Summary of Benefits and Coverage (SBC) Final Regulations

Health Reform’s summary of benefits and coverage (SBC) is a significant disclosure requirement imposed on insurers, group health plans and ultimately, plan sponsors. This new SBC applies to all insurers and group health plans, even those plans that are considered grandfathered programs with respect to health reform. The DOL, HHS, and IRS in a collaborative effort have just recently issued final regulations and related guidance implementing this SBC requirement. These regulations finalize, with some important changes, the original proposed regulations and related guidance that was originally issued back in August 2011.

The original proposed regulations had required an effective of March 23, 2012. The final regulations delay this date, and now the SBC must be provided beginning with the first open enrollment period that begins on or after September 23, 2012. Employers are required to issue this new SBC to employees enrolling in the group health plan outside the annual open enrollment period beginning with the first plan year on or after September 23, 2012. Employers who have a plan anniversary date in the last quarter of 2012 have little time to react to this new disclosure requirement. Here are a few highlights:

SBC Template and Uniform Glossary: The SBC template has been finalized, along with a sample completed SBC, instructions, sample language, coverage examples, and a uniform glossary. These materials are available on the DOL website at http://www.dol.gov/ebsa/healthreform/. The documents are authorized for use only with respect to coverage beginning before January 1, 2014 since several health coverage reforms taking effect on January 1, 2014 will prompt future changes to the SBC. In revising the proposed template, the agencies changed some terminology to make it more appropriate for use by self-insured plans. The disclaimer language at the beginning of the glossary has also been revised to make clear that it is intended to be educational in nature and that the definitions contained in the glossary may not be the same definitions used by a particular plan or insurer.

Application to Account-Type Arrangements: The preamble to the final regulations confirm that the SBC requirements do not apply to “excepted benefits”, which include the majority of Flexible Spending Accounts (FSAs) offered, and limited scope Health Reimbursement Arrangements (HRAs). Excepted benefits are benefit products that are designed to supplement comprehensive medical coverage and are provided under a separate policy that is not an integral part of the coverage offered under a group health plan. These excepted benefits are generally exempt from health reform requirements, including the new SBC. It is important to note, however, that most Health Reimbursement Arrangements (HRAs) offered are not excepted benefits, so the SBC requirement will apply. HRAs that are integrated with the major medical plan will be reported in the appropriate spaces on the major medical SBC. In most cases the HRA information will be reported in the section for deductibles, co-payments, co-insurance, and benefits otherwise not covered by the major medical coverage. Most stand alone HRAs will also
need to satisfy the SBC requirement, and for these nonintegrated arrangements, the SBC requirements must be satisfied independently.

In some rare cases where an HRA is considered to be an excepted benefit because it is designed to cover limited scope vision and/or dental benefits, the SBC requirement will not apply. Health Savings Accounts (HSAs) are generally not group health plans, therefore they are not subject to the SBC requirements. Employers should keep in mind, however, that the SBC for a high deductible health plan can mention the effects of employer contributions to a Health Savings Account in the appropriate spaces on the SBC.

**SBC Content Requirements:** In another change from the proposed regulations, the final regulations do not require the SBC to include premium or cost of coverage information. The agencies acknowledge in the preamble that providing this information would have been “administratively and logistically complex.” In yet another change, only two coverage examples are required during the first year of applicability and the previously proposed breast cancer example has been removed. Health insurance issuers and plan sponsors of self-insured plans are instructed to use the full SBC template, but to the extent a plan’s terms cannot reasonably be described in a manner consistent with the template and instructions, the plan or insurer must accurately describe the relevant terms while using “best efforts” to do so in a manner consistent with the instructions and template format. Examples include cases where a plan is attempting to identify the effects of a related health FSA or HRA, or if a plan provides different cost-sharing based on participation in a wellness program. Duplication and confusion is a concern for plan administrators who have a separate administrative service provider to manage functions like prescription benefits or managed behavioral health benefits. Health insurance issuers and sponsors of self-insured plans should coordinate with their service providers, and with each other, to ensure that the SBCs are complete and accurate.

SBCs must include all of the following information:

1) A description of the coverage, including cost sharing, for each category of benefits identified by the Departments;

2) The exceptions, reductions, and limitations on coverage;

3) The cost-sharing provisions of the coverage, including deductible, coinsurance, and co-payment obligations;

4) The renewability and continuation of coverage provisions;

5) A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines;

6) For coverage beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code), and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;
7) A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage; 

8) A contact number to call with questions and an Internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

**Appearance and Language Requirements**: The final regulations provide that group health plan SBCs may be provided either on a stand-alone basis or in combination with other summary materials, like the SPD. The SBC must be provided in a “culturally and linguistically appropriate” manner, following the rules for distributing appeals notices. To help plans and insurers meet the language requirements, HHS will provide written translations of the SBC template, sample language, and uniform glossary in the four applicable languages (Spanish, Tagalog, Chinese, and Navajo) and may also make these materials available in other languages to facilitate voluntary distribution of SBCs to other individuals with limited English proficiency.

**Providing the SBC**: Health insurance issuers that provide fully-insured health plan coverage to employers are responsible for providing the SBC. If participants and beneficiaries of a fully-insured health plan do not receive an SBC directly from the issuer, the plan administrator of a group health plan will be responsible for providing the SBC to participants and beneficiaries. For self-insured plans, the responsibility to make certain the SBC is prepared and delivered to participants and beneficiaries resides with the plan sponsor or the designated administrator of the plan (i.e., plan administrator) even though the TPA may assist with the preparation. Regardless of who provides the SBC directly to participants and beneficiaries, the document must be provided in writing and free of charge.

**Issuer Providing SBC to the Plan**: There was significant concern initially that the timing requirements in the proposed regulations could be administratively difficult for plans and issuers to meet under certain circumstances. The final regulations harmonize the rules for providing the SBC, while ensuring that individuals and employers have timely and complete information. The final regulations also require that a health insurance issuer provide the SBC to the plan administrator upon request or application for health coverage. The SBC must be provided as soon as practicable, following receipt of the request or application, but in no event later than seven business days following receipt. If there is any change in the information required in the summary before the first day of coverage, the issuer must update and provide a current SBC to the Plan administrator no later than the date of offer or the first day of coverage. The SBC will not need to be provided again for the plan year if the information remains unchanged, unless the SBC is requested.
Issuer Providing SBC to the Plan at Renewal: If written applications are required for renewal, the SBC must be provided no later than the date on which the materials are distributed. This requirement that was in the proposed regulations has not changed. When the renewal is automatic, which means written application materials are not required for renewal, the final regulations indicate the SBC must be provided no later than 30 days prior to the first day of the new plan year or policy year. However, with respect to insured coverage, in situations where it is not practical to provide the SBC within this timeframe because the plan sponsor and issuer have not finalized the terms of coverage for the new policy year, the regulations provide an exception. Under this circumstance, the SBC must be provided as soon as practical, but in no event later than seven business days after the issuance of the policy, certificate, or contract of insurance, or receipt of written confirmation of intent to renew, whichever is earlier. The regulations provide this flexibility only when the terms of coverage are finalized in fewer than 30 days in advance of the new policy year. Otherwise, the SBC must be provided upon automatic renewal no later than 30 days prior to the first day of coverage under the new plan or policy year.

Who is to Receive an SBC: Although the regulators recognize that the language in the statute could have been interpreted differently, there is no change to the requirement that SBCs be provided to participants and beneficiaries. In the absence of any clear definition for these terms in the statute or regulations, experts are referring to ERISA’s definition for participant and beneficiary. We interpret this to mean that a participant is any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan. A beneficiary is a person (spouse and/or child) designated by a participant, who is or may become eligible to a benefit. We expect further clarification as to whether SBCs must be provided to individuals are not yet eligible for coverage and won’t be eligible for quite some time.

Providing SBC to Participants: A group health plan (including the plan administrator) must provide an SBC to a participant or beneficiary with respect to each benefit package offered for which the participant or beneficiary is eligible. The SBC was designed to make certain consumers understand their coverage prior to making an election, which is why it is important that the summaries be provided to eligible employees and not just those who are currently enrolled in the health plan. The SBC must be included along with written application materials during enrollment that are distributed by the plan, and if the participant or beneficiary has a choice from multiple options, a separate SBC for each benefit option will needed to be provided. 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 coverage. If there is any change to the information required to be in the SBC between the application for coverage and the first day of coverage, the issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage. In most cases when the SBC is provided to the plan administrator by the issuer, that plan administrator will need to quickly distribute the SBC to participants. If a participant or beneficiary requests a copy of the SBC outside the enrollment process, the SBC must be provided within seven business days of the request.
The final regulations include an anti-duplication rule, which means a single SBC may be provided to a family unless any beneficiaries (dependents) are known to reside at a different address. Some flexibility is given with regard to electronic disclosure for these individuals, although it is important to note that the DOL’s electronic disclosure safe harbor provisions must still be satisfied.

Summary for SBC Distribution to Participants & Beneficiaries:

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<thead>
<tr>
<th>Enrollment</th>
<th>SBC must be included with written materials distributed for enrollment. If no enrollment materials are distributed, SBC must be provided no later than the 1st date participant is eligible to enroll. If changes to the SBC, a current SBC must be issued no later than the first day of coverage.</th>
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<tr>
<td>Special Enrollment</td>
<td>HIPAA Special Enrollees must be provided the SBC no later than when an SPD is required to be provided, which is 90 days from enrollment.</td>
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<tr>
<td>Renewal - written applications required</td>
<td>SBC must be provided no later than the date written application materials are distributed.</td>
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<tr>
<td>Renewal - automatic</td>
<td>SBC must be provided no later than 30 days prior to the first day of the new plan year.</td>
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<tr>
<td>Renewal delayed</td>
<td>If policy, certificate or contract has not been issued or renewed 30 days prior to the plan anniversary date, the SBC must be provided as soon as practicable, but in no event later than 7 business days after issuance of the new policy or receipt of intent to renew, whichever is earlier.</td>
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<tr>
<td>Upon Request</td>
<td>SBC must be provided within 7 business days of a request</td>
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**Expatriate Plans**: In lieu of summarizing coverage for items and services provided outside the United States, an issuer may provide an internet address, or similar contact information, to allow participants to obtain information about benefits and coverage provided outside the U. S. To the extent the plan or policy provides coverage available within the United States, however, issuer or plan administrator is required to provide an SBC for coverage offered within the U. S.

Plan sponsors, insurers, and advisors now face the arduous task of undertaking and coordinating yet another significant disclosure obligation now that the regulations, template, and other materials have been finalized. We have included with this Health Care Reform Update the DOL sample blank SBC, sample completed SBC and the SBC instructions, all of which can also be found on the DOL website. Even though the regulations delay the applicability date, insurers and plan sponsors will feel a sense of urgency in gearing up for this new compliance obligation.


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