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Departments Issue Proposed Rule on Summary of Benefits and Uniform Glossary

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The U.S. Departments of Labor, Treasury and Health and Human Services have issued proposed rules addressing the form and content of the summary of benefits and uniform glossary requirements of Section 2715 of the Patient Protection and Affordable Care Act (PPACA). The proposed regulations invite comment on the form and content of the summary of benefits and uniform glossary. PPACA requires compliance with the proposed regulations and provision of the summary of benefits and uniform glossary beginning March 23, 2012.

On August 17, 2011, the U.S. Departments of Health and Human Services, Labor and Treasury (Departments) issued proposed regulations for implementation of the summary of benefits and the uniform glossary requirements under Section 2715 of the Patient Protection and Affordable Care Act (PPACA). This section of the PPACA creates disclosure requirements to help plans and individuals better understand their current health coverage, as well as other coverage options that may be available.

The proposed regulations provide rules for providing participants and beneficiaries with an accurate summary of benefits and coverage (SBC). The proposed regulations also provide rules for SBCs that must be provided by insurers to plan sponsors wishing to purchase group health insurance. The rules apply to both group health plans and health insurers providing insurance in the group and individual markets. The rules also apply to Employee Retirement Income Security Act (ERISA) and non-ERISA group health plans, including grandfathered plans. The Departments have invited comment on the form and content of the SBC and uniform glossary and application. PPACA requires compliance with the SBC requirements beginning on or after March 23, 2012. The Departments are also requesting comment on factors that impact the feasibility of meeting this statutory deadline.

Provision of the SBC to Plan Participants and Beneficiaries

The proposed regulations provide that the plan administrator of a group health plan is responsible for providing an SBC to participants and beneficiaries, including enrolled employees, dependents, COBRA-qualified beneficiaries and children covered pursuant to qualified medical child support orders. For administrative convenience, a single SBC may be sent to participants and beneficiaries with the same residence. If a group health plan is fully insured, the health insurance issuer may provide the SBC in lieu of the plan administrator. The SBC must be provided free of charge.

Under the proposed regulations, the SBC must be provided in the following situations.

- Initial Enrollment/Application: Group health plans must provide an SBC upon initial enrollment to all eligible individuals. The SBC must cover all options in which an individual is eligible to enroll. An SBC must also be sent to individuals eligible for special enrollment under the Health Insurance Portability and Accountability Act within seven days of such individual's request for enrollment. If there are any changes in coverage before the first day of coverage, an updated SBC must be provided by the group health plan. This is a significant acceleration from current ERISA disclosure rules, which require that a summary plan description be provided 90 days after becoming a participant in the plan.
- Renewal/Re-enrollment: A group health plan must automatically provide an SBC for the option in which an individual is enrolled at subsequent open enrollment/renewal periods. A participant or beneficiary may also request an SBC for options in which they are not enrolled at renewal.
- Material Change: A group health plan must automatically provide an SBC upon mid-year material modification to coverage that affects the content of an SBC, as described in more detail below.
- Upon Request: A group health plan must provide a participant or beneficiary with an SBC as soon as administratively practicable after a request for an SBC, but no later than seven days after such request.

Provision of the SBC to Plan Sponsors

The proposed regulations require that a health insurance issuer provide an SBC to a plan sponsor within seven days of receiving an application or a request for information about a group health insurance policy, or upon request. If the group health plan applies for coverage and there are any changes in coverage, an updated SBC must be provided by the health insurance issuer. A health insurance issuer must also provide an SBC to a plan sponsor at renewal when the renewal application is distributed or, for automatic renewals, no later than 30 days prior to the first date of the new policy year.

Content of an SBC

The proposed regulations generally parallel the statute with regards to the content of an SBC and provide a template SBC which can be viewed here. In general, an SBC must contain:

- Uniform definitions
- A description of the plan's coverage, including exceptions, reductions and limitations
- The plan's cost-sharing provisions, such as deductibles, copays and coinsurance

- Information about continuation of coverage
- Hypothetical coverage examples selected by the Secretary of Health and Human Services to illustrate the benefits that would be provided for certain common benefits scenarios
- A statement as to whether the plan provides minimum essential coverage and whether the plan pays at least 60 percent of the total cost of benefit (on or after January 1, 2014)
- An internet address (or similar) for obtaining a list of the network providers
- An internet address where an individual may find more information about the prescription drug coverage under the group health plan or health insurance coverage
- An internet address where an individual may review and obtain the uniform glossary
- Premium information for insured plans or cost of coverage for self-insured plans
- A statement that the SBC is only a summary, and that the plan document, insurance policy, contract or certificate of insurance should be consulted for more information about the coverage provided under the plan
- Contact information for questions or for obtaining a copy of the plan document or the insurance policy, contract or certificate of insurance

Appearance, Form and Manner of an SBC

The proposed regulations provide that an SBC must be printed in 12-point or larger font and limited to four double-sided pages. The proposed regulations require the SBC to be a stand-alone document. However, as noted above, the Departments are considering how SBC requirements should be streamlined for ERISA plans that must provide summary plan descriptions, and have requested comments on ways the SBC might be coordinated with summary plan descriptions, annual enrollment materials and other mandatory group health plan disclosures.

An SBC may be provided by a group health plan to participants and beneficiaries in paper form, or with respect to group health plans subject to ERISA or the Internal Revenue Code, in electronic form as long as the group health plan satisfies the Department of Labor electronic disclosure safe harbors. (For non-ERISA plans, electronic distribution may also be used if certain safe harbor requirements are met.) A health insurance issuer may provide an SBC to a plan sponsor in paper form or electronically, provided that any electronic transmittal is readily accessible to the group plan.

The proposed rules require that SBCs be provided in a culturally and linguistically appropriate manner similar to the PPACA rules regarding group health plan claims and appeals communications. Generally, group health plans must disclose the availability of language services and provide written translation of an SBC in a non-English language upon request in certain counties that have been identified by the U.S. Census Bureau as having a concentration of non-English speakers.

Notice of Material Modification—the 60-Day Advance Notice Rule

The proposed regulations clarify that if a group health plan or health insurance issuer makes a mid-year material modification to coverage that affects the content of an SBC, the group health plan or health insurance issuer must provide a 60-day *advance* notice to enrollees. This is a significant change from current ERISA rules, which require provision of a notice of material modification within 60 days after adoption of a material reduction in group health plan covered services or benefits, or within 210 days after adoption of any other type of material modification or change. The 60-day advance notice rule *does not* apply to modifications made at renewal/annual open enrollment. A "material modification" under the proposed rules is the same as a "material modification" under ERISA Section 102 (any change to the coverage offered that independently or in conjunction with other contemporaneous changes would be considered by the average plan participant to be an important change, including changes that enhance or reduce benefits, increase premiums or cost-sharing or impose new referral requirements).

The advance notice may be provided through a separate notice or an updated SBC. For ERISA plans, the rules regarding the timing of a summary of material modification still apply for modifications that do not affect information provided in an SBC.

Provision of a Uniform Glossary

The proposed rules require that group health plans and health insurance issuers make a uniform glossary of terms available to participant and beneficiaries. The uniform glossary may not be modified and must be provided in either paper and electronic form upon request by a participant or beneficiary within seven days. (A paper version of the uniform glossary must be available upon request.)

The health-coverage-related terms and medical terms that will need to appear in the uniform glossary include allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network coinsurance, in-network co-payment, medically necessary, network, nonpreferred provider, out-of-network coinsurance, out-of-network co-payment, out-of-pocket limit, physician

services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care, as well as other terms the Secretary determines are important to define, so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits).

What This Means for Your Group Health Plan?

At this time, there has been no extension of the March 23, 2012, deadline and no exceptions from the SBC requirement for ERISA plans that must already provide summary plan descriptions. Thus, employers that sponsor group health plans should start working with third party administrators and insurance providers to compile the information necessary to meet the SBC requirements. A group health plan or health insurance issuer that willfully fails to provide an SBC will be subject to a fine of up to $1,000 per enrollee who does not receive the SBC. Excise taxes and self-reporting requirements under Section 4980D of the Internal Revenue Code also apply.

McDermott will continue to monitor and alert clients about this and other new health care reform guidance. Please contact your regular McDermott lawyer if you have any questions regarding the above proposed regulations.