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The federal health care reform legislation included a requirement that health plan participants receive a four-page summary of benefits providing an overview of the plan. These requirements were very specific as to the format of the summary and what information should be included; employers and health plans will have little flexibility regarding the look and content. In addition, the summary must be written in a culturally and linguistically appropriate manner. The goal is to ensure that health plans provide consistent and uniform information in such a way that individuals can compare and understand the plan options available to them.

The statute directed the government to work with the National Association of Insurance Commissioners (NAIC) to develop the requirements. Proposed regulations for the implementation of the summary of benefits were released on August 22, 2011 and included much detail, including templates for health plans to use. The government has asked for feedback to the initial guidance by October 21, 2011, so it is likely some of these provisions may be modified in the future.

Overview

The new guidance refers to the "summary of benefits and coverage," or SBC. The NAIC interpreted the four-page limitation to mean two-sided pages; therefore, plans may provide up to eight pages of content. The SBC consists of the required content discussed in the next section and coverage examples. It must be accompanied by a separate four-page uniform glossary of health insurance and medical terms.

The uniform glossary must be distributed in the exact format with the exact content that the government publishes, and can be found at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf. No edits can be made to this glossary. Originally, the legislation set forth a specified list of terms that needed to be included, and the NAIC added more terms. The government has requested comments on whether the terms currently included are sufficient, so the uniform glossary may change in the future.

All health plans are required to provide an SBC to participants at different times. Specifically, for fully insured group health plans, the insurance carrier is responsible for creating the SBC. Both the carrier and the plan sponsor (the employer, in most cases) have the responsibility to distribute the SBC if it is for an ERISA plan. However, the rules state that if one entity distributes the SBC, then the requirement is met for both parties.

For self-funded plans, the plan sponsor must create and distribute the SBC. However, employers with self-funded plans will likely receive help from their third party administrators (TPAs) when creating the SBC. At a minimum, the TPA will need to provide information for the coverage examples.

The Department of Health and Human Services published a number of tools and templates to assist in completing the SBC. These can be found at http://www.dol.gov/ebsa/healthreform/ under the heading *Summary of Benefits and Coverage and Uniform Glossary*.

Required Content in the SBC

The health care reform legislation established a very specific list of items to be included in an SBC, including:

- Uniform definitions of standard insurance and medical terms
- A description of the coverage and cost-sharing for each category of benefits
- Exceptions, reductions and limitations of coverage
- Cost-sharing provisions, including deductibles, coinsurance and any copays
- Renewability and continuation of coverage provisions
- Examples to illustrate common benefit situations and cost-sharing
- A statement as to whether the plan provides minimal essential coverage and if it meets the applicable minimum value requirements **(this will apply in 2014)**
- A statement that the SBC is not the official plan document
- Contact information for whom to call with questions, and the internet address where a copy of the actual group certificate of coverage or individual policy can be reviewed and obtained

All of this content is included in the template provided, with the exception of the minimum essential coverage and value assessments that are not applicable until 2014.

The SBC is in a table format with three basic columns. The first column is a question, such as "What is the Premium?" The middle column is the answer. The final column is titled "Why This Matters." The language for this column's content is fixed, and is designed to provide a more detailed discussion of the plan provision and how it may impact the participant. The instructions for completing an SBC include the optional phrases that can be used in the final column. There are a number of options to choose from for each question, so the plan can select the content that best fits their specific plan.

The NAIC added the following to the SBC template:

- Information on how to access the plan's network of providers
- Information on how to access information on the prescription drug plan's formulary
- Additional information about the premium
- Internet addresses for sites where additional information can be found

The model contains three examples to illustrate common medical situations and their associated cost-sharing. The conditions are having a baby, treating breast cancer and managing diabetes. The health care reform legislation allowed up to six coverage examples to be provided, although the latest guidance included only three.

The coverage examples are presented in a manner similar to a nutritional label, and are designed in a summary format that illustrates how these three conditions will be handled by the plan. This format will ensure that individuals can compare different coverage options at a glance with real-life scenarios. It should aid them in making informed decisions regarding their medical plan elections. However, there is significant debate about these coverage examples. Stakeholders are concerned that they will create an expectation of the total cost for these three example conditions. Although the coverage examples stipulate that they are not cost estimators, there is still an opportunity for confusion. Medical treatment can vary widely for any condition, and the associated costs can vary widely as well. The government has asked for feedback and concerns regarding the inclusion of these coverage examples in the SBC.

Formatting and Culturally and Linguistically Appropriate Language

The SBC must be presented in a uniform format. The content (not including the uniform glossary) cannot exceed four two-sided pages. However, the summary may be fewer pages, depending on the content of the limitations, exceptions and coverage exclusions. The text must appear in at least a 12 point font. The preamble of the proposed rules indicates that the SBC can be printed in black and white at the plan's discretion.

Plans need to be careful, as much of the content and format of an SBC is determined by proposed regulations. Sub-regulatory guidance provides step-by-step instructions on how to complete an SBC.

The SBC must be considered culturally and linguistically appropriate, and carriers and TPAs are likely to assist employers with this requirement. The latest guidance defines the steps that plans must take for any plan participants living in a county where at least ten percent of the population is literate ***only*** in the same non-English language:

- The plan must include a statement in the SBC, in that particular non-English language, advising that the SBC is available in that non-English language upon request
- A translated SBC must be provided upon request
- The plan must provide interpretive services in that language for these participants' questions

The culturally and linguistically appropriate requirements mirror the same requirements in the claim determinations and appeals process. The good news for Michigan employers is that no county in Michigan currently has at least ten percent of its population literate ***only*** in the same non-English language. The federal government will publish an annual list of the U.S. counties where at least ten percent of the population is literate ***only*** in the same non-English language.

Delivery Requirements

An SBC must be provided to participants or eligible participants for the following events occurring after March 23, 2012:

- When a participant is initially eligible for coverage. An SBC for all benefit options available to the employee must be provided.
- When an individual experiences an event that triggers his or her HIPAA special enrollment rights. Special enrollees must be provided with SBCs for all available coverage options within seven days of when the plan is notified of the event.
- At open enrollment, participants must be provided with an SBC only for the plan option in which they are currently enrolled. Participants can request SBCs for other available options. If an SBC is requested, it must be provided within seven days.
- Within seven days of any request.

However, it does not appear that plans must globally distribute SBCs to plan participants as of March 23, 2012.

Who is required to distribute the SBC? The answer depends on how your plan is funded. For fully insured plans, the insurance carrier is required to create an SBC and provide it to the employers. Both the insurance carrier and the employer are responsible for delivering any required SBCs to plan participants. If the insurance carrier distributes it, then the employer requirement is met. If the employer distributes it, then the insurance carrier's obligation is met. Thus, fully insured plans should determine which organization will take responsibility for distribution of the SBCs. In many cases, the employer will likely want to retain responsibility. Employer distribution may be the most expeditious option, as employers are generally the ones notified by participants of an event that triggers distribution of an SBC.

The employer is responsible for distributing the SBC if the plan is self-funded, and should check with the TPA to see if they will create the SBC on behalf of the plan. At a minimum, the TPA will need to complete the coverage examples for the three model medical conditions, based on how the claims would be paid.

How must the SBC be distributed? A plan can send a paper copy of the SBC to the participant's home address. One copy of the SBC sent to the home address meets the distribution requirements for any plan participants living at that same address. However, if the plan is aware of a plan participant living at a different address, such as an adult child covered by the plan, a copy of the SBC must be sent to that participant at his/her own address.

Electronic distribution of the SBC is also permitted. However, the process for electronic distribution must meet the safe harbor requirements for electronic delivery set forth by the Department of Labor. These are discussed in our Benefit Advisor at http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue10.pdf.

There has been much debate about relaxing the standards for the electronic delivery of the SBC. Technology has changed significantly since the DOL first established these requirements in 2002, and home access to the internet has increased dramatically. In addition, the electronic delivery requirements in the individual coverage marketplace are less cumbersome than the requirements for group health plan documents. Thus, it is likely that the DOL's requirements may be amended in the future, making it easier for employers to deliver key documents in an electronic format.

Modifications and Changes to SBC

Health care reform requires health plans to provide a 60-day prospective notice when any of the terms of coverage addressed in the SBC are changed. Employers were highly concerned about this requirement, because many do not receive even a 60-day prospective renewal for their group health plan. For most employers, the few months prior to their health plan renewal are frantic, as plan decisions must be made and communicated and annual enrollment conducted. Providing a summary of material modifications of any element of the SBC, with 60 days' prospective notice, would add another challenge to an already difficult time.

The latest round of guidance brings welcome news. The 60-day notification requirement does not apply to any changes made in connection with a renewal or a reissuance of coverage. Employers will still have to update their SBCs, but changes made at renewal will not be held to the 60-day prospective notice standard. The 60-day notification will apply only to changes made to any element of the SBC that is effective outside of the renewal itself.

In addition, the proposed rules offer latitude with regard to how an employer or plan provides a notice of material modification to any element of the SBC. The plan can provide a copy of the revised SBC, or the plan can issue a separate notification of the changes, such as an annual enrollment newsletter. Either method will meet the notification requirement. At some point the plan will still need to update the SBC and provide it to participants when required; however, that formal step is not required to meet the notification of material modification requirements.

Penalties for Noncompliance

There are substantial penalties for failing to provide an SBC. An insurer or group health plan that willfully fails to provide an SBC will be subject to a fine of up to $1,000 for each plan participant not provided with the SBC.

Several government organizations will have enforcement authority. The Department of Labor will have enforcement authority for ERISA plans, and they intend to provide additional regulations discussing the enforcement of the SBC requirement. The Department of Health and Human Services will have enforcement authority over insurance carriers and non-federal governmental health plans.

Action Steps

At this point, employers may want to start considering how they will implement the SBC process for plan participants. It is very likely that some of the content or requirements related to the SBC will change over the next several months, following feedback received from stakeholders. The federal government recognizes that while the NAIC structured the model SBC on insured plans, many common employer-sponsored elements were not included.

Specifically, the government has solicited comments on:

- Issues that may arise from using the template for different types of plan designs, such as consumer-driven health plans with HSAs, limited network plan options, and the use of different vendors for certain aspects of health benefits, such as a mental health benefit carve-out.
- Changing the language to better meet the needs of group health plans. For example, the term “policy year” is used in the template, but group health plans typically call this the “plan year.”
- The possible inclusion of additional information, such as pre-existing condition limitations (at least until 2014) and information on whether the plan is grandfathered.
- Services to be added or removed from the lists of covered and excluded services.
- Whether the disclaimer stating that the SBC is intended as summary, and not a complete plan document or description, is sufficient.
- If additional terms should be defined in the uniform glossary.
- Delaying the effective date so plans have more time to create SBCs and to develop a process for distribution.

These are the major areas where comments have been requested, but they may be provided on any of the elements addressed in this guidance.

In closing, employers should not feel compelled to create an SBC at this point, because the template is likely to change. However, employers have enough information available now to begin developing a process ensuring that the SBC is delivered at the appropriate times.