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Employee Benefits Briefing

Medical Plan Summary of Benefits and Coverage: The Forthcoming Mini-SPD

On August 22, 2011, the U.S. Departments of Treasury, Labor and Health and Human Services (the "Departments") issued *proposed regulations* relating to the requirement under the Patient Protection and Affordable Care Act (PPACA) that participants in medical plans receive a summary of benefits and coverage (SBC) beginning in March 2012. These regulations are only proposed, and they could change when they are finalized. However, because the requirement to distribute SBCs is statutory, because much of the content of an SBC is dictated by the statute, and because there are significant potential penalties for failing to provide SBCs, benefits administrators should develop an understanding of what will be required once the SBC regulations are finalized.

Background/Overview

Section 2715 of PPACA provides that medical plans and/or medical insurance carriers must provide plan participants with a short, uniform summary of benefits and coverage (known as an SBC) offered under a particular plan or coverage option. The SBC does not replace the requirement of providing participants with summary plan descriptions, but is in addition to this requirement. The general theory behind the SBC requirement is that uniform documents will enable plan participants to compare common terms and conditions of coverage options and other commercially available insurance plans. PPACA also requires health plans and insurance carriers to provide plan participants with 60 days' advance written notice of any material modification to a plan's terms or coverage.

The proposed regulations provide guidance on (i) who must receive an SBC and when, (ii) who must provide an SBC, (iii) the form and content of an SBC and (iv) when a plan or carrier must provide advance notice of a modification.

Discussion

A. Who Gets the SBC, and When Must It Be Provided?

Participants and beneficiaries must receive the SBC for each benefit option at the time they are electing coverage, meaning SBCs must be provided to participants and their eligible dependents when they first become eligible for coverage and annually at open enrollment. This includes participants and their eligible dependents who are newly eligible for coverage and those who have special enrollment rights.

If, at open enrollment, a participant must make an affirmative election to continue coverage, the participant must be provided with SBCs for each coverage option, and the SBCs must be provided along with the open enrollment materials.

If, at open enrollment, benefits continue on a passive basis (i.e., current coverage continues unless the participant elects otherwise), the

participant need only receive the SBC for the current benefit option, and that SBC must be provided at least 30 days before the beginning of the upcoming plan year. Also, even for a participant with a passive enrollment option, SBCs may be requested for each other coverage option available under the plan (and they must be delivered as soon as possible and within seven days).

The proposed regulations provide that plans and carriers may deliver SBCs electronically if applicable Department of Labor standards are satisfied.

The proposed regulations contain significant potential penalties for failure to deliver SBCs. Each of the Departments reserves the right to impose penalties, including a $1,000-per-participant penalty for a willful failure to deliver SBCs.

B. Who Must Provide the SBC?

Insured Plans: Both the insurer of the plan and the designated plan administrator are responsible for providing the SBCs. However, if one provides the SBC, the other is not required to do so.

Self-Insured Plans: The plan sponsor or designated plan administrator is required to provide the SBCs.

C. What Are the Content and Format of the SBC?

The SBC must generally contain the following information:

- Uniform definitions of standard insurance terms and medical terms so that participants may compare health coverage and understand the terms of (or exceptions to) their coverage. Once the Departments finalize these definitions in a uniform glossary, they must be used verbatim in the SBC. Also, this uniform glossary must be provided to participants free of charge upon request.
- A description of the coverage, including cost sharing, for each category of benefits identified by the Departments.
- The exceptions, reductions and limitations on coverage.
- The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations.
- The renewability and continuation of coverage provisions.
- A coverage facts label that includes examples to illustrate the common benefits scenarios (including pregnancy resulting in a normal birth, breast cancer and diabetes) and related cost sharing based on recognized clinical practice guidelines. The Departments may require SBCs to include up to six coverage examples, although initial SBCs would be required to include only the three described above. A benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines available through the National Guideline Clearinghouse Agency for Healthcare Research and Quality. The Departments will specify the types of services, dates of services, applicable billing codes and allowed charges for each claim in the benefits scenario.
- Beginning with the SBC relating to 2014 coverage, a statement about whether the plan provides minimum essential coverage under PPACA, and whether the plan's or coverage's share of the total allowed costs

of benefits provided under the plan or coverage meets applicable requirements.

- A statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage.
- A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.
- For plans that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers.
- For plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan.
- An Internet address where an individual may review and obtain the uniform glossary.
- Premiums (or cost of coverage for self-insured group health plans).

With regard to format, the SBC is required to be no more than four double-sided pieces of paper utilizing 12-point font.

The SBC will be required to be provided, upon request, in a language in addition to English in counties where at least 10 percent of the population residing in the county is literate only in the same non-English language. Also, the SBC in those counties will be required to disclose the availability of language services in the relevant language.

D. 60-Day Prior Notice of Material Modifications

If a medical plan makes a material modification in any of the terms of the plan or coverage that would affect the contents of the most recently published SBC, a notice of that change must be provided at least 60 days prior to the date on which the modification will become effective. The 60-day advance notice requirement applies regardless of whether a change is an increase or a decrease in the benefit.

E. When Does the First SBC Have to Be Delivered?

The statute requires the initial SBCs to be provided to participants on or before March 23, 2012. The proposed regulations do not change that delivery date. However, the Departments have asked for comments on the feasibility of employers' being able to comply with that initial distribution date.

If you have any questions regarding this briefing, please contact **Philip L. Mowery** (312-609-7642) or **Christopher T. Collins** (312-609-7706).

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