Agencies Release Final Regulations Regarding Summary of Benefits and Coverage and Uniform Glossary Requirements

February 2012

On February 9, 2012 the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury (the agencies) jointly released final regulations and a guidance document to implement a provision in the Patient Protection and Affordable Care Act (Affordable Care Act) that requires all group health plans and health insurance issuers to provide consumers with two new disclosure forms to assist them in understanding and comparing their health coverage options. The new disclosure forms include:

- A Summary of Benefits and Coverage (SBC); and
- A Uniform Glossary (Glossary) of common health insurance words, such as "copay" and "deductible."

The SBC template, instructions for completing the SBC, a sample completed SBC, a guide for coverage example calculations, and the Glossary are available on HHS’s website (found in Resources section) for use in describing coverage beginning on or after September 23, 2012 but before January 1, 2014. New templates and instructions will be effective in 2014.

In October 2011, Aon Hewitt provided extensive comments to the agencies in an effort to make compliance with the final SBC regulations more manageable for employers yet preserve the important goals for consumers (For more information, see Aon Hewitt Submits Comments on Summary of Benefits and Coverage). The final regulations reflect many of our suggestions, including permitting more flexibility with respect to providing SBCs electronically, in certain circumstances.

However, the final rules do not provide an exemption for large group health plans with established comprehensive tools and resources that already allow employees to compare plans and benefit packages. In addition, the rules do not account for significant Internet enrollment usage that is now common for populations at most organizations. This, in combination with the need to prepare the SBC in time for this fall’s annual enrollment period, will impose a significant burden on employers.

This Aon Hewitt bulletin focuses on the issuance of the SBC and Glossary to participants and beneficiaries, although the final regulations also require group health insurance issuers to provide the new disclosures to group health plans (and include details around that requirement).

Effective Date

The final rules are effective April 16, 2012. For group health plans, the requirements to provide an SBC, notice of modification, and Glossary apply for disclosures through an open enrollment period (including re-enrollees and late enrollees), beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For employers that sponsor calendar year health plans, this means SBCs must be provided during annual enrollment periods this fall that begin on or after September 23, 2012. For participants and beneficiaries who enroll other than through an open enrollment
period (including special enrollees and newly-eligible individuals), the requirements apply beginning on the first day of the first plan year beginning on or after September 23, 2012. For calendar year plans, the disclosure requirements for such individuals will apply beginning January 1, 2013.

Which Plans Must Comply?

The SBC disclosure requirements apply to all group health plans. However, an SBC is not required for plans, policies, or benefit packages that are considered excepted benefits under the agencies’ regulations. For example, stand-alone dental and vision plans and health flexible spending arrangements (FSAs) are exempt from the SBC disclosure requirements if they meet the criteria for excepted benefits.

Health reimbursement arrangements (HRAs) are group health plans and generally are subject to the SBC disclosure requirements. However, if the HRA is integrated with a major medical plan, information about the HRA can be integrated into the SBC for the major medical plan. Health savings accounts (HSAs) are generally not group health plans and, thus, not subject to the SBC disclosure requirements. However, HSA information may be integrated into the SBC for the high-deductible health plan with which it is associated.

Purpose of the SBC and Uniform Glossary

The SBC and Glossary are intended to enable participants and beneficiaries to make apples-to-apples comparisons of main features of all available health plans, whether the plans are offered by their own employer, a family member’s employer, or are individual policies. Every group health plan benefit package will have its own SBC, which must follow the government-provided template. Generally, the SBC requires a plain language description of covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

The SBC Template and Uniform Glossary

The final rules incorporate a detailed SBC template and Glossary that were drafted in consultation with the National Association of Insurance Commissioners (NAIC). Insurers and plan sponsors must reproduce the SBC template precisely (for example, no smaller than 12-point font and no more than four double-sided pages). However, the final regulations allow employers and insurers some flexibility to make “best efforts” if the plan’s terms do not lend themselves to the SBC template. The Glossary may not be modified by insurers or plan sponsors.

The SBC template requires a combination of chart information, questions and answers, and two plan-specific coverage examples (i.e., the plan’s coverage for giving birth (normal delivery) and managing type 2 diabetes). The SBC must also include the Internet address (or other contact information) for obtaining a list of network providers, the Internet address (or similar contact information) for obtaining more information about the plan’s prescription drug coverage, and the Internet address for obtaining the Glossary.

The SBC is also required to be provided in a “culturally and linguistically appropriate manner.” This requirement is satisfied if the language requirements in the claims and appeals regulations, as amended by the Affordable Care Act, are met. If the SBC is sent to a participant or beneficiary’s address located in
any U.S. county where at least 10% of the resident population is literate only in a non-English language, the insurer or plan sponsor is required to provide:

- Oral language services (e.g., a telephone customer assistance hotline) to answer questions about the SBC in such non-English language;
- Upon request, a copy of the SBC written in the non-English language; and
- In the English version of the SBC, a statement prominently displayed in the non-English language clearly indicating how to access the oral language services provided.

HHS maintains a list of the U.S. counties to which this language threshold applies and the non-English SBC templates on its website at: http://cciio.cms.gov.

It’s important to note the current template is short-term; a new template effective in 2014 will reflect other Affordable Care Act requirements, such as information on whether the plan meets minimum essential benefits coverage requirements and whether the plan’s share of the total allowed costs of benefits meets the necessary requirements. The additional information will help participants know whether the plan is sufficient for purposes of meeting the individual mandate.

Who Provides the SBC?

For fully insured plans, carriers are required to provide the SBC and Glossary to the plan (or its sponsor) and participants and beneficiaries. For self-insured plans, plan administrators are responsible for providing an SBC to participants and beneficiaries. In cases where an employer sponsors a fully insured plan, only one party needs to provide the SBC.

Who Receives the SBC?

The SBC must be provided to participants (and beneficiaries known to reside at a different address) who enroll or re-enroll in group plans (fully insured and self-insured) through open enrollment or outside open enrollment at the time they become eligible to enroll in a plan, when they renew coverage, when they experience a special enrollment event (e.g., birth, adoption, marriage, and loss of coverage in some circumstances), and upon request.

SBC and Glossary Delivery and Timing

The SBC is generally required to be included with any written materials distributed for enrollment. If no written application materials are distributed for enrollment, the SBC is required to be distributed on or before the first day of enrollment. The Glossary is not required to be automatically distributed, but must be made available upon request, in either paper or electronic form (as requested) within seven business days. The SBC may be included with a summary plan description (SPD) or other summary plan materials, if the SBC information is intact and prominently displayed at the beginning of the SPD or materials (e.g., immediately after the Table of Contents), or as a stand-alone document.

If a participant is not required to re-enroll each year (i.e., re-enrollment is automatic), the SBC must be provided to such individuals at least 30 days prior to the first day of the new plan year. If there is any change to the information required to be in the SBC between the application for coverage (e.g., the end of the annual enrollment period) and the first day of coverage, the plan must provide the updated SBC on or before the first day of coverage. If a material modification is made to the terms of a plan mid-year (other than as part of renewal or reissuance of coverage) that is not reflected in the most recently provided SBC,
notice of such modification to the plan’s terms must be communicated to enrollees not later than 60 days prior to the date on which such modification will become effective.

For participants and beneficiaries who enroll in coverage outside open enrollment (e.g., due to special enrollment, new hires, or newly-eligible participants), the SBC is required to be provided within 90 days after enrollment.

The SBC also is required to be provided upon request, as soon as practicable, but no later than seven business days following receipt of the request.

Multiple Benefit Package Situations

For group health plans that offer more than one benefit package (e.g., multiple benefit options, such as a PPO, POS, or HMO), the SBC must be distributed with respect to each benefit package for which the participant is eligible. However, an exception exists if a participant is renewing a benefit package—in that case, the employer or insurer is obligated to provide the SBC only for the benefit package in which the participant is currently enrolled. Renewal situations appear to include both automatic renewals and renewals where a participant must apply to have coverage renewed. SBCs for other benefit packages for which the participant is eligible must be provided as soon as practicable upon request, but in no event later than seven business days following the request.

Paper and Electronic Delivery Options

The SBC may be provided in paper form. Alternatively, the SBC may be provided electronically, if certain requirements are met. For SBCs provided electronically to participants, the final rules distinguish between a participant who is already covered under the group health plan and a participant who is eligible for coverage but not enrolled:

- **Enrolled participants and beneficiaries**—For participants and beneficiaries who are already covered by a group health plan, the SBC for such plan may be provided electronically as long as the requirements of the DOL electronic disclosure rules are followed. Under existing DOL rules, posting on the Internet, by itself, is not sufficient. Further, unless a participant uses a computer as part of his or her “integral work duties,” ERISA’s electronic distribution requirements remain somewhat complicated and require affirmative consent for non-computer-using employees, as well as the beneficiary population. In cases where electronic delivery to an employee satisfies the DOL rules, paper delivery might still be necessary for the employee’s beneficiaries who have not consented to electronic delivery.

- **Eligible but not enrolled**—The rules for electronic disclosure of the SBC to participants and beneficiaries who are eligible for, but not enrolled in, coverage are more lenient. For such individuals, the SBC may be provided electronically if the format is readily accessible, including Internet posting, and a paper copy is provided free of charge upon request. If Internet posting is used, the plan still must notify these individuals via email or in paper form (such as a postcard) of the SBC’s posting on the Internet, the Internet address, and that the SBC is available in paper form upon request.

Penalties for Non-Compliance

The Affordable Care Act imposes a fine of not more than $1,000 per enrollee for each failure by a group health plan that willfully fails to provide the SBC information. The regulations note that the DOL intends to issue separate regulations describing the procedures for assessing such a fine on ERISA-covered group
health plans. The regulations also note that if a group health plan (other than a plan maintained by a governmental entity) fails to comply with chapter 100 of the Internal Revenue Code (which includes the new SBC requirements), an excise tax of $100 per day per individual could be imposed. Internal Revenue Code rules could reduce the amount of the excise tax for failures due to reasonable cause and not to willful neglect. The final regulations instruct group health plans that fail to comply with the SBC requirements to report the excise tax for those failures under current Treasury procedures unless and until future Treasury guidance provides otherwise.

More Information

If you have questions regarding the SBC disclosure requirements, please contact your Aon Hewitt consultant.

Resources

The full text of the final regulations is available at: http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf

The SBC and Uniform Glossary—Templates, Instructions, and Related Materials are available at: http://cciio.cms.gov/resources/other/index.html#sbcug

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