Health Plans: What's Next?

Drinker Biddle's Health Care Reform Update for Employee Benefit Plans

The SBC Countdown Has Begun: Group Health Plan Summary of Benefits and Coverage Final Rules Issued

By Dawn Sellstrom and Rob Jensen

Beginning as early as the 2013 open enrollment period, group health plans will be required to provide the new "Summary of Benefits and Coverage" (SBC) notice. On February 9, 2012, the Department of the Treasury (Treasury), Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, the Departments), issued final regulations regarding the SBC and the uniform glossary requirement under the Patient Protection and Affordable Care Act of 2010, and a template SBC and specific instructions for completion. The final regulations will affect employers that sponsor group health plans, designated plan administrators and insurers. Below is a summary, in question and answer format, of the major provisions of the final regulations and related template guidance. This summary does not address how the requirements apply to the provision of SBCs by insurers to individuals who purchase coverage in the individual market.

What is the purpose of the SBC and uniform glossary requirements?

Under the new rules, group health plans and insurers are required to provide health plan participants and beneficiaries clear and understandable information about their plans in uniform, summary format. The main aim of these requirements is to allow group health plan participants to understand and compare health coverage options, in order to make "shopping" for coverage efficient and easy.

When are the SBC and uniform glossary requirements effective?

As Early as Open Enrollment for 2013 Benefits — For disclosures to participants and beneficiaries who enroll or reenroll in group health coverage through an open enrollment period, the requirements are effective as of the first day of the first open enrollment period that begins on or after September 23, 2012. Depending on the timing of open enrollment for 2013 benefits and the enrollment process, this means a health plan may have to provide its SBC(s) to participants and beneficiaries as early as October or November, 2012 (see "***When are group health plans and insurers required to distribute SBCs?***" below).

For Mid-Year Enrollees — For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements are effective as of the first day of the first plan year that begins on or after September 23, 2012.

For Health Insurance Issuers —The regulations become effective for disclosures by insurers to plans beginning on September 23, 2012.

Who is required to provide the SBC?

In the case of an insured group health plan, insurers are required to distribute the SBC to the group health plan (*i.e.*, the plan sponsor), and the group health plan and the insurer are both required to distribute the SBC to plan participants and beneficiaries. In the case of a self-insured group health plan, the plan's designated plan administrator is responsible.

*Drinker Biddle Note: In the case of an insured plan, because the requirement to provide an SBC to participants and beneficiaries applies to both the group health plan and to the insurer, the parties will want to address the responsibility for providing this disclosure through contractual provisions, including allocation of liability for any non-compliance penalties. Although the rules provide that the requirement to provide an SBC will be considered satisfied for all entities if it is appropriately provided by any entity, the current rules do not provide relief from the noncompliance penalties for reliance on another entity fulfilling the SBC requirement (see "**What happens if a plan sponsor or administrator fails to comply with the SBC or uniform glossary requirements?**" below).*

Is an SBC required for dental plans, vision plans, health FSAs, HSAs, and HRAs?

An SBC is not required for plans that are "excepted benefits" under HIPAA. These include stand-alone dental and vision plans, and health flexible spending arrangements (health FSAs) that are excepted benefits. Health savings accounts (HSAs) generally are not group health plans and thus, generally are not subject to the SBC requirements. Health reimbursement arrangements (HRAs), on the other hand, are group health plans subject to the SBC requirements. To the extent a non-excepted health FSA or an HRA is integrated with other major medical coverage, the SBC that is prepared for the other major medical coverage can denote the effects of the health FSA or HRA in the appropriate spaces in the SBC. In other words, a separate SBC is not required for a non-excepted health FSA or HRA, unless such plan is a stand-alone plan.

Drinker Biddle Note: Whether a particular plan is an "excepted benefit" will depend on how the HIPAA regulations apply to specific plan terms. For example, a health FSA that is funded solely through employee salary reductions will be a HIPAA excepted benefit if health FSA participants are also eligible for the plan sponsor's major medical coverage. Plan sponsors should confirm how the excepted benefit rules apply to their various plans.

When are group health plans and insurers required to distribute SBCs?

Group health plans and/or the insurers are required to distribute SBCs as follows:

Insurers to Group Health Plans — Health insurance issuers must provide an SBC to a group health plan sponsor as soon as practicable following receipt of an application by the plan for health coverage, but no later than seven business days following receipt of the application. If the information in the SBC changes before the first day of coverage, the insurer must update and provide a current SBC to the plan sponsor no later than the first day of coverage. If a plan sponsor requests the SBC or other summary information about an insured product, the insurer must provide an SBC as soon as practicable, but no later than seven business days following receipt of such request. In addition, the insurer must provide the SBC to the plan sponsor upon renewal (the timing rules are similar to those for providing the SBC directly to participants and beneficiaries, described below).

Group Health Plans and/or Participants & Beneficiaries — Group health plans and/or the insurer must provide an SBC to participants and beneficiaries as follows:

- *At enrollment* — As part of any written application materials distributed for enrollment (or if no such application materials are provided, no later than the first date the participant is eligible to enroll in coverage), provided that if there is any change to any information in the SBC following the application, but before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.

- *To special enrollees* — To special enrollees (*i.e.*, those participants and beneficiaries entitled to special enrollment rights under HIPAA) within 90 days after enrollment.

- *At renewal or reenrollment* — If an application is required for renewal or reenrollment (in either paper or electronic form), the plan or insurer must provide the SBC with the application materials. If renewal or reenrollment is automatic, the plan or insurer must provide the SBC at least 30 days prior to the first day of the plan year or policy year. Note: for fully-insured plans, if the policy has not been issued or renewed before this 30-day period, the SBC must be provided as soon as practicable, but no later than seven business days after the new policy is issued (or receipt of written confirmation of intent to renew, if earlier).

  Drinker Biddle Note: The rules do not clearly describe what it means to require an application for renewal or to provide automatic renewal, especially in the context of a health plan that provides an annual open enrollment opportunity, but automatically defaults a participant to the same option the participant enrolled in for the prior year unless the participant changes the prior election.

The rules indicate that health plans with multiple benefit options are required to provide a new SBC automatically upon renewal or reenrollment only for the benefit package in which the participant or beneficiary is enrolled. However, more guidance is needed on how these rules coordinate. In the absence of additional guidance, plan administrators and insurers should consider alternative approaches. One interpretation of the rule is that a plan that automatically renews coverage if a participant takes no action does not require an application; thus, a plan administrator or insurer is required to distribute only an SBC for the option in which a participant enrolls, within 30 days of the new plan year. Alternatively, a more conservative approach is to distribute an SBC for each available health plan option to participants with open enrollment materials.

- *Upon request* — To a participant or beneficiary as soon as practicable, but no later than seven business days following any request for an SBC.
- *Material modification* — To the extent a group health plan implements a mid-year change that is a material modification, and that change affects the content of an SBC, a notice of material modifications must be provided to participants and beneficiaries at least 60 days in advance of the effective date of the change. This rule does not apply when the change is in connection with a renewal or reissuance of coverage.

  Drinker Biddle Note: A "material modification" for this purpose includes any modification to the coverage offered under a plan or policy that, independently, or with other contemporaneous modifications or changes, would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan or policy, including enhancements and reductions in covered services.

What must be included in an SBC?

A separate SBC must be prepared for each benefit package option (*e.g.*, one SBC for the employer's PPO option and one for its HMO option). The template SBC is drafted to apply to a single tier of coverage, so it is clearly acceptable to create a separate SBC for each tier of coverage (*e.g.*, individual, individual plus one, family). In the absence of further guidance to the contrary, if the differences in coverage are discrete (*e.g.*, limited to different deductibles and out-of-pocket amounts) such that including multiple tiers is not confusing, it may be reasonable to provide a combined SBC that covers all tiers of coverage related to a single benefit option. An SBC generally must include the following:

- Uniform definitions of standard insurance and medical terms;
- A description of the coverage, including cost sharing, for each category of benefits identified by the Departments;
- Any exceptions, reductions, and limitations on coverage;
- The cost-sharing provisions of coverage, including deductible, coinsurance, and copayment obligations;
- The renewability and continuation of coverage provisions;
- Coverage examples of common benefits scenarios (including having a baby under a normal delivery and managing type-2 diabetes) and related cost-sharing based on recognized clinical practice guidelines;
- A statement that the SBC is only a summary and that the plan or policy controls;
- Contact information for questions and obtaining a copy of the plan document, insurance policy, certificate, or contract of insurance;
- For plans that maintain one or more networks of providers, an internet address (or similar contact information) for obtaining a list of network providers;
- For plans that maintain a prescription drug formulary, an internet address (or similar contact information) where an individual may find more information about prescription drug coverage under the plan;
- An internet address where an individual may review the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available; and
- Beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage and meets certain cost-sharing requirements.

Note that the final regulations *do not* require the SBC to include premium or cost of coverage information.

What does a group health plan sponsor need to do to comply with the uniform glossary requirements?

In order to help participants and beneficiaries understand and compare the terms of coverage and medical benefits provided, the Departments have developed a glossary of definitions of insurance, medical, and other terms, presented in a uniform format and using terminology that is understandable by the average plan participant and beneficiary. In addition to the information required to be included in the SBC with respect to the uniform glossary (as described above), a group health plan or insurer must make the uniform glossary available upon request within seven business days. Guidance issued on the uniform glossary makes it clear that the glossary cannot be modified in any way.

Can the format of the SBC template be modified?

Generally, no. Under the statute, an SBC must be in a uniform, easy-to-understand format that is culturally and linguistically appropriate, not exceed four double-sided pages, and be in at least 12-point font. To this end, the Departments issued an SBC template (which accommodates both fully-insured and self-insured plans), a sample completed SBC, and instructions for completing the SBC.

Drinker Biddle Note: Plan sponsors will want to carefully review the instructions as they are very specific as to the placement of certain content, and require that all symbols, formatting, bolding, and shading be replicated. Notably, the Departments authorized the template and other materials for the first year of applicability only. The Departments intend to issue updated materials for subsequent years.

But what if required content cannot reasonably be described using the template?

The guidance on the SBC template acknowledges that there may be some situations under which a plan's terms cannot reasonably be described in a manner consistent with the template. In these types of situations, the plan administrator or insurer must accurately describe the relevant plan terms, while using its best efforts to do so in a manner that is still consistent with the template and instructions.

Drinker Biddle Note: Examples of plan terms that may be difficult to describe using the current template include:

- *a plan's provider network or drug tiers that vary from the structure contemplated by the SBC template and instructions;*
- *benefits that vary by facility type (*e.g.*, hospital in-patient vs. non-hospital in-patient);*
- *where the effects of an HRA are being described; and*
- *cost sharing that varies based on participation in a wellness program.*

Plan sponsors considering variations on the SBC template, including how to address special situations, should consult appropriate legal counsel.

Can the SBC be included in the plan's summary plan description (SPD)?

Yes, if certain conditions are met. A plan administrator may choose to provide an SBC in combination with an SPD, as long as the SBC information is intact and prominently displayed at the beginning of the SPD (*e.g.*, immediately following the table of contents) and the timing requirements for providing an SBC are otherwise satisfied.

Does the SBC need to be translated into a foreign language?

Yes, in some instances. The final rules incorporate by reference the same standard for providing language assistance as is required by the enhanced appeals requirements under health care reform. This means that language assistance must be provided if the SBC is sent to an address in a county where 10% or more of the population residing in that county is literate only in the same non-English language. Language assistance includes oral language services (*e.g.*, telephone hotline in the non-English language), providing the notice in the non-English language (if requested), and adding a statement to the SBC in the applicable non-English language(s) about how to access language services. Under current guidance, translation may be required into Spanish, Tagalog, Chinese and Navajo.

What distribution methods can a plan use?

The SBC may be distributed in paper form or electronically. For participants and beneficiaries who are already covered under the group health plan, the plan administrator (or insurer, as applicable) must comply

with the DOL's disclosure rules, which include the safe harbor for electronic disclosures. For participants and beneficiaries who are eligible but not enrolled in coverage, the SBC may be provided electronically if the format is readily accessible and a paper copy is provided free upon request. In this case, if the electronic form is Internet posting, the plan administrator (or insurer, as applicable) must timely advise the individual in a paper form (*e.g.*, a postcard) or email that the documents are available on the Internet, provide the Internet address, and notify the individual that the documents are available in paper form upon request. All participants (both covered, and eligible but not enrolled) have the right to receive an SBC in paper format, free of charge, upon request.

A single SBC may be provided to a family at the family's last known address, unless any beneficiaries are known to reside at a different address.

Drinker Biddle Note: Additional guidance on electronic disclosure would be helpful. For example, what does "readily accessible" mean? Is it sufficient to send an e-mail with a link to the SBC to the individual's work e-mail address even if the individual does not regularly access that e-mail account for job-related reasons? Note that under the current DOL safe harbor for electronic disclosure, generally, the recipient must either have job-related, effective access to the electronic distribution method (including access to the employer's electronic information system as an integral part of the recipient's job), or give affirmative consent to receive the disclosure electronically.

What happens if a plan sponsor or administrator fails to comply with the SBC or uniform glossary requirements?

If a plan administrator willfully fails to provide an SBC, it may be assessed a penalty of up to $1,000 for each failure to provide an SBC to an individual. In addition, a plan sponsor may be subject to an excise tax under the Internal Revenue Code of up to $100 a day, for each affected individual, unless certain exceptions apply.

At this point, what steps should plan sponsors be taking to comply with the final regulations?

- Consider developing a comprehensive communication strategy (or modifying the current strategy) to help participants understand how the SBC is meant to work with the other information provided about the plan.
- Determine how their health plans will comply with the SBC requirements. This may involve talking to insurers (in the case of insured plans), third-party administrators (in the case of self-insured plans), and legal counsel to determine how best to timely prepare and distribute the SBC(s) to comply with the new requirement.
- Determine the number of SBCs that must be prepared and distributed, based on the health benefit options offered and tiers of coverage, and whether the SBC will be combined with a health plan's SPD.
- Review the SBC template, sample completed SBC, and instructions for completing the SBC and identify any open questions.

Employee Benefits & Executive Compensation Practice Group

If you have questions not addressed by this summary, or you would like assistance in preparing to comply with this new reporting obligation, please contact a member of the Drinker Biddle Employee Benefits & Executive Compensation Practice Group or your regular Drinker Biddle attorney.

Heather B. Abrigo
(310) 203-4054
Heather.Abrigo@dbr.com

Kathleen O'Connor Adams
(312) 569-1306
Kathleen.Adams@dbr.com

Gary D. Ammon
(215) 988-2981
Gary.Ammon@dbr.com

Bruce L. Ashton
(310) 203-4048
Bruce.Ashton@dbr.com

Pascal Benyamini
(310) 203-4050
Pascal.Benyamini@dbr.com

Mark M. Brown
(215) 988-2768
Mark.Brown@dbr.com

Summer Conley
(310) 203-4055
Summer.Conley@dbr.com

Barbara A. Cronin
(312) 569-1297
Barbara.Cronin@dbr.com

Joseph C. Faucher
(310) 203-4052
Joe.Faucher@dbr.com

Mona Ghude
(215) 988-1165
Mona.Ghude@dbr.com

Lindsay M. Goodman
(312) 569-1314
Lindsay.Goodman@dbr.com

Megan Glunz Horton
(312) 569-1322
Megan.Horton@dbr.com

Robert L. Jensen
(215) 988-2644
Robert.Jensen@dbr.com

Melissa R. Junge
(312) 569-1309
Melissa.Junge@dbr.com

Sharon L. Klingelsmith
(215) 988-2661
Sharon.Klingelsmith@dbr.com

Christine M. Kong
(212) 248-3152
Christine.Kong@dbr.com

David Levin
(202) 230-5181
David.Levin@dbr.com

Howard J. Levine
(312) 569-1304
Howard.Levine@dbr.com

Sarah Bassler Millar
(312) 569-1295
Sarah.Millar@dbr.com

Joan M. Neri
(973) 549-7393
Joan.Neri@dbr.com

Monica A. Novak
(312) 569-1298
Monica.Novak@dbr.com

Cristin M. Obsitnik
(312) 569-1303
Cristin.Obsitnik@dbr.com

Fred Reish
(310) 203-4047
Fred.Reish@dbr.com

Michael D. Rosenbaum
(312) 569-1308
Michael.Rosenbaum@dbr.com

Dawn E. Sellstrom
(312) 569-1324
Dawn.Sellstrom@dbr.com

Lori L. Shannon
(312) 569-1311
Lori.Shannon@dbr.com

Mark J. Simons
(215) 988-2995
Mark.Simons@dbr.com

Ryan C. Tzeng
(310) 203-4056
Ryan.Tzeng@dbr.com

Michael A. Vanic
(310) 203-4049
Mike.Vanic@dbr.com

Joshua J. Waldbeser
(312) 569-1317
Joshua.Waldbeser@dbr.com

Stephen P. Wilkes
(415) 591-7554
Stephen.Wilkes@dbr.com

David L. Wolfe
(312) 569-1313
David.Wolfe@dbr.com

Drinker Biddle

Employee Benefits & Executive Compensation Practice Group

www.drinkerbiddle.com

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