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Health Care Reform for Employers: The Summary of Benefits and Coverage

The Patient Protection and Affordable Care Act (**"PPACA"**), which was recently upheld by the Supreme Court, imposes a myriad of obligations on employers and group health plans. One of these obligations is a requirement for group health plans to provide a "Summary of Benefits and Coverage" (the **"SBC"**) to anyone who is eligible for the plan. The idea behind the SBC is to help individuals more easily compare coverage options under the plan.

The SBC requirement is deceptively complicated and is primarily governed by federal regulations issued earlier this year. The penalties for noncompliance can be severe, and the new burden this requirement imposes on employers should not be underestimated.

The attached Memorandum provides a brief overview of the SBC rules, with a focus on their impact on employers and their group health plans. Given the complex nature of the SBC rules and PPACA, employers would be well advised to consult with experienced employee benefits counsel to ensure that they are in full compliance.

Here, in very brief form, is our list of the "Top 6" things employers need to know about this new requirement:

(1) The SBC requirement will apply to plan years beginning on or after ***September 23, 2012***. For employers with calendar year plans, this means that the employer will need to:

(a) Have the SBC reflect the coverage it will be offering in 2013; and

(b) Distribute the SBC no later than the first day of the plan's open enrollment period for 2013, which will typically be in November or December 2012.

(2) The requirement applies to all group health plans except federal governmental plans and certain "HIPAA excepted benefits," such as retiree-only plans, stand-alone dental and vision coverage, most health FSAs, and certain HRAs.

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(3) From the perspective of employers, the SBC requirement involves two key components:

(a) Insurance companies are required to provide the SBC to employers that are sponsoring a fully insured group health plan; and

(b) A group health plan is required to provide the SBC to employees who are enrolled in the plan and to their family members. For a fully insured plan, this responsibility is shared by the insurance company and the plan administrator (which is typically the employer). For a self-insured plan, the plan administrator is required to do this.

(4) There are specific rules regarding how to distribute the SBC. These distribution rules are discussed in detail in the attached Memorandum.

(5) The SBC must be prepared using a standard template provided by the Department of Labor.

(6) If the SBC is sent to individuals who are living in a county in which 10% or more of the residents are literate only in the same non-English language, special requirements apply – even if none of the SBC recipients actually speak that non-English language.

So what should employers do now? Very briefly, here are several steps that should be taken:

- Determine which of your company's health benefits are subject to the SBC requirement.
- If your plan is fully insured, contact your benefits consultant or insurance company to make sure the insurance company will be preparing and distributing the SBC in a timely manner.
- If your plan is self-insured, contact your third-party administrator to determine who will take responsibility for drafting the SBC.
- Work with your benefits consultant, insurance company, or third-party administrator to ensure that the SBC distribution rules are followed.

Obviously, there is more to this reporting requirement than we can summarize in a short list. A more detailed analysis of the new SBC requirement may be found in the attached Memorandum. We hope it is helpful to you.

If you have any questions regarding the new SBC requirement or, more generally, regarding the impact of health care reform on employers, please feel free to call Steven Smith, Eric Namee, or Brad Schlozman at (316) 267-2000.

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MEMORANDUM

HEALTH CARE REFORM FOR EMPLOYERS: THE SUMMARY OF BENEFITS AND COVERAGE

AUGUST 16, 2012

Now that the Supreme Court has upheld the Patient Protection and Affordable Care Act (**"PPACA"**), employers need to be prepared to comply with the provisions in PPACA that will soon take effect. One of those provisions is a requirement that group health plans provide a "Summary of Benefits and Coverage" (**"**the **SBC"**) to anyone who is eligible for the plan.

The SBC – a seemingly simple document – is governed by a host of rules, most of which are contained in regulations issued by the IRS, the U.S. Department of Labor, and the U.S. Department of Health and Human Services (the **"Agencies"**) earlier this year. Failure to comply with these rules can result in severe penalties.

This Memorandum offers a brief overview of the SBC rules, focusing on their impact on employers and the group health plans they sponsor. Given the complex nature of the SBC rules and PPACA, employers may wish to consult experienced employee benefits counsel to ensure that they are in compliance.

Q-1. What types of plans are subject to the requirement to provide the SBC?

A-1. Group health plans – both fully insured and self-insured – must provide the SBC. There is no exception for "grandfathered" plans, small employer plans, or high deductible health plans. Except as noted below, all of these plans are subject to the SBC requirement.

Q-2. Are any group health plans exempt from the requirement to provide the SBC?

A-2. Under HIPAA, certain types of group health benefits are not subject to the HIPAA portability requirements. These same HIPAA excepted benefits are also exempt from the SBC rules. These "HIPAA excepted benefits" include the following:

- Retiree-only plans;
- "Stand-alone" dental and vision plans, if coverage under those plans is offered separately from coverage under the employer's "major" medical plan(s);

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- Most health flexible spending accounts (**"health FSAs"**) (see Q&A-3); and

- Some (but not most) Health Reimbursement Arrangements (**"HRAs"**) (see Q&A-4).

Federal governmental plans are also not required to provide the SBC.

Q-3. When are health FSAs exempt from the requirement to provide the SBC?

A-3. Most health FSAs are not subject to the requirement to provide the SBC. To qualify for this exception, a health FSA must satisfy both of the following conditions:

- **Maximum Benefit.** The maximum benefit payable to any participant in a given year cannot be greater than two times the employee's salary reduction election under the health FSA, plus $500; and

- **Availability.** Other group health plan coverage which is *not* excepted from the SBC requirement (such as major medical coverage) must be made available to participants for the year, by reason of their employment.

This exception is trickier than it may seem. For example, if part-time employees are allowed to participate in a health FSA but are <u>not</u> eligible for coverage under one of the employer's major medical plans, the "availability" condition for this exception will not be satisfied. This is an area where those who have health FSAs are encouraged to work with experienced employee benefits counsel or their benefits consultant to determine whether their health FSA is exempt.

Q-4. When are HRAs exempt from the requirement to provide the SBC?

A-4. For an HRA to be exempt from the requirement to provide the SBC, it generally must meet the same maximum benefit and availability conditions outlined for health FSAs in Q&A-3. In practice, *the majority of HRAs will <u>not</u> qualify for this exception*. For example, a 100% employer-funded HRA with an annual limit of $1,000 will not meet the exception, because it will exceed the maximum allowable benefit.

Alternatively, an HRA may be exempt from the requirement to provide the SBC if it is for retirees only or provides reimbursement for only dental and vision expenses.

Those employers that have HRAs are encouraged to work with experienced employee benefits counsel or their benefits consultant to determine whether they are exempt.

Q-5. In what situations must the SBC be provided?

A-5. The SBC must be provided in two different situations:

- **From Insurance Companies to Employer-Plan Sponsors.** The SBC must be provided by an insurance company to an employer that is sponsoring a group health plan if the employer has applied for coverage from the insurance company or if the employer requests a copy of the SBC from the insurance company. In theory, this is supposed to make it easier for employers to compare coverage options.

- **From Plans and Insurance Companies to Individuals.** The SBC must be provided by a group health plan and (if the plan is fully insured) its insurance company to eligible individuals and their family members when they enroll in the plan or are given enrollment information about the plan.

In this Memorandum, we will focus on the requirement for group health plans and insurance companies to provide the SBC to individuals. This requirement will be explained in more detail in the remaining portion of this Memorandum.

Q-6. Who is responsible for providing the SBC to individuals?

A-6. If a plan is fully insured, both the insurance company and the plan administrator are independently responsible for providing the SBC. However, if the insurance company furnishes the SBC in a timely and complete manner, the requirement is satisfied for both the insurance company and the plan administrator. *[Note that for most employer-sponsored health plans, the employer is typically designated to be the plan administrator.]*

If a plan is self-insured, the plan administrator is required to provide the SBC. Most self-insured plans employ a third-party administrator (a **"TPA"**) to assist them in the administration of the plan. It is advisable to contact the TPA to make sure that it is taking responsibility for providing the SBC.

Q-7. Which individuals must be given a copy of the SBC?

A-7. The SBC must be provided to all participants and beneficiaries (as defined by ERISA) who are *eligible* for a given benefit package. This is extremely broad: if someone is merely eligible for (but not enrolled in) a particular plan, they still must receive the SBC for that plan. This applies not only to the eligible participants themselves, but also to their beneficiaries – a class that may, in some cases, be all but impossible for the plan administrator to identify.

Q-8. Does this mean that a separate SBC has to be provided to each member of a participant's family who is enrolled in, or eligible to enroll in, a group health plan?

A-8. Technically the answer is yes; however, the requirement to provide the SBC to participants and beneficiaries will normally be satisfied if a copy is sent to the *participant's* last known address. If, however, the plan administrator *knows* that a beneficiary has a different address, a separate copy of the SBC must be sent to the beneficiary's last known address. This is similar to the COBRA notice requirement.

Q-9. When can SBCs be combined, and when are separate SBCs required?

A-9. A single SBC may be used if a group health plan offers multiple coverage tiers (such as self-only or family coverage) and/or multiple coverage levels (such as varying deductible levels or coinsurance amounts). However, separate SBCs are required if a group health plan offers multiple benefit options (such as a PPO option and an HMO option).

Q-10. What if a plan uses "carve-out arrangements," where different insurers cover different parts of a benefit package?

A-10. A "carve-out arrangement" may exist when, for example, a plan uses one insurer for medical coverage and a separate pharmacy benefits manager for prescription drug benefits. In such cases, the plan is responsible for creating a synthesized SBC that reflects the entire benefit package. However, for the initial SBC that must be distributed once the SBC requirement takes effect, the Agencies are allowing plans to provide separate SBCs that, together, present complete information about the benefit package. If a plan goes this route – again, for the first year only – it must also offer additional assistance to help recipients understand the information.

Q-11. When does the SBC requirement take effect?

A-11. For employer-sponsored group health plans, the SBC requirement will apply to the first "plan year" beginning on or after **September 23, 2012**.

This means that SBCs will need to be provided for the first time during open enrollment for the first plan year that begins on or after September 23, 2012. For calendar year plans, for example, the SBCs will have to be provided in the November/December open enrollment period that precedes the 2013 plan year.

Q-12. At what times must the SBC be provided to individual recipients?

A-12. Once the SBC requirement takes effect, the SBC must be provided at the following times in the following situations:

- **Open Enrollment.** The SBC must be provided at the same time open enrollment materials are distributed.

- **Initial Enrollment (other than Open Enrollment).** The SBC must be distributed with other written application materials. If there are no written application materials, the SBC must be provided no later than the first day the participant is eligible to enroll.

- **Special Enrollment.** For HIPAA special enrollees, the SBC must be provided within 90 days following enrollment.

- **Upon Request.** If a participant or beneficiary requests a copy of the SBC, the plan administrator or insurance company, as applicable, must provide it within seven business days.

- **Changes Before the First Day of Coverage.** If the SBC has been distributed and, prior to the first day of coverage, there are changes to the plan that affect the content of the SBC, a new SBC must be provided no later than the first day of coverage. *[Note: This applies to changes made prior to the start of the plan year. The effect of mid-year changes is addressed in Q&A-13.]*

Q-13. If there are "material modifications" to the plan that affect the content of the SBC after the plan year begins, does a new SBC have to be provided?

A-13. No. However, notice of the "material modifications" (defined in Q&A-14) must be provided to enrollees at least 60 days *before* the effective date of the material modification. The notice may be provided in paper or electronic format, subject to the electronic disclosure rules discussed in Q&A-16.

The advance notice requirement does not apply to material modifications that take effect at renewal, since a new SBC will be provided at that time.

Q-14. What is a "material modification"?

A-14. A "material modification" (as defined under ERISA) is either an enhancement or a reduction of benefits, services, or other plan terms.

Q-15. Can the SBC be distributed with the plan's Summary Plan Description ("SPD") or other disclosures?

A-15. Yes, the SBC can be packaged with other materials, but only if the following requirements are met:

- The SBC must be prominently displayed at the beginning of the materials; and
- The timing requirements for the SBC must be satisfied.

Because the timing requirements for the SBC and SPD differ, it may not always be possible to distribute both documents at the same time.

Q-16. Can the SBC be distributed electronically rather than in paper format?

A-16. Yes. However, electronic distribution is subject to relatively complicated IRS and U.S. Department of Labor regulations, which are beyond the scope of this Memorandum. Those who want to distribute the SBC electronically should consult with experienced employee benefits counsel to ensure that they are in compliance with these regulations.

Q-17. What are the appearance requirements for the SBC?

A-17. The SBC must meet the following requirements:

- A uniform format, as prescribed by the Agencies, must be used;
- The terminology must be understandable to the average plan participant;
- The font size must be 12-point or larger; and
- The SBC may not exceed four double-sided pages or eight single-sided pages, not including the four-page glossary that must be provided with the SBC. *[Note: PPACA actually provided for a four-page SBC, but in regulations, the Agencies expanded this.]*

Plans and insurance companies have the option of providing the SBC in color or in grayscale.

Q-18. When must the SBC be provided in languages other than English?

A-18. If the SBC is being sent to recipients in a county where, according to the latest U.S. Census, at least 10% of the population is literate only in Spanish, Tagalog, Chinese, or Navajo, then the SBC must include a prominent, one-sentence statement in the appropriate language on how to access oral language services in that language.

According to the regulations, 255 counties meet the 10% requirement. (The regulations do not specify whether "Chinese" refers to Mandarin or Cantonese. Mandarin is by far the most spoken Chinese language globally, but Cantonese is more common in America.) A list of the affected counties is available on the following webpage: http://www.cciio.cms.gov/resources/factsheets/clas-data.html

The language requirement applies *regardless of the actual language proficiency of the plan's SBC recipients*. Therefore, if the SBC is sent to someone who lives in one of these counties, that SBC *must* comply with the language requirement, even if the recipient speaks only English.

Some commentators have suggested that it might be simpler to include the language notice in *all* SBCs — not just those sent to persons in the affected counties. However, if an employer or insurance company does this, it must be prepared to provide oral language services in the non-English language to any SBC recipient.

Q-19. What information must be included in the SBC?

A-19. Each SBC must include the following information:

- The uniform glossary, which contains definitions of standard insurance and medical terms (see Q&A-21);
- A "Why this Matters" column (see Q&A-22);
- A description of the coverage, including cost sharing, for each category of benefits;
- Exceptions, reductions, and limitations on coverage;
- Cost-sharing provisions, including deductible, co-insurance, and co-payment obligations;
- Renewability and continuation of coverage provisions;
- Coverage examples illustrating common benefit scenarios (see Q&A-20);

- Beginning with the 2014 plan year, a statement about whether the group health plan provides "minimum essential coverage" and whether the group health plan's share of the total allowed costs of benefits meets the applicable requirements;

- A statement that the SBC is only a summary and that the group health plan should be reviewed to determine the governing contractual provisions of the coverage;

- A telephone number to call with questions;

- An Internet address where a copy of the group certificate of coverage can be obtained and reviewed (for self-insured plans, this probably means a copy of the SPD);

- An Internet address for obtaining a list of the plan's network providers and information about the plan's prescription drug coverage; and

- An Internet address to access and review the uniform glossary and a phone number to obtain a paper copy of the glossary, along with a disclosure that paper copies are available.

Q-20. What are the required "coverage examples" illustrating common benefits scenarios?

A-20. The required coverage examples are intended to estimate what proportion of expenses might be covered by the plan in common benefits scenarios specified by the regulations. Currently, two coverage examples are required – having a baby (with a normal delivery) and routine maintenance of well-controlled type 2 diabetes. However, the Agencies have indicated that up to four more required coverage examples could be added in the future.

For the first year only, the Agencies are providing a "coverage calculator" to help plans and insurers prepare the coverage examples. The coverage calculator and related materials are available here: http://cciio.cms.gov/resources/other/index.html#sbcug

Q-21. What is the required "uniform glossary"?

A-21. The uniform glossary defines standard insurance and medical terms and must be provided with the SBC. This document was prepared by the Agencies and is available on the following websites:
http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf
http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

Plans and insurers can satisfy the requirement to disclose the uniform glossary by providing an Internet address where the recipient may review and obtain the uniform glossary. However, if a participant or beneficiary requests a paper copy of the uniform glossary, it must be provided to them within seven business days.

Q-22. What is the required "Why this Matters" column?

A-22. The definitions in the uniform glossary are not plan-specific and, according to the Agencies, may not enable recipients of the SBC to understand what the terms actually mean in the context of a specific plan. Therefore, in addition to the uniform glossary, the SBC must include a "Why this Matters" column. Instructions in the SBC template specify how each coverage component must be described in the "Why this Matters" column. For instance, the instructions indicate what information must be provided about a plan's out-of-pocket limit on cost sharing, including whether co-payments, out-of-network co-insurance, and deductibles are subject to this limit.

Q-23. Should COBRA language be included in the SBC?

A-23. Yes. The instructions to the SBC template provide language that must appear without alteration under the "Your Rights to Continue Coverage" section of the SBC.

Q-24. What are the penalties for failing to provide the SBC?

A-24. If a plan or insurer "willfully" fails to provide the SBC, it will be subject to a penalty of up to $1,000 per failure. A failure with respect to each participant or beneficiary constitutes a separate offense, and the penalty cannot be paid out of plan or trust assets. In addition, each failure may trigger an excise tax of $100 per day under the Internal Revenue Code.

The Agencies have indicated that, during the first year, they will not pursue penalties against plans that are "working diligently and in good faith" to comply with the SBC requirement.

Because the SBC requirement is new, it is important that the initial SBCs be carefully reviewed by experienced employee benefits counsel to ensure compliance with the regulations. This may be advisable even if the SBC is prepared by an insurance company.

If you have any questions regarding the new SBC requirement, or, more generally, regarding the impact of health care reform on employers, please feel free to call Steven Smith, Eric Namee, or Brad Schlozman at (316) 267-2000.