Legislative Brief

HCR - Summary of Benefits and Coverage

June 2015

FINAL RULE UPDATES THE SBC REQUIREMENT

SUMMARY:

- A final rule published on June 16, 2015, updates certain aspects of the ACA's SBC requirement.
- The final regulations generally apply to coverage that begins on or after Sept. 1, 2015.
- The final rules apply to individual market coverage that begins on or after Jan. 1, 2016.
- The new template, instructions and uniform glossary will not be finalized until January 2016.

On June 16, 2015, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) published final regulations on the summary of benefits and coverage (SBC) and uniform glossary requirement under the Affordable Care Act (ACA).

These regulations finalize provisions in proposed regulations that were published on Dec. 30, 2014, in order to amend prior final regulations from Feb. 14, 2012. According to the Departments, the changes made by these final regulations are designed to improve consumers' access to important health plan information and to provide clarification that will make it easier for group health plans and health insurance issuers to comply with the SBC requirement.

Effective Date

The final regulations generally apply to coverage that begins on or after **Sept. 1, 2015**. However, for disclosures to individuals and dependents in the individual market, the requirements apply to coverage that begins on or after **Jan. 1, 2016**.

Until these final regulations become applicable, plans and issuers must continue to comply with the 2012 final regulations, as applicable.

New SBC Template

In conjunction with the December 2014 proposed regulations, the Departments issued a draft-updated template, instructions and supplementary materials. The Departments previously issued an FAQ on March 31, 2015, announcing that the finalized template, instructions and uniform glossary are not expected to be finalized until January 2016. The final rule reiterates this expected timeline.

These new documents will apply for plan years beginning on or after Jan. 1, 2017 (including open enrollment periods in fall of 2016 for coverage beginning on or after Jan. 1, 2017).

SBC and Uniform Glossary Requirements

The ACA expanded ERISA's disclosure requirements by requiring group health plans and issuers to provide an SBC to applicants and enrollees at certain times, such as before enrollment and re-enrollment. The SBC requirement became effective for plan coverage that began on or after Sept. 23, 2012.

In addition, plans and issuers must make a uniform glossary of health coverage-related terms and medical terms available to participants. Plans and issuers must provide the uniform glossary upon request, in either paper or electronic form, within seven business days after receipt of the request.

After the 2012 regulations were issued, the Departments released a series of FAQs on the SBC requirement. FAQs Parts VII, VIII, IX, X, XIV and XIX addressed questions related to compliance with the 2012 regulations, implemented additional safe harbors and released updated SBC materials.

On Dec. 30, 2014, the Departments issued additional proposed regulations, as well as a new proposed SBC template, instructions, an updated uniform glossary and other materials. The draft-updated template, instructions and supplementary materials are available on the DOL website under the heading "Templates, Instructions, and Related Materials—Proposed (SBCs On or After 9/15/15)."

The ACA establishes a penalty of up to **$1,000** for each willful failure to provide the SBC. Failing to provide the SBC may also trigger an excise tax of $100 per individual for each day of noncompliance. However, the Departments have stated that their approach to implementation emphasizes assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the SBC requirement.

Overview of the Final Regulations

The 2015 regulations generally finalize the December 2014 proposed regulations without significant changes, which implement certain changes to the SBC requirement. Overall, the modifications in the final regulations:

- Clarify when and how a plan or issuer must provide an SBC;
- Streamline the SBC template; and
- Add certain elements to the SBC template that the Departments believe will be useful to consumers.

In addition, the final regulations make some of the SBC enforcement safe harbors and transitions permanent, with several modifications.

Providing the SBC

The final regulations provide additional guidance on when a plan or issuer must provide the SBC to participants and beneficiaries. For example, the final regulations clarify how to satisfy the requirement to provide an SBC in the following situations:

- **The issuer provides the SBC upon request before application for coverage**—If the issuer provides the SBC upon request before application for coverage, the requirement to provide an SBC upon application is deemed satisfied, and the issuer is not required to automatically provide another SBC upon application to the same entity or individual (provided there is no change to the information required to be in the SBC). However, if there has been a change in the information required to be included in the SBC, a new SBC that includes the changed information must be provided upon application (that is, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application).
- **The terms of coverage are not finalized**—If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided to the plan or its sponsor (unless an updated SBC is requested) until the first day of coverage. The updated SBC is required to reflect the final coverage terms under the policy, certificate, or contract of insurance that was purchased.

Reducing Duplication

The 2012 regulations provide three special rules to avoid unnecessary duplication when providing the SBC. For example, the 2012 regulations provide that if either the plan or the issuer provides the SBC to a participant or beneficiary in accordance with the timing and content requirements, both will have satisfied their SBC obligations. The final regulations retain these rules, and also add new rules to prevent unnecessary duplication where:

- A group health plan utilizes a binding contractual arrangement where another party assumes responsibility to provide the SBC (provided the group health plan: (1) monitors the other party's performance, (2) corrects any non-compliance determined to have occurred, and (3) if it does not have information necessary to correct the non-compliance, it communicates with participants and beneficiaries about the non-compliance and takes significant steps as soon as practicable to avoid future violations);
- A group health plan uses two or more insurance products provided by separate issuers to insure benefits with respect to a single group health plan (the group health plan administrator is responsible for providing complete SBCs with respect to the plan; it may synthesize the information into a single SBC or provide multiple partial SBCs that together provide all relevant information necessary to meet the SBC content requirements); and
- The SBC for student health insurance coverage is provided by another party (such as an institution of higher education), but similar duty to monitor as described above to ensure compliance.

Formatting and Content Changes

The ACA limits the length of the SBC to four pages, but the 2012 regulations interpret this requirement to be four double-sided pages. The final regulations retain this interpretation, allowing the SBC to be four double-sided pages.

However, some plans and issuers have expressed concern regarding the difficulty of complying with the page limit while including all of the required information. Therefore, the final regulations provide that the Departments will address specific issues related to completing the four-page template, as well as the issues plans and issuers encounter while meeting these requirements, with the finalization of the new template and associated documents, separate from the final regulations.

The proposed regulations also included a number of changes to the content of the SBC and uniform glossary to reflect the ACA's insurance market reforms. For example, references to annual limits for essential health benefits and pre-existing condition exclusions would be removed. In addition, the disclosures relating to continuation of coverage, minimum essential coverage and minimum value would be revised to provide more useful information to consumers, including those shopping in the individual market. These content changes were not finalized in the final regulations, but will likely be addressed when the new template and associated documents are finalized.

However, the final regulations do clarify that all plans and issuers must include the following on the SBC:

- An internet address (or similar contact information) for obtaining a list of the network providers;
- For plans and issuers that use a formulary in providing prescription drug coverage, an internet address (or similar contact information) for obtaining information on prescription drug coverage under the plan or coverage;
- An internet address for obtaining the uniform glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available;
- A internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained; and
- Contact information for additional SBC questions.

In addition, the Departments have clarified that no enforcement action will be taken against a plan or issuer that provides an SBC with a cover letter or similar disclosure (if the SBC template cannot be modified to include such language) with required statements regarding whether the plan or coverage provides minimum essential coverage, and whether the plan or coverage provides minimum value (i.e., plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60% of those costs).

Please contact your Client Executive at Kapnick Insurance Group for more information regarding SBCs.