

Health Reform Update

Guidance Issued on Summary of Benefits and Coverage

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The Affordable Care Act requires group health plans to provide a standardized 4-page summary of benefits beginning in 2012, and to provide updates to that summary no later than 60 days prior to the effective date of any changes made. By requiring coverage information in a standardized format, the reform allows consumers and plan participants to make direct comparisons between the coverage available under different policies or coverage options.

Proposed regulations were recently issued regarding the Summary of Benefits and Coverage (SBC), and guidance was also issued regarding a Uniform Glossary of Insurance Terms. The guidance addresses when, how and to whom the SBC must be distributed and provides templates, instructions and related materials to assist with the SBC and Uniform Glossary. Several gaps were left in the guidance, and comments on the regulations are requested by October 21, 2011; thus, we can expect further guidance to be issued.

Who Must Provide the SBC?

In general, for both grandfathered and non-grandfathered plans, the insurance carrier must provide the SBC for a fully insured group health plan and the plan administrator must provide it for a self-insured plan. In the fully insured context, the regulations discuss that the carrier would likely provide the SBC to the plan, which would then provide it to participants and beneficiaries. The SBC requirement applies jointly to plans and carriers, but the regulations provide that the requirement will be satisfied if either party provides a timely and otherwise compliant SBC.

Content of SBC

The regulations describe specific requirements for content, all of which are contained in the sample SBCs which can be found at www.dol.gov/ebsa/pdf/SBCtemplate.pdf and www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf. Uniform definitions, a description of the coverage, exceptions, renewability and coverage examples are some of the items that must be included. Note that, although the Affordable Care Act requires plans and insurers to include a statement in the SBC as to whether the plan or coverage provides minimum



essential coverage, this statement will not be required in SBCs prior to January 1, 2014 since the individual mandate and related rules are not effective until such time. The SBC must be presented in a uniform format with print no smaller than 12-point font and must be no longer than four double-sided pages. It must also be provided in a “culturally and linguistically appropriate manner.” In general, this means that it must be provided in a non-English language upon request if 10% or more of the population residing in the county is literate only in the same non-English language.

Providing the SBC

In general, plans and insurance carriers must comply with the SBC requirements beginning or on after March 23, 2012 (although the regulations note that a mid-plan year change could cause problems, the effective date has not yet been changed). The SBC must be a stand-alone document, though comments are being sought as to whether it should be permitted to be provided in the SPD or other plan materials. It may be provided electronically or in paper form. If it is provided electronically, the ERISA electronic disclosure safe harbor must be met. To avoid duplication, the regulations state that if a participant or any beneficiaries are known to reside at the same address, a single SBC may be provided to that address, unless the plan has a different last known address for any of the covered individuals.

The SBC must be provided as follows:

- From the carrier to the plan: automatically, upon an application or request for information from the plan, and upon renewal.
- From the plan (or carrier) to participants: automatically with respect to each benefit package offered for which the participant or beneficiary is eligible. It must be provided as part of the enrollment materials, or no later than the first date the participant is eligible to enroll in coverage. The SBC must also be sent to special enrollees upon a special enrollment request (within 7 days of the request), and upon renewal of coverage. If the SBC changes between the time it is first provided and the date coverage starts, a new one must be provided as of the first day of coverage.
- Upon request by the plan to the carrier and by a participant to the plan. It must be provided as soon as practicable upon request, but in no event later than 7 days after the request.

Modifications to Coverage

If there is a material modification made to the plan, other than in connection with a renewal of coverage (i.e., for mid-year modifications), that would affect the content of the SBC, a Notice of Modifications must be used. A modification is “material” if alone, or in conjunction with other changes, it would be considered by an average participant to be an important change in covered benefits or other terms of coverage. It can be either an increase or decrease in

benefits or coverage. The notice must be provided no later than 60 days before the changes become effective. This requirement is different from the Summary of Material Modifications (SMM) requirement under ERISA, which requires notice within 210 days after the close of the plan year in which the modification was adopted, or in the case of a material reduction in covered benefits, not later than 60 days after the date of adoption of the modification. The notice requirement may be satisfied either by a separate notice describing the material modification, or by providing an updated SBC reflecting the modification. The SBC can be drafted to comply with this notice requirement, as well as the SMM requirement under ERISA.

Uniform Glossary

The Affordable Care Act also required the government to develop standard definitions for insurance and medical-related items, and other terms that will help consumers understand and compare terms of coverage and medical benefits. The Uniform Glossary is available at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf and must be made available by a plan or carrier upon a participant’s request within 7 days. The document may be provided on an Intranet or Internet site, or a link to the DOL or HHS site may be provided; however, if a paper copy is requested, it must be provided.

Penalties for Noncompliance

A penalty of up to \$1,000 may be assessed for the willful failure to provide the SBC or Uniform Glossary. Each failure with respect to a participant or beneficiary constitutes a separate offense. Additional excise tax penalties and reporting obligations may also apply.

Action to Take

For calendar year plans, these new requirements do not apply to the 2012 open enrollment. If the next plan year begins in or after February 2012, the new requirements must be included in open enrollment materials. Employers with fully insured group health plans should check with their carriers to ascertain whether the carriers will deliver SBCs directly to participants. If not, they will need to make arrangements to prepare and/or distribute the SBCs. Self-insured group health plan sponsors should consult with counsel and/or their third party administrators to develop a compliant SBC and delivery of same.