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New Requirement in 2012: Plans Must Provide a Summary of Benefits and Coverage

The Affordable Care Act (ACA) imposed a new requirement on group health plans and health insurers to provide a new concise document that would summarize the key benefits and coverages provided, their costs to the participant, lists of excluded services and other significant conditions or limitations. These summary documents must also contain standardized formatting, type style, font size and terminology so that comparisons can readily be made between different coverage offerings. These Summaries of Benefits and Coverages (SBC) must be distributed in connection with any initial, special or open enrollments on or after March 23, 2012, and any new Plan coverages that become effective on or after that date.

In August of this year, the Department of Labor (DOL), the Department of Treasury, and the Department of Health and Human Services (DHHS) (together, the "Agencies") issued proposed regulations governing the form, content and distribution requirements for these SBCs.

Who Must Provide the SBCs?

SBCs must be provided by health insurers and the Plan Administrators of employer-sponsored group health plans (GHPs), whether insured or self-funded, if the GHP is subject to the requirements of the ACA. Thus, retiree only plans, plans that provide "excepted" limited scope dental or vision benefits and health care flexible spending accounts, likely are not subject to the requirement to provide SBCs. Grandfathered plans, however, must provide SBCs.

For insured GHPs the provision of the SBC by either the health insurer or the Plan Administrator will satisfy the obligation for both. Employers should note, however, that if it contracts with its health insurer to provide the SBC, and the insurer fails to do so, it remains liable if it is also the Plan Administrator. In short, one can contract away the obligation, but not the liability.

SBCs must be provided free of charge for each separate insurance policy providing coverage under a GHP, and, for self-funded plans, an SBC must be provided for each separate benefit package available under a GHP. The proposed regulations do not define "separate benefit packages," but the HIPAA portability rules defined a benefit package as any coverage arrangement with a difference in either benefits or cost sharing, and that is probably a good working definition to apply here.

To Whom Must the SBCs Be Provided?

Health insurers must provide an SBC to employers who request information about having the insurer provide coverage under the employer's GHP.

Health insurers or Plan Administrators must provide SBCs to all Plan participants and beneficiaries, which includes not only all those currently enrolled, but also COBRA qualified beneficiaries, and those eligible to enroll (including, if applicable, former employees).

When Must the SBCs Be Provided?

At Initial Enrollment. SBCs must be provided to newly eligible individuals (both employees and dependents) with any written or electronic enrollment materials distributed as part of the initial enrollment process. If such materials are not distributed as part of the initial enrollment process, the SBC must be provided no later than the first day on which the individual would be eligible to enroll (*i.e.*, by the last day of any waiting period). Note that at initial enrollment, each individual must receive an SBC for each benefit package available under the GHP, and if there are any changes to the coverage between the time an initial SBC is issued and the individual's enrollment, a new SBC must be issued.

At Special Enrollment. Individuals enrolling under a special enrollment provision must be provided with the SBCs within seven days of their special enrollment request.

At Annual Enrollment. An SBC must be provided with the open enrollment materials, but in no case, later than 30 days prior to the first day of coverage for the new Plan Year. The SBC must be provided even where enrollment is automatic – *i.e.*, if no affirmative election need be made, and the prior elections continue in force for the following Plan Year. At annual enrollment, however, an SBC need only be provided for the benefit package in which the individual is currently enrolled.

Upon Request. An SBC must be provided within seven days of an individual's request for a copy.

Material Modification. Where a change in benefits or coverage is made that would impact the information in the most recently distributed SBC, and the change is not made in connection with a renewal of coverage that would have been disclosed during open enrollment, then a new SBC must be distributed that reflects the change at least 60 days prior to the effective date of the change. On the bright side, the provision of a modified SBC will likely satisfy the ERISA requirement for distributing a summary of material modifications to communicate plan changes.

In all cases, the SBC must be provided free of charge.

How May the SBCs Be Distributed?

Paper copies of the SBCs may be distributed by first class mail to the last known address of the individual. Where employees and dependents share a common residence, an SBC sent to the last known address will satisfy the requirement for all persons at that address, but if the Plan Administrator knows that the spouse or any dependents (*e.g.*, an adult child) resides elsewhere, a separate SBC must be sent to each separate address. Handing out the SBC will be effective for employees, but likely not for dependants.

SBCs may be distributed electronically, but only in compliance with the DOL regulations regarding electronic distribution of plan information. Thus, electronic distribution may be more difficult for getting the SBCs to non-employee dependents. Certain information may also be distributed electronically by making it available on the insurer's or company's website, and some information will

be available on government websites (*e.g.*, the standard glossary), and where this method is to be used, the URL addresses for the websites must be clearly set forth in the SBC.

What Are the Content and Format Requirements for the SBC?

The regulations set forth very specific content and formatting requirements. The SBC can be no longer than four pages, double-sided (so this in effect allows for eight pages). The glossary must also be provided (which will extend the number of pages). The type size for the SBC must be at least 12 pt., the font must be Times New Roman, and the layout of the SBC must (with some minor exceptions) track the format, order of presentation and color scheme of the template provided in the proposed regulations.

The topics to be covered in an SBC are: (1) an explanation of the plan's cost-sharing structure in a three-column table that must answer nine "important questions," (2) a table that describes the plans treatment of ten common medical events, (3) the classification of 14 specified services as either "Covered" or "Not Covered," and (4) a "Fact Label," which is an illustrative description as to how the GHP would cover three common benefit scenarios, *i.e.*, those for having a baby, treating breast cancer and managing diabetes. The SBC template provided by the Agencies can be found at:

<http://www.healthcare.gov/news/factsheets/labels08172011b.pdf>

The glossary will contain terms such as deductible, co-pay, allowed amount, balanced billing, complication of pregnancy, emergency medical conditions, preauthorization, prescription drugs, primary care physician, *etc.*, and will be updated periodically by the DOL and DHHS. Employers who have sets of defined terms in their plan documents and SPDs should download the glossary to ensure that the definitions provided with the SBC and those provided with their other Plan documents are in harmony. The glossary will be posted at the following websites:

<http://www.healthcare.gov> and <http://www.dol.gov/ebsa/healthreform/>

In addition to the uniform glossary of insurance and medical terms, the SBC must contain:

- A description of the coverage, including cost sharing for each category of benefits shown;
- The exceptions, reductions and limitations on coverage;
- Descriptions of all cost-sharing provisions;
- Coverage examples showing three benefit scenarios;
- A statement that the SBC is only a summary and that the plan document, policy, certificate of insurance should be consulted for the exact terms of coverage;
- A contact number to call with questions and an Internet web address where a copy of the plan document or insurance certificate/booklet can be obtained and reviewed;
- An internet address to obtain an updated standard four-page glossary of health insurance and medical terms;
- For plans with provider networks, an internet address for obtaining a list of network providers;

- For plans with prescription drug coverage, an internet address for obtaining information about that coverage, including drug formularies;
- The amount of the total premium cost (for self-funded plans, the cost of coverage – likely, the COBRA premium equivalent), and how much of that cost the employee is responsible for; and
- After January 1, 2014, a statement about whether the plan’s coverage provides minimum essential coverage and whether the plan’s share of the total allowed costs of benefits meet the applicable minimum value.

The SBC must also be provided in a “culturally and linguistically appropriate manner” which means the SBC must be available in any language in which at least 10% of the residents of the county in which the Participant resides are literate in the same non-English language. The English language version of the SBC must disclose the availability of the SBC in those languages. The DOL says that it will maintain an updated list of the counties and languages in which SBCs must be provided.

What Are the Penalties for Failing to Provide an SBC?

The penalty for willfully failing to provide an SBC is a fine of up to \$1,000 for each such failure, to be imposed on the Plan sponsor or designated Plan Administrator. These penalties are to be enforced by the DOL. States may enforce these penalties against insurers, and if a state does not, the DHHS may do so. The Internal Revenue Code also imposes an excise tax of \$100 per day per individual for each day a GHP fails to provide an SBC, though this tax may be mitigated if due to reasonable cause and not willful neglect, and so long as the failures are corrected within 30 days of actual or constructive discovery. Taxpayers must self-report these excise taxes on IRS Form 8928. The Agencies have indicated they will be issuing regulations regarding enforcement of these penalties in the near future.

Action Steps

Plan sponsors should review their current health care benefit offerings to determine which benefit packages will require SBCs. If the benefits are insured, they should contact their insurer to determine if it will be providing the SBCs, and, if so, enter into a written agreement for them to do so. If the benefits are self-funded, Plan sponsors should contact the Plan’s third party administrator (TPA) about contracting with them to provide the SBCs. If neither the insurer nor the TPA (as applicable) is willing to undertake this obligation, the Plan sponsor should download the template and their instructions to see how the template form should be completed for each benefit package. If the Plan sponsor does business in any of the 255 counties identified in the regulations as having a population group that is not literate in English, and that comprises 10% or more of the county’s population, it should find out in which languages it will have to provide SBCs. Note that, under the ACA, these same non-English language requirements apply to the provision of claim adjudication notices, as well as the SBCs.

If you have any questions about these new SBC requirements, any other aspect of complying with the new health care reform law, or any other issues with respect to providing benefits to your employees, please contact any of the Honigman attorneys listed in this alert.