

Compensation and Benefits Insights

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Departments Issue Final Summary of Benefits and Coverage Regulations and Clarifying FAQs

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On February 14, 2012, the Departments of Health and Human Services, Labor and the Treasury (the “Departments”) issued final regulations regarding the summary of benefits and coverage (“SBC”) disclosure requirement imposed by the Patient Protection and Affordable Care Act (“PPACA”) (the “Final Regulations”). A little over one month later, on March 19, 2012, the Departments issued clarifying “frequently asked questions” and answers regarding the implementation of the Final Regulations (the “FAQs”). Together, the Final Regulations and the FAQs provide detailed instructions on how to comply with PPACA’s SBC disclosure requirement. However, plan sponsors and insurance issuers do not have much time to comply with the new SBC disclosure requirement: SBCs must be included in application materials provided to participants and beneficiaries during open enrollment periods that begin on or after September 23, 2012, and must be distributed to new hires and mid-year enrollees in plan years that begin on or after that date.

The SBC Requirement - In General

PPACA requires all group health plans (including grandfathered plans) and all health insurance issuers offering group or individual health insurance coverage to compile and provide to enrollees and participants a SBC that “accurately describes the benefits and coverage under the applicable plan or coverage,” such that enrollees and participants can more easily compare benefits and coverage available under different plan options offered by such plans and issuers. Pursuant to PPACA, the Departments were required to develop standards for group health plans and health insurance issuers to use in preparing the SBC, including “standards for the definitions of terms used in health insurance coverage.” The Departments issued proposed regulations on the SBC disclosure requirement (along with templates, instructions, and related materials) on August 22, 2011. The Final Regulations direct plan sponsors and insurance issuers to prepare the SBCs required by PPACA in accordance with a detailed set of instructions and other guidance documents provided by the Departments as part of the Final Regulations, including a template SBC on which all SBCs should be based. All SBCs must be drafted using the health coverage and medical terms listed on a “uniform glossary” that was issued by the Departments as part of the Final Regulations. The FAQs provide additional information on how to format and complete the SBC, and on when and to whom the SBC should be distributed.

Preparing the SBC

The Final Regulations specify a number of content and appearance requirements for the SBCs. Every SBC must include: (1) uniform definitions of standard insurance terms and medical terms; (2) a description of the coverage, including cost-sharing, for each category of benefits identified by the Departments; (3) any applicable exceptions, reductions, and limitations on coverage; (4) the cost-sharing provisions of coverage (including deductible, coinsurance, and copayment

obligations); (5) the renewability and continuation of coverage provisions; (6) a coverage facts label that includes examples (referred to as “coverage examples”) to illustrate two common benefits scenarios (pregnancy and managing type 2 diabetes) and related cost-sharing based on recognized clinical practice guidelines; (7) a statement about whether the plan provides “minimum essential coverage” (as defined by PPACA), and whether the plan’s or coverage’s share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements; (8) a statement that the SBC is only a summary and that the plan document or insurance policy governs; (9) contact information for questions and obtaining a copy of the plan document or insurance policy; and (10) internet addresses for obtaining a list of network providers, if applicable, obtaining information on prescription drug coverage, if the plan or issuer uses a formulary, and accessing the uniform glossary (as well as a phone number for obtaining a paper copy). If a major medical plan is integrated with a health flexible spending account (a “Health FSA”) or health reimbursement account (a “HRA”), the plan sponsor may describe the major medical plan and Health FSA or HRA on the same SBC. (A stand-alone Health FSA or HRA that does not constitute an excepted benefit under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) must be described on a separate SBC.)

The Final Regulations state that each SBC must use terminology “understandable by the average plan enrollee” and be presented in a “uniform format” that may not exceed four double-sided pages in length or include print smaller than 12-point font. The Final Regulations do not include specific instructions for preparing the SBCs; however, the Departments of Labor (“DOL”) and Health and Human Services (“HHS”) recently posted a number of guidance documents that contain detailed instructions and sample language to be used in preparing the SBCs, including: (1) a blank SBC template in MS Word format; (2) a sample completed SBC; (3) instructions for completing the SBC template ; (4) sample “yes” and “no” answers for the “Why This Matters” column on the first page of the SBC template; and (5) guidance for performing coverage example calculations. The “uniform glossary” referred to in the template SBC is also posted on the DOL and HHS websites.

Content Requirements

The preamble to the Final Regulations provided that plan sponsors and issuers “must accurately describe the relevant plan terms” when drafting each SBC, while using their best efforts to do so in a manner that is as “consistent with the instructions and [SBC] template format as reasonably possible.” The compliance guidance, published at the same time that the Final Regulations were issued, directs plan sponsors to follow the SBC template when preparing each SBC. In addition, the instructions for completing the SBC template provide that form language and formatting must be “precisely reproduced” unless the instructions allow otherwise, and that all symbols, formatting, bolding, and shading must be replicated. (The only exception is that printing may be done in grayscale instead of color.) Based on these requirements, it was unclear, prior to the issuance of the FAQs, how much flexibility plans and issuers would have to deviate from the SBC template in situations where the plan’s terms deviated from the SBC template (such as where a plan provided a different structure for provider network tiers or drug tiers than is represented in the SBC template).

However, the FAQs clarify that plan sponsors and insurance issuers may deviate from the SBC template to the extent necessary, so long as they are working diligently and in good faith to provide the required SBC content “in an appearance that is consistent” with the Final Regulations.

For example, the SBC template issued in conjunction with the Final Regulations was intended to address only one tier of coverage (such as self-only coverage, employee +1 coverage, family coverage, etc.); the SBC template has a “coverage for” blank in which the instructions direct plans and issuers to enter “who the coverage is for (such as Individual, Individual + Spouse, Family).” As a result, if a plan sponsor or insurance issuer offered multiple coverage tiers, the Final Regulations and the SBC template would seem to suggest that a separate SBC would be required for each coverage tier. However, the FAQs clarify that multiple coverage tiers may be addressed in a single SBC, so long as the appearance of

the information is “understandable” (i.e., the coverage examples should be given using one tier of coverage, such as the self-only tier, and note that the examples reflect that assumption).

The format of the SBC template raised similar questions regarding other common deviations in plan terms from the SBC template that were also addressed in the FAQs, as follows:

Plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments and co-insurance) in one SBC, provided the appearance is “understandable” (i.e., the information can be presented in the form of options (such as deductible options and out-of-pocket maximum options), so long as the coverage examples note these assumptions); and

“Add-ons” to major medical coverage, such as Health FSAs, HRAs, Health Savings Accounts (“HSAs”), and wellness programs, that could affect the participants’ cost-sharing and other information in the SBC can be combined in a single SBC with the major medical coverage, so long as the appearance is “understandable” (i.e., the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage, so long as the coverage examples note the assumptions used in creating them).

According to the preamble to the Final Regulations, the Departments eliminated premium and cost of coverage information from the list of required content in order to avoid requiring different SBCs for every possible family size. The FAQs clarify that if a plan or issuer wants to add premium information to the SBC, it may do so, but require that the information be added at the end of the SBC. (Likewise, a plan or issuer may voluntarily choose to add a statement to the end of the SBC about whether the plan is a grandfathered health plan.)

However, the FAQs failed to resolve several issues regarding the required content and format of the SBCs. First, it is still unclear whether deviation from the SBC template’s use of bolded terms that correspond to definitions in the uniform glossary is permitted. The Final Regulations provide that the uniform glossary may not be modified, and the instructions to the SBC template provide that the sample answers for the “Why This Matters” column, which use the bolded terms, must be replicated exactly. Sponsors of plans for which the terms in the uniform glossary do not correspond to the definitions in the plan’s other documentation will have to decide whether to alter the terms or rely on the following disclaimer in the uniform glossary: “These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs.”

Second, the discrepancy between the disclaimer in the SBC template and the disclaimer statement requirement in the Final Regulations remains an issue. The Final Regulations provide that an SBC must include a statement that it “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.” The disclaimer statement provided in the footer of the SBC template is much less strongly worded, however: “This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.\[insert\]](#) or by calling 1-800-[insert].” According to the instructions, this disclaimer “should be replicated and the plan or issuer may not vary the font size, graphic, or formatting” (other than to insert a website and telephone number). Plan sponsors and issuers who wish to use language more clearly indicating that the provisions of the plan document control will have to decide whether to use the disclaimer language from the Final Regulations rather than the language in the SBC template.

The FAQs do not address either of these issues, but do state that, although an SBC is not permitted to substitute a reference to the SPD or other document for any content element required by the Final Regulations or the SBC template, an SBC may include a reference to the SPD in the SBC footer. Plan sponsors and issuers should consider including this reference to help establish the relationship between the SPD and SBC.

Providing the SBC

The Final Regulations provide that the plan sponsor and plan administrator are responsible for providing the SBC. With respect to fully insured coverage, the insurance issuer is also responsible for providing the SBC (though only one party needs to comply). SBCs must be provided to beneficiaries as well as participants (including qualified beneficiaries under COBRA). However, a separate SBC must be provided to a beneficiary only if his or her last known address is different from the participant's last known address.

In general, the Final Regulations require that SBCs must be provided automatically upon enrollment or renewal of coverage as well as upon request. An SBC must be included with any written application materials or, if written application materials are not distributed, be provided no later than the first day on which the participant is eligible to enroll in coverage. (The FAQs state that "written application materials" include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment.) If there is any change to the information reported in the SBC provided upon application, an updated SBC must be provided by the first day of coverage. With respect to participants and beneficiaries who are already enrolled in coverage, an SBC for the benefit package in which the participant or beneficiary is enrolled must be provided when coverage is renewed. If written application is required for renewal, the deadline is the date on which the written application materials are distributed. If renewal is automatic, the deadline is 30 days prior to the first day of the new plan year (or within seven business days after the issuance of a new insurance policy, if later). Participants and beneficiaries who enroll following a mid-year change of status event must receive an SBC no later than 90 days following their enrollment. Finally, SBCs must be provided within seven business days of a participant or beneficiary request. (The FAQs clarify that the term "provided" means "sent," which means that a plan or issuer has seven business days to send out the SBC after receiving the request.) The uniform glossary must also be provided in either paper or electronic form within seven business days of a participant or beneficiary request.)

Unlike the proposed regulations, which required that the SBC be a stand-alone document, the Final Regulations allow SBCs to be provided in combination with summary plan descriptions ("SPDs") or other summary materials if "the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in a summary plan description)."

The Final Regulations provide that SBCs may be distributed electronically to enrolled participants and beneficiaries only if the DOL's safe harbor requirements for electronic disclosure are met. However, the Final Regulations establish a separate (and less onerous) set of rules for distribution to participants and beneficiaries who are eligible for, but not enrolled in, coverage. Electronic disclosure to such participants and beneficiaries is permitted if the format in which the disclosure is made is "readily accessible" and the SBC is provided in paper form free of charge upon request. If the electronic form is an internet posting, the plan or issuer must also notify the individual in paper form (such as a postcard) or email that the documents are available at a specified Internet address and in paper form upon request. The FAQs clarify that plans and issuers may make this disclosure by email, and include sample provisions that may be used to inform individuals that the SBC is posted on a website.

If 10 percent or more of the population residing in a claimant's county are literate only in the same non-English language (as determined by Census Bureau data), the plan or issuer must provide the SBC in that language. This requirement may be satisfied by including in the SBC the same statement recommended for such purposes in claim denials under PPACA (e.g., a "statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer"). The Department of Health and Human Services is expected to provide written translations of the SBC template in Spanish, Tagalog, Chinese and Navajo shortly.

Notice of Modification

The Final Regulations provide that in the event of a material mid-year coverage modification that affects the content of the SBC and that does not occur in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of such modification to enrollees at least 60 days prior to the date on which such modification will become effective. This requirement is a marked departure from the SPD rules, under which the deadline for providing a summary of material modification (“SMM”) falls after the plan year in which the change is adopted. As the Final Regulations do not specify a format for this notice, the plan or issuer may provide either an updated SBC or a separate notice describing the change in content. The same electronic distribution requirements that apply to SBCs apply to the notice.

Effective Date

With respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period, the SBC and uniform glossary disclosure requirements apply beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. With respect to disclosures to participants and beneficiaries who enroll outside of an open enrollment period, the requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012. These effective dates are six months later than the effective dates in the proposed regulations.

Because the elimination of annual limits and certain other PPACA mandates go into effect on January 1, 2014, the Departments are expected to revise the SBC template and accompanying guidance materials next year.

Penalties

A group health plan or health insurance issuer that willfully fails to provide any information required by the regulations is subject to a fine of up to \$1,000 for each participant and beneficiary affected. The DOL plans to issue separate regulations describing the procedures for assessment of this fine.

However, the FAQs clarify that until further guidance is issued, certain failures to provide a timely or complete SBC will not subject the plan or issuer required to provide such SBC to enforcement action by the Departments, where (1) the plan or issuer has entered into a binding contractual arrangement, under which a vendor has assumed responsibility (i) to complete the SBC, (ii) to provide required information to complete a portion of the SBC, or (iii) to deliver an SBC with respect to certain individuals; and (2) the plan or issuer monitors the vendor’s performance under the contract, and either (i) if the plan or issuer has knowledge of a violation of the Final Regulations and the plan or issuer has the information to correct it, the violation is corrected as soon as practicable, or (ii) if the plan or issuer has knowledge of a violation of the Final Regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.

King & Spalding would be happy to assist you with any questions you have about the SBC disclosure requirement.

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