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BENEFITS BRIEF

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AGENCIES ISSUE SUMMARY OF BENEFITS PROPOSED REGULATION UNDER PPACA

On August 22, 2011, the Departments of Health and Human Services, Labor, and Treasury published a proposed rule under the Patient Protection and Affordable Care Act (PPACA) that requires group health plans and health insurance issuers providing group or individual coverage to provide applicants and enrollees with a uniform Summary of Benefits and Coverage. 76 Fed. Reg. 52442 (Aug. 22, 2001). The proposed rule requires plans to deliver a 4-page (front and back) document that describes the benefits under the plan, in addition to the SPD or certificate of coverage plans or insurers already provide. The proposed rule also requires plans to provide a uniform glossary to participants. 76 Fed. Reg. 52475 (Aug. 22, 2011).

The new summary of benefit requirement applies to insured and self-funded ERISA group health plans, including grandfathered plans, as well as to non-ERISA group health plans. The new rules also apply to individual health insurance coverage. The Departments request comment as to whether the requirement should apply to expatriate health insurance coverage.

Even though the rule is in proposed form, plans should start paying attention now. The effective date of the summary of benefits and coverage requirement has not been extended, and there may not be very much lead time to draft these documents once final rules are issued. Plans should be aware of the content of this new summary of benefits requirement so they can hit the ground running.

Comments are due October 21, 2011. The requirement is effective March 23, 2012.

I. Background

PPACA added Public Health Services Act section 2715, which requires plans to issue a summary of benefits to applicants and enrollees that describes the plan's coverage in a uniform manner. The statute required that the summary be limited to 4 pages with 12-point font and be understandable by the average reader. The statute also provided that if the plan had a material modification that would cause a change to the summary of benefits, the plan had to provide notice of the change to enrollees 60 days in advance. The penalty for failing to comply with the new requirement would be $1,000 per failure.

The statue required the Secretary of Health and Human Services (HHS) to consult with National Association of Insurance Commissioners (NAIC) on the content to be included in the summary and required HHS to develop standards within 12 months of enactment (which would have been March 23, 2011). The statute then set the effective date for plans and insurers for 24 months after enactment – or March 23, 2012.

II. Proposed Regulation

The Departments issued a proposed rule and supplementary material (both in the Federal Register) on August 22, 2011. The proposed rule sets out when and to whom a Summary of Benefits and Coverage (SBC) must be delivered, the format and appearance for the SBC, requirements of electronic delivery, and content requirements.

Regarding content, the Preamble notes that the Departments largely adopted the NAIC recommendations "as is" but request comment on a number of issues. The Preamble also notes that the NAIC documents were drafted "primarily for use by health insurance issuers" so additional modifications may be needed for self-funded group health plans.

We set out below the specific requirements of the proposed rule.

Who Must Provide the SBC?

The proposed rule requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide the SBC. For group health plans, the proposed rule would make the plan administrator responsible for providing the SBC. For insured group health plans, the proposed rule allows the SBC to be delivered either by the group health plan or the insurer – only one SBC needs to be delivered. The SBC must be provided free of charge.

What Information Must Be Included in the SBC?

The supplementary materials to the proposed rule (also found in the Federal Register at 76 Fed. Reg. 52475) set out an SBC template and instructions for completing the SBC. Generally, all SBCs will include the same information in the same format and order so that applicants and enrollees can compare this information.

The SBC template requires reporting of:

- Uniform definitions;
- A description of coverage;
- A description of the plan's exceptions, reductions, and limitations;
- The plan's cost-sharing provisions, including deductibles, coinsurance, and copayments;
- Renewability and continuation of coverage provisions;
- For coverage beginning on or after 1/1/14, a statement whether the plan provides minimum essential coverage, as defined under IRC §5000A(f), and whether the plan's share of total allowed costs of benefits meets applicable requirements;
- A statement that the SBC is a summary only and that the plan document or policy should be consulted to determine governing provisions;

- Contact information for questions or to obtain a copy of the plan or policy (such as a phone number for customer service and Web address for obtaining a copy of documents);

- If the plan maintains more than one network, the Internet address or similar contact information for obtaining a list of network providers;

- If the plan uses a prescription drug formulary, the Internet address or similar contact information for obtaining information on prescription drug coverage;

- The Internet address for obtaining the uniform glossary (see below); and

- Information on premiums for insured coverage or the cost of coverage for self-funded coverage.

In addition, the SBC must include coverage examples for common benefits scenarios adopted by HHS. The coverage examples would be based on criteria provided by HHS that all plans must use (such as type of treatment and dates of service). The plan then would have to calculate and report whether the service would be covered and what level of cost-sharing would apply. Initially, HHS has adopted three coverage examples – for pregnancy, breast cancer treatment (except for individual policies), and diabetes. The proposed rule states that HHS may adopt up to six coverage examples.

HHS will specify the information necessary to create the coverage examples on its website (http://cciio.cms.gov) and update this information annually. The Preamble to the supplementary materials says that a plan or issuer must incorporate any new information from the HHS website into its coverage examples in the next SBC required 90 days after the website is updated. (However, this change would not be considered a material modification under the 60-day advance notice rule below.)

Under the preemption rule of the proposed regulation, states may impose additional disclosure requirements on health insurance issuers.

What Are The Formatting Requirements for the SBC?

The proposed rules require that the SBC be a stand-alone document, although the Preamble solicits comments on whether a plan or health insurance issuer should be permitted to provide the SBC in the SPD or other plan materials. The SBC may be no more than 4 pages (front and back – a total of 8 pages) in 12-point font. The Preamble notes that the SBC may be printed in color or black and white. The SBC may be provided in paper format or electronically, if electronic delivery rules are met (discussed below).

Must the SBC Be Translated into Non-English Languages?

The proposed rule requires that the SBC be provided in a "culturally and linguistically appropriate manner." The rule says that a plan will be considered to meet this requirement if thresholds and standards under the PPACA appeals rules are met. The appeals rule requires plans to disclose the availability of language services and translate adverse benefit determinations into a non-English language for notices sent to addresses in certain counties that have been

identified by the US Census Bureau as having a concentration of non-English speakers. A recent amendment to the appeals interim final rule includes a chart of such counties and the applicable languages (which are Spanish, Mandarin, Navajo, and Tagalog). 76 Fed. Reg. 37208 (June 24, 2011).

When Must a Group Health Plan Deliver an SBC to Plan Participants and Beneficiaries?

- At Enrollment - The plan must provide an SBC for all options for which an individual is eligible to enroll with any written application materials distributed by the plan. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first day the participant is eligible to enroll. In addition, if there is any change to the SBC before the first day of coverage, the plan must provide an updated SBC no later than the first day of coverage. The plan also must provide an SBC to HIPAA special enrollees within 7 days of a request for enrollment.

  The proposed rules allow a plan to deliver a single SBC to participants and beneficiaries residing at the same address, unless the plan has a different last known address on file for any of the covered individuals.

- At Renewal – The plan must provide an SBC for the option in which the individual is enrolled at renewal. The plan also must provide SBCs for options in which the participant or beneficiary is eligible, but not enrolled, upon request. If a written application is required for renewal, the plan must provide the SBC no later than the date application materials are distributed. If benefits automatically are renewed, the plan must provide the SBC at least 30 days prior to the first day of the new plan year.

- Upon Request - If a participant or beneficiary requests, the plan must provide an SBC as soon as practicable, but no later than 7 days after request.

When Must an Insurer Deliver an SBC to a Group Health Plan?

- Upon Application – An insurer must provide the SBC upon the group health plan's application or as soon as practicable after a request for information, but no later than 7 days after the request. If the plan subsequently applies for coverage, a second SBC must be provided if there has been a change to the SBC. In addition, if there is any change to the SBC before coverage is offered or the first day of coverage, the insurer must provide an updated SBC no later than the date of offer or first day of coverage, as applicable.

- At Renewal – An insurer must provide an SBC to a group health plan when a policy is renewed or reissued. If a written application is required, the insurer must provide the SBC no later than the date materials are distributed. For automatic renewals, the insurer must provide the SBC at least 30 days prior to the first day of the new policy year.

- Upon Request – An insurer must provide an SBC to a group health plan as soon as practicable upon request, but no later than 7 days after the request.

When Must an Insurer Deliver an SBC to an Individual Policyholder?

- Upon Application – An insurer must provide an SBC upon application or as soon as practicable after a request for information, but no later than 7 days after the request. If an individual subsequently submits an application, a second SBC must be provided if there has been a change to the SBC. In addition, if there is any change to the SBC after receipt of the application, the insurer must provide an updated SBC as soon as practicable but no later than the date on which the offer of coverage is made. If an individual accepts an offer of coverage, the insurer must provide a new SBC before the first day of coverage if there has been change to the SBC.

- At Renewal – The insurer must provide a new SBC annually to policyholders at least 30 days prior to the first day of a new policy year.

- Upon Request - If a policyholder or covered dependent requests, the insurer must provide an SBC as soon as practicable, but no later than 7 days after request.

May the SBC Be Delivered Electronically?

Electronic delivery rules vary by which party is receiving the SBC.

- For Delivery from Group Health Plans to Individuals – For ERISA group health plans, the SBC may be delivered in electronic form if the delivery meets ERISA's general delivery rules at 29 CFR § 2520.104b-1 (which include the electronic delivery safe harbor). For non-federal governmental plans, the SBC may be delivered in electronic form if the delivery meets either ERISA's general delivery rule or the individual coverage electronic delivery rules below.

- For Delivery from Insurers to Group Health Plans – The SBC may be delivered in electronic form if: (1) the format is readily accessible by the plan; (2) the SBC is provided in paper form free of charge upon request; and (3) if the electronic form is an Internet posting, the insurer timely advises the plan in paper form or email that documents are available on the Internet with the Web address.

- For Delivery from Insurer to Individuals in Individual Insurance Policy - Unless otherwise requested by individual, the SBC must be provided in paper form (along with subsequent SBCs) if: (1) the request for information/application is made in person, by phone, or by mail; and (2) the application is submitted by phone or mail.

  The SBC may be delivered electronically if (1) the request for information/application is made electronically; or (2) the application is submitted electronically. In addition, an insurer must: (1) request that the individual acknowledge receipt of the SBC; (2) make the SBC available in an electronic format that is readily usable by the general public; (3) if posted on the Internet, post the SBC in a location that is prominent and readily accessible and provide timely notice to each individual who requests information or applies for coverage, in electronic or non-electronic form, of the Web address at which the SBC is posted; (4) provide without charge

or penalty (or any other condition or consequence) a paper copy of the SBC upon request; and (5) provide the ability to request a paper copy of the SBC on the insurer's website or by phone (the number for which should be listed prominently on the insurer's website, policy documents, and other marketing materials).

Must a New SBC Be Issued If There Are Modifications?

If a plan or insurer makes a mid-year material modification to coverage that would affect the content of the SBC, the plan or insurer must provide notice of the modification to enrollees no later than 60 days prior to the date the modification becomes effective. The requirement does not apply to modifications at renewal. The proposed rule defines a "material modification" the same as defined in ERISA §102, which includes 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 Preamble notes that a modification notice can either be a separate notice describing just the material modification or an updated SBC. If delivered electronically, the modification notice must follow the electronic delivery rules for SBCs.

Does this Mean That All Plan Amendments Require Advance Notice?

No. ERISA requires that a plan provide a summary of material modification (SMM) within 210 days of the close of the plan year in which the change is adopted (or in the next SPD if sooner). For material reductions in health benefits, the SMM must be delivered within 60 days after adoption. These rules still apply. However, if a plan amendment would cause a corresponding change to the SBC, notice must be provided 60 days in advance.

What is the Uniform Glossary and How Must it Be Delivered?

The proposed rules require that group health plans and insurers also make a glossary available to participants and beneficiaries with uniform definitions for all plans (plans may not modify the uniform glossary). The SBC must disclose the right of an individual to request a copy of the uniform glossary, and plans must make the glossary available upon request in either paper or electronic form (as requested) within 7 days.

Is There a Penalty for Not Providing an SBC?

Yes – an insurer or health plan that willfully fails to provide an SBC will be subject to a fine up to $1,000 for each failure. The proposed rule provides that a failure with respect to each participant and beneficiary constitutes a separate offense. DOL has enforcement authority over ERISA plans and indicated it will issue separate penalty regulations. HHS has enforcement authority over insurers and non-federal governmental plans. The Preamble notes that failures also are subject to the excise tax reporting requirements for group health plans (other than governmental group health plans) under Internal Revenue Code §4980D.

When Must Plans and Insurers Start Providing SBCs?

PPACA required that HHS deliver SBC standards by March 23, 2011 and that plans and insurers begin delivering SBCs by March 23, 2012. Even though HHS missed its deadline to issue regulations (and then issued proposed regulations that are subject to change), the proposed rule does not extend the applicability date. However, the Departments did seek comments on the feasibility of the effective date.