements of the SBC?
- What are the requirements of the SBC related to appearance and form?
- When must a notice of modification be provided to plan enrollees, beneficiaries, or insured individuals?
- What common definitions will apply in the SBC?

Providing the SBC

Under the regulation, the SBC must be provided by a health insurance issuer offering health insurance coverage within the United States, and, in the case of a self-insured plan, the plan sponsor or designated administrator of the plan. The Departments rejected comments they had received that this requirement is unnecessary for self-insured group health plans, which are already required under ERISA to make many similar documents available, such as the ERISA Summary Plan Description (SPD). Ultimately, the Departments rejected these suggestions because the statute does not authorize any exceptions and in fact specifically applies the requirement to self-insured plans.

The final rule also addresses what types of plans are required to provide an SBC. Generally, an arrangement, such as a flexible spending arrangement (FSA) or health reimbursement account (HRA), is subject to the requirement unless benefits under the arrangement constitute “excepted health benefits” such as stand-alone vision or dental plans. With respect to health savings accounts (HSAs), no SBC is required because health savings accounts are not group health plans. However, an SBC must be provided with respect to each benefit package offered by the plan or issuer for which the beneficiary is eligible.

The SBC must be provided to applicants, enrollees, and policyholders or certificate holders. It must also be provided to special enrollees (i.e., an enrollee in a special enrollment period due to a major life

event). However, the final rule extends the deadline for provision of the SBC for special enrollees to 90 days from enrollment.

Under the final rule, the SBC must be provided in writing, and free of charge. It must be provided when an individual or employer is comparing health coverage options, including prior to enrolling in or purchasing a particular plan or policy. It must also be provided on request, generally within seven business days (not calendar days, as in the proposed rule) from the date of the request.

Content of the SBC

As required by the statute, the SBC must contain the following items:

- Uniform definitions;
- Description of coverage (and cost-sharing);
- Exceptions, reductions and limitations on coverage;
- Cost-sharing requirements;
- Renewability and continuation of coverage provisions;
- A coverage facts label (which the Departments compare to the nutrition label on food);
- Statement regarding whether or not the coverage provides minimum essential coverage (but not required until January 1, 2014);
- Notice that the SBC is only a summary, not the actual plan; and
- Contact information.

The final regulations add additional required items, proposed by the National Association of Insurance Commissioners (NAIC). These include:

- An Internet address where provider networks can be obtained;
- An Internet address with information regarding prescription drug coverage; and
- An Internet address where individuals can review the uniform glossary of definitions, as well as a phone number where individuals can receive a paper copy (and a notice that a paper copy is available).

The SBC need not contain premium or cost of coverage information, which the Departments had proposed requiring in the proposed rule.

Appearance of the SBC

As in the proposed rule, the SBC must be no longer than four (double-sided) pages in 12-point print. Also under the final rule, a group health plan issuer may include the SBC along with other summary materials such as the SPD as long as the SBC is intact and prominently displayed at the beginning of the materials. For health insurance in the individual market, the SBC must be provided as a stand-alone document.

Form of the SBC

Electronic transmittal of the SBC is permissible as long as certain conditions are met. Generally, an SBC may be provided electronically to individuals already enrolled in a group health plan if the group health plan sponsor or administrator complies with the Department of Labor's SPD electronic disclosure safe harbor. The Departments note that the Department of Labor is considering comments to expand this safe harbor and state that if it is revised, those revisions would apply to the SBC. For participants and beneficiaries who are not enrolled, electronic disclosure is permitted as long as a paper copy is also made available.

With respect to disclosure to individuals purchasing insurance in the individual market, the final rule establishes the general standard that an issuer must provide the SBC in a manner that can reasonably be expected to provide actual notice, regardless of the format. It then gives several examples of delivery that can satisfy this requirement – for example, an issuer can assume that someone has received the SBC if it is sent by email in response to an email request (with an email address) to receive it.

Modifications of Benefits and Notice

A notice of any material modification must be provided if there is a modification in benefits under the plan since the most recently-provided SBC. The final rule provides clarification on what constitutes a "material modification." It is:

- Something that would affect the content of the SBC;
- Is not reflected in the most recent SBC; and
- Occurs other than in connection with renewal or re-issuance of coverage.

The Departments further explain that it is a change that would be considered by an average plan participant to be an important change in coverage. It can include more generous or expansive coverage, as well as, of course, a material reduction of benefits. in these circumstances where there is a "material modification," notice must be provided 60 days prior to the change taking effect to enrollees.

Uniform Glossary

Finally, the regulation describes the requirements of the uniform glossary. Under the statute, the Departments are required to establish a standard list of common terms used in health insurance contracts (such as co-insurance, co-payment and deductible) in order to ease comparison of information for consumers. The final rule implements this requirement, essentially as proposed, along with additions to terms proposed by the NAIC. In response to comments, the Departments note that an SBC may convey "more accurate descriptions" of these defined terms in the context of a particular plan.

As with the SBC, a plan or an insurance issuer must make the uniform glossary available within seven business days on request. A plan is deemed to comply with this requirement where, with distribution of an SBC, the Internet address where the glossary is available is included.

Pre-Emption

The final regulation also addresses the issue of pre-emption of state law. In essence, the provisions of § 2715 of the PHS Act do not pre-empt any state law that is stricter than the requirements imposed by the section. Conversely, § 2715 does pre-empt any state law that is less restrictive than the section. Thus, the Departments conclude, states can impose additional requirements on health plans or issuers beyond those imposed by § 2715. This is a departure from general principles of ERISA law, which generally pre-empt state laws that relate to employee benefit plans.

Penalties

The regulation also addresses penalties for failure to provide the SBC. Under the statute, an intentional failure to provide the SBC can result in a penalty of up to $1,000 per instance. Because HHS, and the Treasury and Labor Departments, have different enforcement mechanisms, the regulation discusses the applicable enforcement policies. With respect to HHS, penalties are in the first instance imposed by states. As long as the states are enforcing the requirements, HHS will exercise enforcement discretion.

With respect to the Departments of Labor and Treasury, their enforcement powers are coordinated. The regulation notes that future guidance will be forthcoming from those departments with respect to enforcement.

Conclusion

The final SBC rule is yet one more item of guidance issued by regulatory agencies implementing the health reform law enacted in March of 2010. Because of the importance of compliance with the SBC regulation, employers, group health plan sponsors and health insurance issuers should study it carefully to ensure compliance with the many requirements of the final rule. In many cases, the final rule provides important nuance missing from the statute.

In addition to the rule, as noted in the introduction above, the Departments also issued corresponding model templates, the uniform glossary, and instructions that are now available on their websites. These documents are integral parts of the final rule and should be used and consulted as well.

Please contact the authors of this client alert, or your regular Foley Hoag attorney, if you have any additional questions. We would be happy to provide additional guidance for you.

[1] Departments of Health and Human Services, Treasury and Labor, Summary of Benefits and Coverage and Uniform Glossary, Final Rule, Display Copy (Feb. 9, 2012), available at http://www.ofr.gov/(X(1)S(vk0hyqkylbsmz4n4014gssta))/OFRUpload/OFRData/2012-03228_PI.pdf .

[2] Additional documents include: SBC template, Sample Completed SBC, Instructions, Why This Matters Language, Coverage Examples, and the Uniform Glossary.