GROOM LAW GROUP CHARTERED

BENEFITS BRIEF

July 8, 2015 www.groom.com

Authors: Sravya Boppana, Emily C. Lechner, Tamara S. Killion

If you have questions, please contact your regular Groom attorney or one of the attorneys listed below:

Kathryn Bjornstad Amin
kamin@groom.com
(202) 861-2604

Sravya Boppana
sboppana@groom.com
(202) 861-6338

Jon W. Breyfogle
jbreyfogle@groom.com
(202) 861-6641

Lisa M. Campbell
lcampbell@groom.com
(202) 861-6612

Thomas F. Fitzgerald
tfitzgerald@groom.com
(202) 861-6617

Katy S. Kamen
kkamen@groom.com
(202) 861-6646

Christine L. Keller
ckeller@groom.com
(202) 861-9371

Tamara S. Killion
tkillion@groom.com
(202) 861-6328

Emily C. Lechner
elechner@groom.com
(202) 861-9386

Rachel Leiser Levy
rlevy@groom.com
(202) 861-6613

Mark C. Nielsen
mnielsen@groom.com
(202) 861-5429

Seth T. Perretta
sperretta@groom.com
(202) 861- 6335

Malcolm C. Slee
mslee@groom.com
(202) 861-6337

Ryan C. Temme
rtemme@groom.com
(202) 861-6659

Christy A. Tinnes
ctinnes@groom.com
(202) 861-6603

Vivian Hunter Turner
vturner@groom.com
(202) 861-6324

Allison Ullman
aullman@groom.com
(202) 861-6336

Will E. Wilder
wwilder@groom.com
(202) 861-6640

Brigen L. Winters
bwinters@groom.com
(202) 861-6618

Agencies Issue Final Rule Amending Summary of Benefits and Coverage Requirements

Agencies Issue Final Rule Amending Summary of Benefits and Coverage Requirements
On June 16, 2015, the Departments of Health and Human Services, Labor and Treasury (the "Agencies") jointly published a final rule amending current guidance governing Summaries of Benefits and Coverage ("SBCs") ("Final Rule"). 80 Fed. Reg. 34292. This rule finalizes the guidance issued in the Agencies' proposed rule dated December 30, 2014 ("Proposed Rule"). For additional information on the Proposed Rule, please consult our February 19, 2015 client alert, available at: http://www.groom.com/resources-947.html.

Please note that the Agencies have not finalized the new SBC template and associated documents. However, the Agencies anticipate finalizing those documents by January 2016.

What Actions You Should Take

While the rule primarily codified previous guidance and FAQs related to SBCs, and we expect that the biggest changes related to SBCs will be seen when the Agencies finalize the template and instructions, issuers in particular are subject to new requirements under the rule, including a requirement to post the actual certificates of coverage. Entities that rely upon others to provide the SBC now also have a duty to monitor that performance.

As a result, group health plans and health insurance issuers should carefully review the modifications to the SBC regulation to determine how those modifications will change the plan or issuer's compliance efforts. Note, particularly, that group health plans and health insurance issuers of group plans are required to comply with this regulation by September 1, 2015. The rule is effective for 2016 SBCs with respect to individual plans.

As discussed further below, significant changes to the SBC regulation include:

- Requiring Online Access to Individual Underlying Policy or Group Certificate: Issuers must include an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

- Duty to Monitor (Applicable to Group Health Plans and Student Health Insurance): Where an entity required to provide an SBC to an individual has entered into a binding contract with another party to provide the SBC, the entity satisfies the requirement to provide the SBC if the entity monitors performance under the contract (among other requirements).

- Permitting More Than One SBC: Where a group health plan uses two or more insurance products provided by separate issuers with respect to a single group health plan may synthesize the information into a single SBC or provide multiple partial SBCs.

- Requiring Disclosure of Abortion Services by QHP Issuers: For coverage sold through an individual market Exchange, Qualified Health Plan ("QHP") issuers must disclose whether abortion services are covered or excluded, and whether coverage of such services is limited to services for which federal funding is allowed.

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.

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 were seeking to amend the regulation and update the SBC template and instructions in order to incorporate feedback the Agencies had 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 believed will be useful to consumers. A summary of these proposed regulations is available at http://www.groom.com/resources-947.html.

On March 30, 2015, the Agencies released an FAQ stating that the Agencies intend to finalize changes to the regulations in the near future but intend to utilize consumer testing and offer an opportunity for the public, including the NAIC, to provide further input before finalizing revisions to the SBC template and associated documents.

II. Final Regulation

On June 16, 2015, the Agencies issued a final rule amending the final SBC regulations. The Final Rule finalizes most of the proposals in the proposed rule.

While they amended the final SBC regulations, the Agencies did not release a new SBC template and associated documents. The Agencies stated that they anticipate the new template and associated documents will be finalized by January 2016. They anticipate the documents will apply to coverage that would renew or begin on the first day of the

first plan year (or, in the individual market, policy year) that begins on or after January 1, 2017 (including open season periods that occur in the Fall of 2016 for coverage beginning on or after January 1, 2017).

Below is a summary of some of the key issues raised by the changes to the regulation.

Applicability Date

The effective date of the final regulation requires plans to come into compliance with the Final Rule quickly. Specifically, the SBC requirements under the Final Rule apply as follows:

- Group Health Plan Participants (Open Enrollment): SBCs 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 have to comply the first day of the first plan year that begins on or after September 1, 2015;
- Issuer to Plans: For disclosures with respect to plans, SBCs have to comply beginning September 1, 2015.
- Issuer to Individual Market Participants and Beneficiaries: For disclosures with respect to individuals and covered dependents in the individual market, SBCs have to comply with respect to coverage that begins on or after January 1, 2016.

SBC Content

The Agencies changed the content of the SBCs in two main ways that affect health insurance issuers:

- For coverage sold through an individual market Exchange, QHP issuers must disclose whether abortion services are covered or excluded, and whether coverage of such services is limited to services for which federal funding is allowed. The Agencies stated that until the new template and associated documents are finalized and applicable, individual market QHP issuers may adopt any reasonable wording and placement of the disclosure on the SBC. Individual market QHP issuers may also provide the disclosure in a cover letter or other similar disclosure provided with the SBC.
- Issuers must include a web address where copies of the actual individual coverage policy or group certificate of coverage can be reviewed or obtained. 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.

One major difference between the Proposed Rule and the Final Rule relates to flexibility in providing minimum essential coverage ("MEC") and minimum value ("MV") disclosures. In contrast to the Proposed Rule, the Agencies, in the final rule, provide that until the finalized template and associated documents are issued and finalized, the Agencies will not take enforcement action against plans and issuers that provide SBCs with a cover letter or similar disclosure with the required MEC or MV statements. The Agencies also stated that because the MV requirements do

not apply with respect to individual market coverage, until the finalized template and associated documents are applicable, no enforcement action will be taken against individual market issuers for omitting the MV statement.

Appearance

The Agencies also issued guidance on the appearance of the SBCs:

- The Agencies restated their position set forth in the Proposed Rule that a group health plan that utilizes two or more benefit packages (*e.g.*, major medical coverage and health FSA) may synthesize the information into one SBC or provide multiple SBCs.

- The Agencies also reiterated the statutory rule that SBCs can be up to four double-sided pages.

Timing

Consistent with the Proposed Rule, the Final Rule clarifies 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 is 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 adopted in the Rule 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, so long as the disclosure is made in accordance with the DOL's electronic disclosure regulations. In either case, the individual must have the option to receive a paper copy of the SBC upon request. The Agencies declined to expand the electronic safe harbor further.

Special Rules to Prevent Unnecessary Duplication

Consistent with the Proposed Rule, the Agencies added provisions to prevent group health plans and health insurance issuers from unnecessarily duplicating SBC creation and delivery. In so doing, the Agencies introduced a new monitoring requirement.

- 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 satisfies 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 has 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 codified this safe harbor in the final rule.

The Agencies also addressed student 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. The Agencies also added a duty to monitor student health SBCs that parallels the duty to monitor that is being added with respect to the anti-duplication rule for group health plans.

Provision of the SBC by an Issuer Offering Individual Market Coverage

Consistent with the Proposed Rule, the Final Rule addresses the provision of SBCs by issuers offering individual market coverage, as follows:

- Upon Application. The final rule clarifies 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 is not 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 is 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. 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 Final Rule adopts the Proposed Rule's clarification providing 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 or to individual health insurance coverage.

Applicability of SBC Requirements to Specific Coverages

The Final Rule also addresses the applicability of the SBC requirements to specific coverage.

- Medicare Advantage Plans. The Agencies finalize without change the proposal to exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits.

- Closed Blocks. The Agencies reiterate this enforcement relief. 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 again 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.

Unlike the Proposed Rule, there is no discussion of applicability with respect to other excepted benefits.

Language

Plans and issuers will be considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards applicable to the form and manner of claims and appeals notices are met as applied to the SBCs.

Conclusion

We expect that the biggest changes related to SBCs will be seen when the Agencies finalize the template and instructions. Nonetheless, the Agencies have adopted new requirements that affect issuers in particular, including a requirement to post the actual certificates of coverage with a relatively short timeframe until the rule is effective. As a result, group health plans and health insurance issuers should carefully review the modifications to the SBC regulation to determine how those modifications will change the plan or issuer's compliance efforts.

Please contact any of the attorneys in the Health and Welfare Practice Group at Groom Law Group or your regular Groom Law Group attorney for further information.