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LEGAL ALERT

April 9, 2012

Agencies Issue FAQs on SBC Requirements

The tri-agency task force[1] has released new FAQs on the rules requiring group health plans and health insurers to issue Summaries of Benefits and Coverage (SBCs) under the Patient Protection and Affordable Care Act (PPACA). The FAQs are Part VIII in a series of informal PPACA guidance issued by the task force since March 2010. These FAQs address the effective date for the SBC rules; the ability to consolidate certain information on an SBC; certain other format, delivery and content requirements; and the agencies' expected enforcement approach during the first year. In perhaps the most significant FAQ, the agencies also provide at least temporary relief from the rule in the final regulations that would have made plans and issuers responsible for the accuracy and timeliness of SBCs even if they had contracted with a provider to prepare and/or deliver the SBCs.

Background

Section 2715 of the Public Health Service Act (PHSA), as added by PPACA, directs the agencies to work with a National Association of Insurance Commissioners (NAIC) working group to develop standards for compiling a four-page summary of benefits and coverage for enrollees in group and individual health plans. On August 22, 2011, the task force issued proposed SBC regulations and a draft template with an effective date of March 23, 2012, but requested comments on a number of open issues. In response to public comments, the task force issued FAQs on November 17, 2011, delaying the effective date of the rules until final regulations were released. The agencies released the final SBC regulations, the final SBC template and other related guidance on February 14, 2012, all of which were discussed in a previous Sutherland Legal Alert that can be found here. Although a number of questions remain unanswered by that guidance, most calendar year group health plans will be required to issue SBCs to participants as soon as the fall 2012 open enrollment season.

The FAQs clarify a number of these issues and emphasize certain rules that were addressed in the final regulations and related guidance. The FAQs also note that while discrete changes to the SBC content requirements will be implemented beginning in 2014 when additional PPACA requirements are currently scheduled to take effect, the agencies do not plan to make significant changes to the final rules. This Legal Alert discusses only those FAQs that address issues affecting group (as opposed to individual) health plans.

Effective Date

The FAQs begin by reiterating the bifurcated effective date for the final rules, which is referred to in the rules and the FAQs as the applicability date. With respect to group health plan participants and beneficiaries who enroll or re-enroll during the plan's open enrollment period, the plan must provide an SBC no later than the first day of the <u>first open enrollment period</u> beginning on or after September 23, 2012. With respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period, the plan must provide the SBC no later than the first day of the <u>first plan year</u> beginning on or after September 23, 2012. Accordingly, most calendar year plans will need to compile the necessary data, draft, and finalize SBCs by late summer to be ready for fall open enrollment. Plans will not be required to provide SBCs to new employees, special enrollees and COBRA qualified

[1] The tri-agency task force consists of the Departments of Health and Human Services (HHS), Labor (DOL), Treasury and the Internal Revenue Service (IRS), which are also referred to above as the agencies.

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beneficiaries until the first day of the next 2013 plan year, to the extent that these individuals first become eligible to enroll after the plan's fall 2012 open enrollment period has ended.

Combining Information on SBCs

The SBC final rules require that plans and issuers provide a separate SBC for each plan option and imply that a separate SBC may also be necessary for each coverage tier (self, self plus one, family, etc.) available under each option. The SBC final rules were also vague regarding the method for describing the impact of cost-sharing options (such as different co-payments or deductible levels), ancillary accounts (such as health savings accounts (HSAs), flexible spending accounts (FSAs) and health reimbursement accounts (HRAs)), and employer incentives (such as wellness benefits) on participant costs.

The FAQs include helpful guidance on each of these issues. With the caveat that the appearance of the SBC must be understandable, the SBC may:

- Combine cost and coverage information for different coverage tiers in one SBC, though the SBC must use the cost-sharing limits associated with the self-only coverage tier for purposes of the coverage examples and must disclose that is how the examples are prepared.
- Include information regarding various participant cost-sharing options available under a particular benefit package in the SBC for that package, provided that the coverage examples note any assumptions used in developing the examples. The sample completed SBC published by the agencies includes a sample of a note explaining assumptions used in creating the coverage examples.
- Include information on the impact of add-ons, such as HSAs, FSAs, HRAs, or wellness incentives on participant out-of-pocket costs, if those are noted in the appropriate sections of the SBC. By way of example, the FAQs point to the wellness program note contained in a text box of the last coverage example in the sample completed SBC.

Time for Delivery

The final rules require plans and issuers to provide an SBC within seven business days of a request. The FAQs clarify that this rule requires that the SBC must be sent, as opposed to delivered, within seven business days. An SBC must also be provided upon application for coverage, which some find confusing since participants generally enroll in a plan but are not generally required to apply for coverage under an insured or a self-insured plan. The FAQs clarify that for a plan that provides any written materials that a participant must complete for enrollment, including any forms or requests for information, whether on paper or electronically, the SBC must be sent with those materials. If these types of written materials are not distributed, the SBC must be provided no later than the first date on which a participant is eligible to enroll in coverage.

The FAQs also clarify that, for a plan, the requirement to provide the SBC upon renewal requires delivery with open enrollment materials if participants must actively elect or re-elect coverage for the next year. However, if the plan provides for evergreen coverage elections, with no opportunity to change coverage options during an open enrollment period, the SBC must be provided no later than 30 days before the first day of the new plan or policy year. If the coverage has not been renewed under an insurance policy within this 30-day period, the SBC must be provided as soon as practicable, but in no event later than seven business days after the earlier of the actual date of issuance or the date of receipt of a written confirmation of intent to renew.

Finally, the FAQs note that a COBRA qualified beneficiary who has elected benefits has the right to receive an SBC at the same time employees receive SBCs in connection with open enrollment, and the

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beneficiary must also receive an SBC under circumstances in which he or she would be entitled to change enrollment options, such as when moving to an area not covered by his or her previous provider network.

Responsibility for Delivery

Under PPACA and the final rules, plans and issuers are solely responsible for the content and delivery of the SBC and for non-compliance penalties. However, the FAQs ease these rules at least until further guidance is issued. Specifically, the FAQs say that, if a plan or an insurer has contracted with a provider to (1) complete the SBC, (2) provide information needed to complete the SBC (such as a pharmacy benefit manager for prescription drug coverage or a managed behavioral health organization for mental health and substance abuse coverage), or (3) deliver the SBC, the plan or issuer will not be subject to penalties for failing to provide a timely or complete SBC as a result of the provider's failure to perform, if the plan or issuer:

- Monitors the performance of the provider under the contract;
- Corrects any known violation of the SBC rules by the provider as soon as practicable if it has the information to do so; and
- If it does not have the information necessary to make the correction, communicates with participants and beneficiaries regarding any violation and begins taking steps to prevent future violations.

This relief is available only if the plan or the insurer has a legally binding contract with the provider regarding the provider's responsibilities with respect to the SBC; also, the relief is available to an insured plan if the insurer agrees to be contractually responsible for preparing and/or delivering the SBC. While this standard will require plans and issuers to have formal contracts with and monitor providers that take on SBC responsibilities, it provides welcome relief from the position taken in the final regulations that plans and issuers could not avoid liability for a provider's failure to perform.

Method of Delivery

The SBC may be delivered electronically to participants and beneficiaries who are eligible but not enrolled in coverage[2] if the format used is readily accessible (for example, html, Word or pdf) and a paper copy is provided free of charge upon request. If the SBC is provided via an Internet posting, the plan must advise participants and beneficiaries, on paper or via email, that the SBC is available via Internet and provide the Internet address. The FAQs provide model language to meet this notice requirement. An insurer may also follow these rules for delivery of an SBC to a plan.

Format and Content Requirements

The FAQs provide information on a number of format and content issues not addressed in the final rules. For instance, while the SBC may be delivered along with the plan's SPD, it may not simply cross-reference the SPD to satisfy the SBC content requirements. However, the SBC may reference the SPD in the footer as a source for additional information or may include references to specific pages or portions of the SPD to supplement or elaborate on SBC content. Plans and issuers may also add premium information to the SBC voluntarily, if it is added at the end of the SBC.

[2] The DOL electronic delivery rules still apply to SBCs delivered to participants and beneficiaries who are already covered under the plan.

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With respect to the SBC template, the FAQs provide that a plan or issuer may opt to include the template header information (plan name, name of the sponsor or insurer, coverage period, coverage tier and type of plan) on the first page of the SBC, but not subsequent pages, and may reference the coverage period for the plan as a whole, rather than the coverage period for the person to whom the SBC is delivered (for example, for a new hire mid-year). Also, the plan names used in the header may include generic terms, such as "standard option" or "high option," and an insured plan may list either the issuer's name or the plan name first. Plans and issuers may opt to include the required SBC template footer information (toll-free number and web address for questions, website where uniform glossary can be located) only on the first and last pages, rather than every page, of the SBC. Plans may add barcodes and control numbers to the SBC template for quality control purposes, but the OMB control numbers found on the agency-issued SBC template should not be displayed on any SBC issued by a plan or issuer. Plans and issuers may make minor adjustments to the size of the rows or columns in the SBC template in order to accommodate the plan's information, but the content must be understandable, and columns or rows may not be deleted. In addition, while grandfathered plans may include a statement on grandfather status at the end of the SBC, it is not required.

Consistent with the requirement that the SBC must be written in a "culturally and linguistically appropriate manner," the FAQs clarify that if a plan or issuer sends an SBC to an address in a county where at least 10%[3] of the population is literate only in a non-English language, all English versions of the SBC must include information on the availability of language assistance services. The statement must be included on the final page of the SBC along with information on coverage continuation and grievance and appeals rights. The FAQs also provide a link to the model notice of adverse benefit determination issued by the DOL, which contains sample language for the notice, and links to sites where written translations of the SBC template and uniform glossary will be posted in Spanish, Chinese, Tagalog, and Navajo (presumably prior to September 23, 2012). The FAQs do not state whether, and how, this requirement will be triggered if SBCs are delivered electronically, but presumably the plan will need to review participants' addresses for the relevant information before preparing its SBCs regardless of the method of delivery that will be used.

Enforcement

The FAQs explicitly state that the departments will apply a "good faith" standard during the first year of compliance, focusing on educating and assisting, rather than penalizing, plans and issuers that fall short of full compliance. Future SBC guidance is likely to provide additional detail regarding enforcement – the FAQs include references to "transition periods, grace periods, safe harbors, and other policies..." as potential tools that the agencies are considering to ease the compliance burden on plans and issuers.

The FAQs reiterate a statement from the instructions for the SBC, which says that if there are aspects of a plan that do not correspond with the instructions and the SBC template, the SBC should be completed in a manner as consistent with the instructions as possible, but without making any inaccurate representations regarding plan terms.

The FAQs signal that the agencies will take a somewhat relaxed approach to the detailed SBC content and appearance requirements in the first year by foregoing penalties if plans and issuers are making a diligent, good faith attempt to deliver the required content in a format that is consistent with the regulations.

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[3] The FAQs note that plans may voluntarily include this statement in any non-English language in counties that do not meet the 10% threshold.

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