INTERNATIONAL LAWYERS NETWORK

September 22, 2011 by Michelle Capezza

Get Ready for the Summary of Benefits Coverage under PPACA

On March 23, 2012, another requirement under the Patient Protection and Affordable Care Act (the "Act") will be effective-the requirement to provide group health plan participants and beneficiaries with a summary of benefits coverage that accurately describes the benefits and coverage available under the plan and a uniform glossary of terms ("SBC"). These requirements were incorporated under the Internal Revenue Code and ERISA (in addition to existing summary plan description requirements). Under currently proposed regulations, health insurance issuers will also be required to provide this type of information to group health plan sponsors at the time of application or request for information regarding coverage within seven days of the request (including an obligation to update such information should it change); this information must also be provided upon renewal (30 days in advance of a new policy year in a case of an automatic renewal).

It is important for plan sponsors of group health plans (both insured and self-insured) to become familiar with these requirements as the effective date will soon be here. Some of the key elements of the SBC are as follows. The SBC must address each benefit package offered and be provided with application materials for enrollment or no later than the time of enrollment (with additional rules for special enrollment periods) and no later than 7 days following a request. If the health insurance issuer offering the coverage provides a complete, timely SBC to the plan's participants and beneficiaries, the plan's requirement to provide the SBC will be satisfied. The SBC must include such information as uniform definitions of insurance and medical terms, description of coverage (as well as cost-sharing information, exceptions and limitations on coverage), continuation of coverage and renewability provisions, examples of coverage/cost for common scenarios (e.g., pregnancy, chronic conditions), premiums and various other statements and contact information. A statement must also be included regarding whether the plan provides minimum essential coverage-although this requirement will be effective January 1, 2014 to coordinate with other requirements under the Act.

Under the proposed regulations, the SBC may not exceed four double-sided pages in length, and may not include print smaller than 12-point font. Where 10% of a county is literate only in the same non-English language, interpretive services and written translations of the SBC must be available to those participants and beneficiaries. Plans and issuers subject to ERISA or the Code may provide the SBC electronically if the rules under the Department of Labor's electronic disclosure safe harbor are met. Any state laws that impose on health insurance issuers requirements that are stricter than those imposed by the Act will not be superseded. The proposed regulations also clarify

that material modifications to plans or coverage terms that are not reflected in the SBC must be communicated no later than 60 days prior to their effective date.

There are still many unanswered questions with regard to the SBC such as whether the SBC can be provided as part of a summary plan description (e.g., after a cover page or table of contents) as well as certain timing requirements for providing the SBC (such as providing it along with other plan materials during open enrollment), the terms that should be included in the glossary, and the coverage example scenarios. The comment period on the proposed regulations will close on October 21, 2011. It is anticipated that following the close of the comment period, final guidance will be issued with sufficient time to prepare for the March 23, 2012 effective date. Failure to adhere to these rules results in penalties: $1000 penalty for any willful failure to provide this information including a separate fine for each individual or entity for whom there is a failure to provide an SBC (with more guidance concerning the enforcement of these penalties against group health plans to be issued by the Department of Labor), as well as potential $100 per day per individual excise taxes (which will need to be reported on an IRS Form 8928). It is important to start preparing for these requirements now, and coordinating efforts with plan service providers and insurers to properly organize and present this information to participants and beneficiaries.