



Benefits Alert

Legal developments affecting employee benefits

A publication of Nixon Peabody LLP

SEPTEMBER 13, 2011

New disclosure requirements mandated by health care reform

By Brian Kopp

One of the goals and mandates of the Patient Protection and Affordability Care Act (“PPACA”) is to make health care coverage more transparent and understandable. The premise is simple. If each health plan and health insurer provides consumers with easy-to-understand explanations of the benefits available under a particular coverage and the explanations are provided in a uniform format, consumers will be able to easily compare coverages and make intelligent choices on what coverage works best for them.

On August 22, 2011, the IRS, DOL, and HHS issued proposed regulations on PPACA’s new disclosure mandate. The new disclosure requirements are currently due to become effective March 23, 2012, and generally require health plans and insurers to develop and distribute summaries of the benefits and coverage offered under their plans in a uniform format (these new documents are referred to as “SBC’s”). The regulators have asked for comments on the regulations, as well as the feasibility of complying with the new requirements by March 23, 2012. Below is a summary of some of the key provisions in these regulations as they apply to employers offering group health coverage.

Who has to provide the SBC’s?

Health plans (including self-insured plans) and health insurance issuers offering group health insurance coverage must provide a written summary of benefits and coverage for each benefit package they offer. The SBC must be provided free of charge. For group insured plans, an insurer must provide the SBC to the plan sponsor and to plan participants. The plan administrator for both self-insured and insured health plans (typically the employer) is also responsible for providing SBC’s to plan participants. Insurers and employers can coordinate their efforts so that if one party provides the SBC to plan participants that delivery satisfies the obligations of the other party.

Who gets an SBC?

Group health plans need to provide SBC's to each participant or beneficiary who is eligible to receive benefits under a group health plan. A person is eligible to receive benefits under a group health plan if the person has the right to enroll in coverage—actual enrollment is not required. If a participant and any beneficiaries are known to reside at the same address, a single SBC sent to that address will satisfy the SBC requirement for all individuals residing at that address. If a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

Separate SBC's need to be provided for each benefit package offered by the plan. Accordingly, if an employer offers new employees and their eligible dependents the opportunity to choose from four different health plans, four separate SBC's must be provided.

What events trigger the need to provide an SBC, and when do the SBC's have to be provided?

Events that trigger the need to provide an SBC include:

- Open enrollment. The SBC must be provided as part of any written application materials that are distributed by the plan for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage. If there is any change to the information required to be in the SBC before the first day of coverage, the plan must update and provide a current SBC no later than the first day of coverage. If the plan requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or issuer must provide a new SBC when the renewal materials are distributed; although, in this case, only the SBC for the coverage in which the participant is currently enrolled needs to be provided (i.e., SBC's for other coverages do not have to be provided to the participant).
- Automatic Renewals. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of coverage under the new plan year.
- Special Enrollment Rights. If a participant has special enrollment rights under HIPAA (e.g., enrollment rights triggered as a result of marriage, adoption, birth, loss of coverage, etc.), the plan must provide SBC's to the special enrollees within seven days of a request for enrollment pursuant to a special enrollment right.
- Upon Request. A plan must provide the SBC to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request.

What information needs to be provided in an SBC?

There are essentially three sections to an SBC. The first section describes the coverage and cost sharing under the plan. The second section provides up to six examples of how the plan works under common benefits scenarios. One of the examples must explain how benefits are provided for a pregnancy and another example must explain how benefits are provided to a participant who has a

chronic condition. The last section must provide a glossary of standard insurance and medical terms used by medical plans so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage. Examples of model SBC's can be found at <http://www.dol.gov/ebsa/healthreform/index.html>.

Information that must be provided in the SBC includes:

- A description of the coverage for specified categories of benefits;
- The exceptions, reductions, and limitations of the coverage;
- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
- A summary of the renewability and continuation of coverage provisions;
- A statement that the SBC is only a summary and that the plan document or insurance contract should be consulted to determine the governing contractual provisions of the coverage;
- Contact information for obtaining a copy of the plan document or the insurance contract (such as a telephone number for customer service and an internet address for obtaining a copy of the plan document or insurance contract);
- Contact information for and asking questions about the plan;
- For plans that maintain one or more networks of providers, an internet address (or similar contact information) for obtaining a list of network providers;
- For plans that use a formulary in providing prescription drug coverage, an internet address (or similar contact information) for obtaining information on prescription drug coverage;
- An internet address for obtaining the uniform glossary;
- The total cost of the coverage; and
- Beginning on or after January 1, 2014, a statement as to whether the plan or coverage provides "minimum essential coverage" and whether the plan's share of the total costs of eligible benefits meets applicable requirements.

Because one of the goals of PPACA is to make it easy for consumers to compare coverages, the content and form of the SBC is rigid. The SBC must comply with uniform format requirements, the language used in SBC's must be simple and understandable, the SBC cannot exceed four double-sided pages in length (excluding the glossary), and the SBC may not include print smaller than 12-point font. Employers in some areas must give participants the opportunity to receive the SBC in a language other than English.

How should SBC's be delivered?

The SBC is intended to be a standalone document to be delivered to participants and beneficiaries in paper form. However, SBC's may be sent electronically if the DOL requirements for electronic delivery are satisfied. Currently, those delivery requirements are cumbersome for employees who do not use computers as part of their daily work environment; the DOL is taking a closer look at this issue. The regulators have also asked for comments on how the SBC requirements may be coordinated with other disclosure requirements that apply to employer-sponsored group health plans (e.g., summary plan descriptions).

What happens if the information in the SBC changes?

If a group health plan makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, and that change occurs other than in connection with a renewal or reissuance of coverage (e.g., open enrollment), the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which such modification will become effective. For example, if an employer makes a mid-year change in its self-insured medical plan that impacts the provisions of the SBC, the employer must notify participants and beneficiaries of the change at least 60 days before the change becomes effective.

What are the consequences of not complying with the new rules?

There are potentially significant consequences to not complying with the SBC requirements. These include a \$1,000 fine for each willful failure to provide participants and beneficiaries with compliant SBC (a separate fine may be imposed for each individual for whom there is a failure), as well as a \$100 per day per participant excise tax.

Employers will find that complying with these new rules will be cumbersome, particularly for their self-insured plans. The regulations are just in proposed form, and there are lots of details that still need to be resolved. However, their proposed effective date of March 23, 2012, will be coming soon (assuming the regulators do not delay or phase-in the requirements). Accordingly, it is important that employers start working with their insurers, third-party administrators, and consultants to strategize how best to comply with these new rules.

If you would like any assistance in reviewing your benefit plan and policies in light of the new disclosure requirements and other related developments, please do not hesitate to contact us.

- Christian D. Hancey at 585-263-1147 or chancey@nixonpeabody.com
- David S. Foster at 415-984-8331 or dfoster@nixonpeabody.com
- Brian Kopp at 585-263-1395 or bkopp@nixonpeabody.com
- Thomas J. McCord at 617-345-1337 or tmccord@nixonpeabody.com
- Eric Paley at 585-263-1012 or epaley@nixonpeabody.com