Summary of Benefits and Coverage and Uniform Glossary Final Rule

Overview

On Aug. 17, 2011, the Departments of Health and Human Services (HHS), Labor, and Treasury (the "Agencies") issued a set of proposed rules relating to the Summary of Benefits and Coverage ("SBC") and Uniform Glossary requirements, copies of the uniform template documents and instructions, and guidance regarding the timing for issuance of summaries of material plan modifications. On Feb. 9, 2012, the Agencies issued a Final Rule providing guidance for compliance.

Key changes

- Delays effective date for six months. **For disclosures to members of group health plans** – For delivery to members of group plans with open enrollment periods, effective the first day of the first open enrollment period beginning on or after Sept. 23, 2012; for delivery to members that enroll other than through an open enrollment period (including special enrollees), effective the first day of the first plan year on or after Sept. 23, 2012. **For disclosures by issuers to group health plans** – Effective on or after Sept. 23, 2012. **For disclosures in the individual market** – Effective on Sept. 23, 2012.
- No exclusion for self-funded groups
- Eliminates premium from SBC form
- Provides more flexibility for electronic distribution to "eligible but not enrolled" members, including providing SBC via email or through paper notice (e.g., postcard) that an electronic SBC is available. For e-delivery in the individual market, eliminates requirement to acknowledge receipt
- Provides flexibility on requirement to provide SBC 30 days prior to renewal, by allowing SBC distribution seven days after re-issuance of policy when renewal decision is not made 30 days prior to renewal
- Provides seven business days (rather than calendar days) to provide SBC upon request and at other times
- Retains state pre-emption of the SBC rules, but the Agencies urge states to harmonize state benefit summary requirements with federal rule/forms and require any state modifications to use a separate addendum
- Allows flexibility in SBC format to accommodate innovative product design
- Retains Coverage Example format but eliminates breast cancer as example, now limited to maternity and diabetes

A high-level summary of the Final Rule and supplemental guidance issued by the Agencies ("Final Rule") follows below.

Applicability Date

When originally passed the Affordable Care Act (the "Act") required the Agencies to develop standards to provide, by March 23, 2012, "applicants, enrollees, and policyholders or certificate holders" an SBC

describing the benefits and coverage under each policy or plan. Due to the late issuance of the Final Rule the Agencies modified the effective dates as follows:

- **For disclosures to members of group health plans** – For delivery to members of group plans with open enrollment periods, effective the first day of the first open enrollment period beginning on or after Sept. 23, 2012; for delivery to members that enroll other than through an open enrollment period (including special enrollees), effective the first day of the first plan year on or after Sept. 23, 2012.
- **For disclosures by issuers to group health plans** – Effective on or after Sept. 23, 2012.
- **For disclosures in the individual market** – Effective on Sept. 23, 2012.

Who is Responsible for Sending the SBC?

The Act and Final Rule place the responsibility to provide an SBC on:

- **For delivery to an insured group health plan:** The issuer.
- **For delivery to members of insured group plans:** the **health insurance issuer and the group health plan** including the plan administrator as defined by ERISA
- **For delivery to members of self-insured plans:** the **group health plan** or designated administrator of the plan as that term is defined under ERISA. **The Final Rule does not include an exemption for large or self-insured plans.**

When must an SBC be provided?

SBC Provided by Issuer to a Plan

- The Final Rule requires a health insurance issuer to provide an SBC to an insured group health plan upon an application by the plan for coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.
- If there is any change to the information required to be in the SBC before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the first day of coverage.
- The SBC must be provided upon renewal as follows:
  - **Renewal When a Reapplication is Required:** The proposed rule required that, if written application materials are required for renewal, the SBC must be provided **no later than the date on which the materials are distributed**. This requirement has been retained without change in the Final Rule.
  - **Automatic Renewal**: The Final Rule requires that, in general, if renewal or reissuance of coverage does not require re-application, the SBC must be provided **no later than 30 days prior to the first day of the new plan or policy year**. With respect to insured coverage, the Final Rule provides flexibility with the 30 day rule when the terms of coverage are finalized in fewer than 30 days in advance of the new policy year (e.g., negotiation of coverage terms).
- Upon request, as soon as practicable, but in no event later than seven business days.

SBC provided by plan and/or issuer to participants and beneficiaries.

- The Final Rule requires the issuer (for insured membership) and the group health plan to provide an SBC to participants and beneficiaries as part of written application materials or no later than the first date on which the participant is eligible to enroll if an application is not required.
- If there is any change to the information required to be in the SBC before the first day of coverage, an updated SBC must be provide no later than the first day of coverage.
- The SBC must be provided upon renewal as described above.
- Upon request, as described above.

- The Final Rule provides that **"special enrollees" under HIPAA must be provided the SBC** no later than when a summary plan description is required to be provided under the timeframe set forth in ERISA, which is **90 days from enrollment**.

The Final Rule retains the requirement that the SBC be provided to both participants and beneficiaries, however it retains an anti-duplication rule under which a **single SBC may be provided to a family unless any beneficiaries are known to reside at a different address**.

Additional Content Elements

- **Minimum Essential Coverage and Minimum Value Statement:** The Act also required that the SBC include a statement about whether a plan or coverage provides minimum essential coverage, and whether the plan's share of the total allowed costs of benefits provided under the plan met the applicable minimum value requirements. The Agencies recognize that this content is not relevant until other elements of the Act are implemented, therefore, the **Final Rule requires the minimum essential coverage and minimum value statements to be included in SBCs with respect to coverage beginning on or after Jan. 1, 2014**
- **Coverage Examples:** The proposed regulations included three coverage examples relating to having a baby (normal delivery), breast cancer, and diabetes. **The Final Rule indicates only two coverage examples — having a baby (normal delivery) and managing diabetes** — need to be included in the SBC. Future guidance will likely add and modify these coverage examples.
- **Best Efforts Provision:** To the extent a plan's terms that are required to be in the SBC template "cannot reasonably be described in a manner consistent with the template and instructions", **the plan or issuer must accurately describe the relevant plan terms while using its "best efforts" to maintain the integrity of the uniform template**.

Method of Issuance

- **Group Plans:** SBCs provided in connection with group health plan coverage may be provided either as a stand-alone document or in combination with other summary materials (e.g., an SPD), if the SBC information is intact and prominently displayed at the beginning of the materials, and in accordance with the timing requirements for providing an SBC.
- **Individual Plans:** For health insurance coverage offered in the individual market, the SBC must be provided as a stand-alone document, but may be included in the same mailing as other plan materials.

Electronic Transmission of the SBC

- **Transmission to Members in Group Market:** The Final Rule makes a distinction between a participant or beneficiary who is already covered under the group health plan, and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan.
  - **For participants and beneficiaries who are already** covered under the group health plan, the **Final Rule permits distribution of the SBC electronically** if the requirements of the Department of Labor's regulations are met.
  - **For participants and beneficiaries who are eligible for but not enrolled in coverage,** the Final Rule permits the **SBC to 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 Market:** The Final Rule substantially retains the **safeguards for electronic disclosure** in the proposed regulations. Under the Final Rule, an issuer providing the SBC electronically must ensure that:
  - Format is readily accessible
  - SBC is placed in a location that is prominent and readily accessible
  - SBC is provided in an electronic form that is consistent with the appearance, content, and language requirements of the Final Rule
  - The issuer notifies the individual or dependent that the SBC is available in paper form without charge upon request.

  The Final Rule removes the "acknowledge receipt" requirement.
- **Transmission by Issuer to Plan Sponsor:** With respect to an SBC provided by an issuer to a plan sponsor, the **SBC may be provided in paper form or electronically** (such as email transmittal or an Internet posting on the issuer's website).

Language

The Final Rule retains the approach of the proposed regulations and provides that, to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, **a plan or issuer follows the rules for providing notices with respect to claims and appeals**. Under those rules, plans and issuers must provide notices in a culturally and linguistically appropriate manner when 10 percent or more of the population residing in the claimant's county are literate only in the same non-English language, as determined based on American Community Survey data published by the U.S. Census Bureau.

Uniform Glossary Changes

The Agencies made several changes that were suggested in the public comments. Some of these changes were made at the request of self-insured plans, which commented that terminology in the SBC template was appropriate only for insured coverage. For example, terms such as "policy" and "insurer" have been changed to "coverage" and "plan", respectively. The Agencies also revised the **disclaimer language at the beginning of the uniform glossary, to make clear that the glossary is intended to be educational in nature and that the definitions contained in the glossary may not be the same as the definitions used by a particular plan or issuer (e.g., in the SPD)**. The Final Rules also require issuers to notify members that they can request a paper copy of the Uniform Glossary.

Summaries of Material Modifications

The Act directs that a group health plan or insurance issuers (group or individual) provide notice of a material modification of coverage (as defined under ERISA section 102), at least 60 days in advance, if any of the changes in coverage are not reflected in the most recently provided SBC. In other words, the notice must be provided to enrollees (or, in the individual market, policyholders) no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided, and occurs other than in connection with a renewal or reissuance of coverage.

The Final Rule does not change the proposed rule's 60 day notice provision. **This provision requires that plans and issuers provide at least 60 days advance notice of any material modification that would change the content of the SBC. This applies to mid-year changes only and does not affect changes made in connection with a renewal or reissuance.** The notice of modification **may consist of a new SBC or a specific notice detailing the change.**

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