200+ Pages of guidance on How to Construct a 4-Page Summary of Benefits and Coverage ...but questions remain for group health plans

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The long awaited guidance on the "four page summary" was finally released on August 17, well after the statutory deadline of March 23, 2011. In two releases that exceed 200 pages, the federal Departments (IRS, DOL and HHS) described the content, format, and distribution rules for the 4-page notice, to be known as the Summary of Benefits and Coverage or "SBC." However, much of the discussion is focused on insured products, and there are significant gaps for employer-sponsored group health plans. The Departments have requested comments on a number of those gaps so we can expect further guidance.

The bottom line:

- We cannot yet fill in the blanks of the template to create SBCs for group health plans.
- You do not need to include SBCs in January 1, 2012 open enrollment materials that you will be sending out in fall 2011.
- You are supposed to start using SBCs for enrollments in and after March 2012, although the Departments may extend that deadline.

Overview of the SBC

One of the most interesting features is the creative interpretation that "4 page" means 4 double-sided pages, and does not include the uniform glossary. The model SBC consists of a 6-page summary (that will often expand to 7 / 8 pages after the plan's details are inserted) plus a 4-page glossary (or 10 12 pages total).

The uniform glossary will be posted on various government websites and cannot be modified. Plans that use different terminology may want to consider migrating to the uniform definitions to ease employee communication efforts.

You can find a sample SBC here. As currently proposed, a separate SBC is required for each benefit option offered under a plan. These separate SBCs may be less useful to employees than the tables many employers currently use to communicate differences between plan options.

The first page of the SBC is designed to describe the plan's cost-sharing structure of deductible, coinsurance and copayments through a three column table that must answer nine "important questions" about the premium or cost of coverage for self-insured plans (without any employer subsidy), overall deductible, any special deductibles, out-of-pocket limits, expenses that don't count toward the out-of-pocket limit, whether the plan uses a network of providers, whether referrals are required and whether there are services the plan doesn't cover. The plan's answer for each question must be flanked by a column titled "why this matters" which will contain one of two standardized explanations, depending on the plan's "answer."

Internet addresses must be included where employees can access a list of in-network providers and the prescription drug formulary, if applicable.

Immediately following the information box will be a table that describes the plan's treatment of ten common medical events (which correlate to the statutory list of essential benefits). These events include doctor visits; tests; prescription drugs; outpatient surgery; immediate medical attention; hospital stays; mental health, behavioral health or substance abuse care; pregnancy; recovery or special health needs (like rehabilitation services, skilled nursing care or durable medical equipment); and pediatric dental or vision care.

For each required event, the table would include the event, types of services that might be needed (like facility fees and surgeon's fees for outpatient surgery), the patient's cost in-network or out-of-network (coinsurance rate, copayment amount or "not covered") and a description of any limitations or exceptions that apply to that service (or "---none---").

The summary next classifies fourteen services (acupuncture, bariatric surgery, non-emergency care when travelling outside the U.S., chiropractic care, cosmetic surgery, dental care (adult), hearing aids, infertility treatment, long-term care, private duty nursing, routine eye care (adult), routine foot care, and weight loss programs) in one of two text boxes: "Services Your Plan Does NOT Cover" or "Other Covered Services". Both boxes note that they are not complete lists and the current proposed regulations prohibit the inclusion of any other services in the "other covered services" box.

Although the SBC repeats several times that not all of the plan's exclusions are listed and it is a summary, plans will want to consider expanding the list of exclusions to provide more complete information. At a minimum, plans that still apply pre-existing condition limitations will want to reference that exclusion. Other exclusions (like treatment of injuries sustained in an act of war) do not easily fit within this exclusion framework.

The model SBC then describes "Your Rights to Continue Coverage" which provides that the employee may keep coverage as long as premiums are paid, unless one of the following happens: the employee or employer commits fraud or an intentional misrepresentation of material fact; the insurer stops offering the product or services in the state; the employee moves outside of the coverage area; the employer changes insurance carriers; the employer cancels or fails to renew the coverage; or the employee terminates employment and is not eligible to continue coverage under COBRA or state law. Obviously, this list does not address numerous situations where an individual's eligibility might end (for example, transfer to an ineligible classification, reduction in hours, divorce, reaching the limiting age for a dependent, etc.). It also does not describe COBRA continuation (which most of us expected to see as the most common "right to continue coverage").

The last two pages of the model SBC contain coverage "facts labels" to illustrate three common benefits scenarios (having a baby, treating breast cancer and managing diabetes). The examples illustrate the application of the plan's cost sharing provisions and may help employees better appreciate the value of the coverage provided and are accompanied by questions and answers about the

coverage examples. The Departments have requested comments on phasing in these examples.

Gaps in the Model SBC

Because the Departments have not yet defined "minimum essential coverage" or how to determine if a plan covers at least 60% of the costs of benefits (i.e., whether the coverage is "adequate") and that information is not relevant until 2014, the proposed regulations provide that the SBC does not need to address those topics for coverage before 2014. The Departments have also asked for comments on whether to allow employers to use the SBC to communicate whether the plan coverage is "affordable."

The model SBC does not have room to describe the plan's eligibility standard (eligible classes or waiting period).

The model SBC does not appear to contemplate company provided health reimbursement account (HRA) or health savings account (HSA) contributions, wellness incentives (whether compensation, contributions or premium reductions) or tiered provider networks.

The Departments requested comments as to whether to add a checkbox indicating grandfathered status to the SBC. The implication is that the SBC for a grandfathered plan might not need to include the normal grandfathered plan notice (probably due to space constraints).

Form of Delivery

Although the regulations state that the SBC must be a stand-alone document, the Departments requested comments on whether plans should be allowed to incorporate the SBC into a summary plan description or other employee communication materials.

The SBC may be delivered to participants in paper form or by electronic delivery if the plan meets the DOL's electronic disclosure safe harbor. Although the DOL is considering expanding the rules governing electronic delivery, expanded rules have not been issued. For now, many employees will need to still receive paper copies.

Timing

If your group health plan is insured, a potential insurer must provide a SBC no more than 7 days after a request for a bid. If any information in the SBC changes between an initial inquiry and the purchase of coverage, a revised SBC must be provided. In addition, a new SBC must be provided at each renewal, even if there are no changes.

A plan must provide SBCs to benefits-eligible employees: (1) with enrollment materials; (2) within seven days after a request for special enrollment due to a change in status; or (3) within seven days after a request for the information (with no limit on the number of requests that may be made during a year).

If you make a material change to any of the plan features described in the notice, you must provide a copy to enrollees no later than 60 days before the date the

change would become effective. If you are making a mid-year change in only one benefit option, you could limit that automatic update to participants and beneficiaries currently enrolled in that coverage.

As we have mentioned before, this means that you will need to accelerate open enrollment to ensure that there is at least 60 days between the date enrollment materials are distributed and the effective date of any benefit design changes.

We note that it may be impossible to provide the 60 days prior notice in certain situations (like sales and merger transactions) and we hope that the final regulations will contain a process for situations when prior notice cannot be provided.

If HHS updates the model SBC, plans will have 90 days to revise their form for future mailings. This change will not trigger the requirement to send the revised SBCs (except upon request).

Penalties

The regulations restate the various statutory penalties that can be imposed for the failure to provide SBCs. The penalties include a penalty of up to $1,000 per failure for a willful failure to provide the notice; PLUS a state may impose a fine under its enforcement mechanism or an HHS penalty of up to $100 per day per affected individual; PLUS the IRS and DOL intend to coordinate enforcement of the potential civil fines under ERISA and excise taxes of $100 per day per affected individual under the Internal Revenue Code.

2014 Health Insurance Exchanges

The Departments are starting to sketch out their vision of the operation of the state health insurance exchanges in 2014. The Departments issued proposed regulations on August 17 addressing the role of the exchanges and the availability of tax subsidies for individuals purchasing health insurance on an exchange. The Departments are considering various ways to corroborate whether you offer affordable, adequate coverage to employees (which will determine whether anyone in an employee's household is eligible to purchase subsidized coverage on the exchange and whether you are subject to penalties). Please feel free to contact us to discuss how these 2014 tax subsidies and penalties may impact your company as you consider long-term strategy for your employees' health benefits.
