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# Agencies Issue Proposed Rule Amending Summary of Benefits and Coverage Requirements and Revising Templates, Instructions, and Uniform Glossary

On December 30, 2014, the Departments of Health and Human Services, Labor and Treasury (the "Agencies") jointly published a proposed rule amending the current Summary of Benefits and Coverage ("SBC") regulation. 79 Fed. Reg. 78578. At the same time, the Agencies revised the SBC template; the sample completed SBC; the instructions for completing the SBC applicable to group coverage and to individual coverage; the "Why This Matters" language template; the Coverage Examples; and the Uniform Glossary. Comments are requested by **March 2, 2015** on the proposed rule and the revised documents.

### What Actions You Should Take

Group health plans and health insurance issuers should carefully review the proposed modifications to the SBC to determine how those modifications will change the plan or issuer's compliance efforts. Note, particularly, that the Agencies propose to require plans and issuers to use these new templates for this fall's open enrollment. As with the previous final SBC rule, given the complexity of the rule, and the potential for civil penalties, it is important that plan sponsors and health insurance issuers to carefully evaluate the time and resources necessary to comply with the rule.

Comments are due March 2, so there is still time to share any thoughts or concerns you have with the proposed rule with the Agencies.

### I. Background

The Patient Protection and Affordable Care Act ("ACA") added section 2715 to the Public Health Service Act ("PHSA") which requires group health plans and health plan issuers to compile and provide an SBC that "accurately describes the benefits and coverage under the applicable plan and coverage."

The SBC requirement applies to insured and self-funded ERISA group health plans, including grandfathered plans, as well as to non-ERISA group health plans and individual health insurance coverage.

The SBC must follow a uniform format which includes a series of content requirements such as: uniform standard definitions of medical and health coverage terms; a description of the coverage including the cost sharing requirements (i.e. deductibles, coinsurance, and copayments); and information regarding any exceptions, reductions, or limitations under the coverage. On August 22, 2011, the Agencies issued proposed regulations on 76 Fed. Reg. 52442 (Aug. 22, 2011); 76 Fed. Reg. 52475 (Aug. 22, 2011). The final regulations were published in the Federal Register on February 14, 2012 and were effective on April 16, 2012. A summary of those final regulations is available at http://www.groom.com/resources-653.html.

## II. Proposed Regulation

On December 30, 2014, the Agencies issued a proposed rule amending the final SBC regulations and at the same time, the Agencies also issued for comment revised SBC templates, samples, instructions, coverage examples and the uniform glossary. The Agencies stated that they are seeking to amend the regulation and update the SBC template and instructions in order to incorporate feedback the Agencies have received. The Agencies also made some improvements to the template in order to streamline and shorten it while also adding certain additional elements that the Agencies believe will be useful to consumers.

Below is a summary of some of the key issues raised by the changes to the regulation, templates and instructions.

### Applicability Date

The effective date of the proposed regulation would require plans to come into compliance with the Proposed Regulation quickly. Specifically, the SBC requirements under the proposed regulation would apply as follows:

- Group Health Plan Participants (Open Enrollment): SBCs would have to comply by the first date of the first open enrollment period that begins on or after September 1, 2015;
- Group Health Plan Participants (Other than Open Enrollment): For group health plan participants who do not enroll in open enrollment, SBCs would have to comply the first day of the first plan year that begins on or after September 1, 2015;
- Issuer to Individual Market Participants and Beneficiaries: For applications, renewals, reissuance, reenrollment, or requests beginning on September 1, 2015.

### SBC Content

The Agencies propose to make the following changes to the content of the SBC:

- First, statements regarding minimum essential coverage ("MEC") and minimum value ("MV") are required to be included in the SBC. As of the applicability date, including this information in a cover letter or similar disclosure furnished with the SBC is no longer permissible.

- Second, the Agencies propose to require a Qualified Health Plan ("QHP") issuer to disclose on the QHP SBC whether abortion services are covered or excluded and whether coverage is limited to services for which federal funding is allowed. The draft instruction guide for individual health insurance indicates that coverage of abortion services must be described in the "services your plan does not cover" or "other covered services" section.

- Third, all plans and issuers must include on the SBC contact information for questions regarding the plan or policy. However, issuers must also include an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. These documents must be easily available to individuals, plan sponsors, and participants and beneficiaries shopping for coverage prior to submitting an application for coverage. For the group market only, an issuer would be permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample group certificate of coverage for each applicable product. After the actual certificate of coverage is executed, it must be easily available to plan sponsors and participants and beneficiaries via an Internet web address.

### Coverage Examples

The Agencies propose to add a Coverage Example (specifically, a foot fracture with an emergency room visit). The Agencies are publishing draft updated claims and pricing data underlying the two existing coverage examples, propose to change the data source for the claims and pricing information, and propose to add narrative description and claims pricing data for the third proposed coverage example.

Perhaps most importantly for group health plan sponsors, the Agencies propose that the coverage example calculator be authorized for continued use.

### Appearance

The proposed regulations would make several changes to the appearance of the SBC, most notably the following:

- First, the sample, completed template has been reduced from four double-sided pages to two and a half double-sided pages. The reduction stems primarily from the elimination of the last page (which currently is entirely Questions and Answers about the Coverage Examples), moving many definitions to the uniform glossary (e.g., the definitions of copayments, coinsurance, etc. from the top of the second page), as well as eliminating some of the required information (e.g., removing the question "Is there an overall annual limit on what the plan pays?" from the first page).

- Second, the instructions now specify that plans and issuers are encouraged to use the font types Arial and Garamond when reproducing the SBC template, which consumer focus groups found to be easy to read.

- Third, the Agencies propose to retain the requirement that SBCs provided in connection with group health plan coverage be provided either as a stand-alone document or in combination with other summary materials (for example, an SPD), so long as the SBC information is intact and prominently displayed at the beginning of the materials and in accordance with the timing requirements for providing an SBC. For health insurance coverage offered in the individual market, the SBC must be provided as a stand-alone document, but it can be included in the same mailing as other plan materials.

### Timing

The proposed regulations would clarify when a health insurance issuer or a plan offering group health coverage must provide the SBC again if the issuer or plan already provided the SBC before application.

- Issuer to Plan
    - Before application. 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. If there has been a change in the information required, a new SBC must be provided as soon as practicable following receipt of the application, but not later than seven business days following receipt of the application.
    - After application. If the plan sponsor is negotiating coverage terms after an application has been filed and the information changes, an updated SBC would not be required to be provided to the plan (or its sponsor) (unless an updated SBC is requested) until the first day of coverage.
- Plan or Issuer to Participants and Beneficiaries
    - Before application. If the plan or issuer provides the SBC prior to application for coverage, it is not required to automatically provide another SBC upon application if there is no change to the information. If there is any change to the information, the plan or issuer must update the SBC and provide a current SBC as soon as practicable following receipt of the application, but not later than seven business days following receipt of the application.
    - After application. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan or issuer is not required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage.

### Electronic Delivery

The Agencies propose to adopt a safe harbor (first adopted in ACA FAQs Part IX, question 1) allowing SBCs to be provided electronically to participants and beneficiaries (i) in connection with their online enrollment or online renewal of coverage under the plan, and (ii) who request an SBC online. In either case, the individual must have the option to receive a paper copy of the SBC upon request.

### Special Rules to Prevent Unnecessary Duplication

The Agencies propose to add provisions to prevent group health plans and health insurance issuers from unnecessarily duplicating SBC creation and delivery:

- First, where an entity required to provide an SBC to an individual has entered into a binding contract with another party to provide the SBC to the individual, the entity would satisfy the requirement to provide the SBC to the individual if:

    (1) The entity monitors performance under the contract;

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and
(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

- Second, where a group health plan uses two or more insurance products provided by separate issuers to insure benefits under the plan, the responsibility for providing complete SBCs is placed on the group health plan administrator. The group health plan administrator may contract with service providers to provide the SBC; however, absent a contract to perform the function, an issuer would have no obligation to provide an SBC containing information for benefits that it does not insure.

- Third, previously the Agencies permitted the group health plan administrator to synthesize the information into a single SBC or provide multiple partial SBCs to provide all the relevant information. The Agencies reiterate that the safe harbor continues to apply.

The Agencies also propose to add a provision to prevent unnecessary duplication with respect to individual health insurance coverage. The requirement to provide an SBC with respect to an individual will be considered satisfied for an entity (such as an institution of higher education) if another party (such as a health insurance issuer) provides a timely and complete SBC to the individual.

**Provision of the SBC by an Issuer Offering Individual Market Coverage**

The proposed regulations would address the provision of SBCs by issuers offering individual market coverage, as follows:

- Upon Application. The Proposed Rule would clarify when the issuer must provide the SBC again if the issuer already provided the SBC prior to application. If the issuer provides the SBC prior to application for coverage, the issuer would not be required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. If there is any change to the information required to be in the SBC that was provided prior to application for coverage by the time the application is filed, the issuer must update and provide a current SBC to the same individual or dependent as soon as practicable following receipt of the application, but not later than seven business days following receipt of the application.

- Automatic Re-Enrollment. If an issuer automatically re-enrolls an individual covered under a policy (including every dependent) into a policy under a different plan or product, the issuer would be required to provide an SBC with respect to the coverage in which the individual (including every dependent) will be enrolled, consistent with the timing requirements that apply when the policy is renewed or reissued (e.g., no later than 30 days prior to plan year).

- Upon Request. Health insurance issuers in the individual market will be deemed to be in compliance with the requirement to provide the SBC to an individual requesting summary information about a health insurance product prior to submitting an application for coverage, if the issuer provides the content required under paragraph (a)(2) of the regulations to the federal health reform Web portal. HHS proposes that an issuer must provide all SBCs other than the "shopper" SBC contemplated in the deemed compliance provision as required under the 2012 final regulations (and any future final regulations), including providing the SBC at the time of application and renewal.

### Self-Insured, Non-Federal Governmental Plans

The proposed regulations would clarify that a self-insured, non-Federal governmental plan may provide SBCs in paper form, or may provide them electronically if the Plan conforms to either the substance of the provisions applicable to ERISA plans (in paragraph (a)(4)(ii)) or to individual health insurance coverage (in paragraph (a)(4)(iii)).

### Applicability of SBC Requirements to Specific Coverages

The proposed regulations also address the applicability of the SBC requirements to specific coverages.

- Expatriates. In May 2012, the Agencies issued FAQs that provided expatriate plans with temporary relief from enforcement. Under recently enacted legislation, expatriate health plans are not subject to the requirement to provide an SBC. Until the Agencies issue guidance implementing this legislation, the temporary relief from enforcement for expatriate plans will remain in place.

- Medicare Advantage Plans. The Agencies propose to exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits.

- Closed Blocks. Under this enforcement relief, a plan and issuer need not provide an SBC if the following conditions are met: (1) The insurance product is no longer being actively marketed; (2) The health insurance issuer stopped actively marketing the product prior to September 23, 2012; and (3) The health insurance issuer has never provided an SBC with respect to such product. The Agencies note that if an insurance product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the product, the plan and issuer must provide the SBC with respect to such coverage.

- Excepted Benefits. The Agencies propose that, as under the 2012 final regulations, an SBC need not be provided for plans, policies, or benefit packages that are excepted benefits. The Agencies note that if an EAP qualifies as excepted benefits, the EAP need not separately satisfy the SBC requirements.

### Language

The preamble to the proposed regulations notes that the Agencies anticipate that translations (Chinese, Navajo, Spanish and Tagalog) of the updated SBC template, sample language, and uniform glossary will be available when the proposed regulations are finalized.