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BENEFITS BRIEF

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Summary of Benefits and Coverage Final Regulations May Impact You as Early as Open Enrollment 2012

Summary of benefits and coverage ("SBC") final regulations are available. Insurers, employers and administrators - pay close attention to these rules because they will apply to open enrollment that begins on or after September 23, 2012.

Keep reading for a brief summary of the rules.

I. Background

The Patient Protection and Affordable Care Act ("ACA") added section 2715 to the Public Health Service Act ("PHSA") which requires group health plans and health plan issuers to compile and provide an SBC that "accurately describes the benefits and coverage under the applicable plan and coverage." The SBC requirement applies to insured and self-funded ERISA group health plans, including grandfathered plans, as well as to non-ERISA group health plans and individual health insurance coverage. The SBC must follow a uniform format which includes a series of content requirements such as: uniform standard definitions of medical and health coverage terms; a description of the coverage including the cost sharing requirements (i.e. deductibles, coinsurance, and copayments); and information regarding any exceptions, reductions, or limitations under the coverage. On August 22, 2011, the Departments of Health and Human Services, Labor, and Treasury (the "Agencies") issued proposed regulations on 76 Fed. Reg. 52442 (Aug. 22, 2011); 76 Fed. Reg. 52475 (Aug. 22, 2011). A summary of those proposed regulations are available at http://www.groom.com/resources-614.html.

II. Final Regulation

On February 9, 2012, the Agencies released final regulations on the requirements for drafting and issuing SBCs and the uniform glossary that is required to be provided by plans as well. The new rules were published in the Federal Register on February 14, 2012 and are effective on April 16, 2012.

The final regulations do not significantly modify the proposed regulations, and provide no flexibility or relief for large employer self-insured plans despite a significant effort to get such relief. Group health plans and issuers should pay close attention to the newly finalized SBC regulations because there is only a short amount of time to assemble necessary information, coordinate responsibilities between parties and prepare for distribution. Failure to provide compliant SBCs could result in potential civil penalties for group health plans and health insurance issuers.

The regulation does clarify the applicability of the SBC requirement. SBCs need not be provided for plans that constitute excepted benefits. Excepted benefits include: stand-alone dental or vision plans, certain supplemental plans, and health FSAs (if the FSA constitutes excepted benefits under HHS regulations). Expatriate plans were also granted some relief from the final rule and HSAs are exempt since they are generally not subject to ERISA. Note, an HRA is a group health plan subject to ERISA and is not an excepted benefit, and therefore is generally subject to the SBC requirements.

Although the final regulations maintained many of the existing requirements under the proposed regulations, below we highlight some of the key changes within the final regulations.

Applicability Date

The Agencies have delayed compliance with the SBC requirements for six months. This delay was shorter than hoped for and requires plans to come into compliance fairly quickly. Specifically, the SBC requirements shall apply as follows:

- Group Health Plan Participants (Open Enrollment): SBCs will have to be offered by plans and issuers to participants in group health plans during open enrollment if first day of the enrollment period is on or after September 23, 2012;

- Group Health Plan Participants (Other than Open Enrollment): For group health plan participants that do not enroll in open enrollment, SBCs will have to be provided first day of plan year after September 23, 2012 (this effectively means that plans with an early OE period will still have to have SBCs available by 1/1/13);

- Issuer to Individual Market Participants and Beneficiaries: September 23, 2012.

Form, Appearance and Coverage Examples

The final regulations make no meaningful changes to the form and appearance requirements of the SBC. Thus, groups will have to follow the NAIC specific format exactly (font, shading, column width, content). The template and instructions are available electronically on the Agencies' websites.

However, the Agencies made the following four helpful changes to the template:

- First, the final regulations eliminate the requirement to provide premium and cost information as part of the SBC template. This is a particularly helpful change in that many employers have multiple benefit options and tiers.

- Second, the final regulations reduce the number of coverage examples required for SBCs issued during the first two years to (1) having a baby (normal delivery) and (2) managing type 2 diabetes (routine maintenance of a well-controlled condition). The Agencies removed the breast cancer coverage example from the template, but have said they may add additional coverage examples.

- Third, the final regulations specify that to the extent a plan's terms are required to be in the SBC template and cannot be described in a manner consistent with the template and the instructions, the plan or issuer must use its best efforts to provide an accurate description of relevant plan terms.

- Finally, the final regulations have changed the requirement that the SBC be a stand-alone document. Instead the final regulations now provide that the SBC may either exist as a stand-alone document or in combination with other materials, such as an SPD, as long as it is displayed prominently, follows the same format, and is provided in accordance with timing requirements.

Timing

The proposed regulation includes complex rules specifying the timing of the delivery of the SBC by an insurer to a group health plan, by a group health plan or insurer to plan participants, and by an insurer to individuals in the individual market, as described in our earlier summary, available at http://www.groom.com/resources-614.html. The Agencies largely adopted these timing requirements without modification in the final regulations, except for the following few helpful changes:

- First, the Agencies have slightly extended the timing requirement from 7 calendar days to 7 business days for all scenarios in which an SBC must be provided within 7 days of application, renewal and request.

- Second, they extend the timing for delivering an SBC for a special enrollee to 90 days from enrollment.

- Finally, the final regulations create an exception from the requirement that an SBC be provided no later than 30 days prior to the first day of a new plan or policy year upon automatic renewal, if the SBC cannot be provided in such a time frame. This may happen if for example the issuer and purchaser have not finalized the terms of coverage for the new policy year. In such a situation, the policy, certificate, or contract of insurance would have to be provided within seven business days of issuance.

Electronic Delivery

Some helpful changes were made regarding electronic delivery.

- Group Health Plans

The Agencies provided additional guidance on electronic transmittal of SBCs. First, they differentiated between participants and beneficiaries who are already covered versus participants and beneficiaries who are eligible but not yet enrolled. For covered individuals, a group health plan may provide SBCs electronically if it meets the requirements of the Department of Labor's regulations at 29 CFR 2520.104b-1 (the general ERISA delivery rule, which includes a safe harbor for electronic delivery). This generally tracks the proposed rule, though there was some uncertainty as to whether the "safe harbor" had to be met under the proposed rule or whether the more general e-delivery standard applied.

For individuals who are eligible but not yet enrolled, the SBC may be provided electronically if the format is readily accessible and a paper copy is provided free of charge upon request. Additionally, if the electronic form is an Internet posting, the plan or issuer must timely advise the individual in paper form (such as 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.

- Individual Health Insurance

For individual health insurance, the regulation was revised to facilitate electronic delivery establishing a general standard whereby the issuer "must provide the SBC in a manner that can reasonably be expected to provide actual notice regardless of the format." One example provides that the internet may be used if the individual is provided written or electronic notice that the documents are available on the internet. An issuer providing the SBC electronically must ensure that the format is readily accessible; the SBC is placed in a location that is prominent and readily accessible; the SBC is provided in an electronic form that is consistent with appearance, content and language requirements; and that the issuer notifies the individual or dependent that the SBC is available from the issuer in paper form without charge upon request. The final regulations also removed the requirement that a recipient acknowledge receipt of an SBC received electronically.

Civil Penalty

Group health plans and issuers who do not comply with the SBC requirements will face potentially large civil penalties. While PHSA section 2723(c)(i) already imposes a civil penalty of $100 per day for each affected individual, section 2715(f) imposes an additional new penalty of up to $1,000 per day for each affected individual for willful violations of the SBC rule. Additionally, IRC section 4980D imposes an excise tax on a group health plan (other than a plan maintained by a governmental entity) if it fails to comply with the requirements of chapter 100 of the Code. The excise tax is generally $100 per day per individual for each day that the plan fails to comply with chapter 100 of the Code with respect to that individual. However, the excise tax is generally reduced for failures due to reasonable cause and not from willful neglect. Finally, taxpayers subject to the excise tax under IRC section 4980D must voluntarily report the failure and the amount under IRS Form 8928.

What Actions You Should Take

If you are an insurer, employer, or administrator, hopefully you have started the implementation process by familiarizing yourself with the SBC template and all of its detailed requirements. Given the complexity of the rules and the potential for civil penalties, it is important that you assess your needs on an individualized basis and not underestimate the time and resources you will need to comply with these rules. Please note that although TPAs may be instrumental to self-insured health plans in the implementation process, the TPA is not required by law to do so. Furthermore, even if the TPA agrees to provide this service, the employer will want to work with the TPA because ultimately the group health plan (including the entity or person(s) designated as the plan administrator) will be liable for any penalties.