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Summaries of Benefits and Coverage under Health Care Reform: Your Guide to the New Requirements

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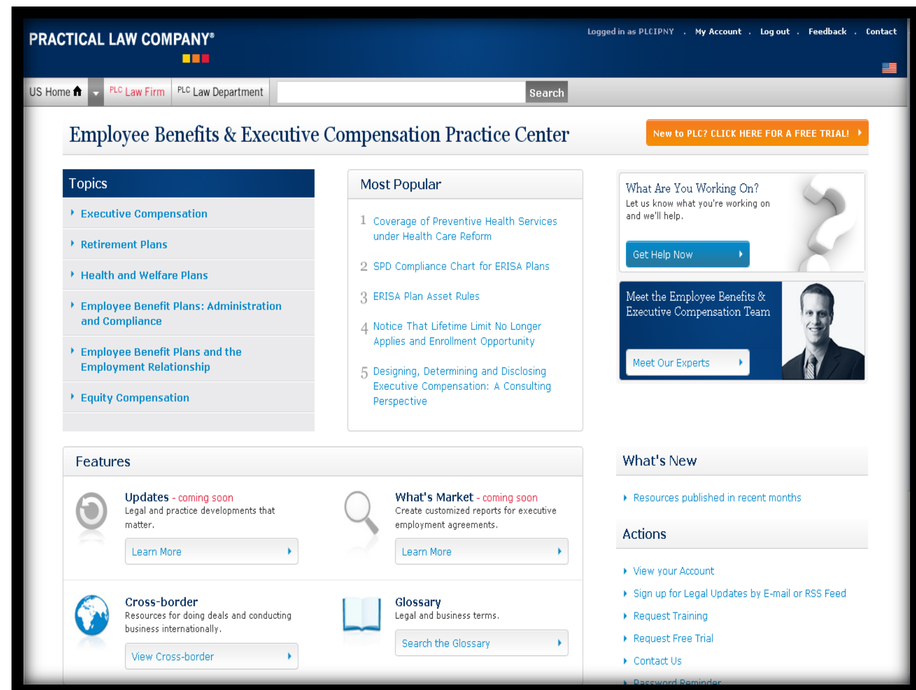

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Summaries of Benefits and Coverage

Topics we will cover today:

- Extensive new guidance on summaries of benefits and coverage (SBCs), including proposed—
  - Regulations
  - SBC template and instructions
  - Guide for coverage examples calculations
  - Uniform glossary
- Who must provide and receive SBCs
- When and how SBCs are provided
- Penalties for noncompliance

Acronyms

- SBC: Summary of benefits and coverage
- DOL: Department of Labor
- ERISA: Employee Retirement Income Security Act
- HHS: Department of Health & Human Services
- HIPAA: Health Insurance Portability and Accountability Act
- NAIC: National Association of Insurance Commissioners
- PHSA: Public Health Service Act
- SPD: Summary plan description

Summaries of Benefits and Coverage

Overview

- PHSA §2715, added under health care reform, requires a disclosure that "accurately describes the benefits and coverage" under the plan
- SBC requirement applies—
  - In addition to ERISA's SPD requirement
  - To grandfathered plans under health care reform, but not to excepted benefits (e.g., most dental and vision plans)
  - Beginning March 23, 2012, though the Departments requested comments on a possible phased-in approach
- Guidance developed in consultation with NAIC

Who Provides the SBCs?

Insurers and plans share responsibility

- For self-insured group health plans, the plan (including plan administrator) must provide SBCs
- For insured plans, either the plan or insurer are responsible for providing SBCs
- If one entity, e.g., the plan or insurer, provides an SBC, the requirement is met for *all* entities
  - Assuming timing and content rules are met
  - Plans and insurers should make contractual arrangements for sending SBCs

When Must SBCs Be Provided?

SBCs are provided—

- To participants and beneficiaries:
  - Automatically as part of written application materials
  - Upon request
  - When there are material modifications to the information
- Free of charge
- For each benefit option for which a participant or beneficiary is eligible

When Must SBCs Be Provided?

SBCs for newly-eligible individuals

- SBCs must be given automatically to participants and beneficiaries as part of any written enrollment materials distributed by the plan or insurer
  - If no written enrollment materials are distributed, SBCs must be furnished by the first date the individual is eligible to enroll
- If SBC-required information changes before the first day of coverage, an updated SBC must be provided no later than the first day of coverage

When Must SBCs Be Provided?

Providing SBCs at annual enrollment

- A new SBC must be provided when coverage is renewed (i.e., at annual enrollment)
- If enrollment in writing is required, either paper or electronic, the SBC must be provided by the date the enrollment materials are distributed
- If enrollment is automatic, the SBC must be provided no later than 30 days before the first day of coverage for the new plan year

When Must SBCs Be Provided?

SBCs must also be provided—

- On request by participants or beneficiaries
  - As soon as practical, but not later than seven days after the request
- To HIPAA special enrollees within seven days of a special enrollment request

When Must SBCs Be Provided?

Health insurers must provide SBCs to a group health plan (or its sponsor)—

- On application or request for information about the coverage
- As soon as practical, but not later than seven days following the request
- If the plan requests information and later applies for coverage, a second SBC must be provided only if SBC-required information has changed

When Must SBCs Be Provided?

SBCs provided by health insurers to plans

- The insurer must provide an updated SBC if there are any changes in SBC-required information—
  - Before the coverage is offered
  - Before the first day of coverage
- The updated SBC must be provided to the plan no later than, as applicable—
  - The first date of the offer
  - The first day of coverage

When Must SBCs Be Provided?

SBCs provided by health insurers to plans

- If written application for renewal is required, the SBC must be provided to the plan when the written materials are distributed
- If renewal is automatic, the SBC must be provided no later than 30 days before the first day of the new policy year
- Plans may also request an SBC from the insurer, which must be provided—
  - As soon as practical
  - Not later than seven days following the request

Streamlining SBC Disclosures

Avoiding Duplication

- If a participant and any beneficiaries are known to live at the same address, a single SBC can be provided to that address
  - Doing so satisfies the SBC requirement for all individuals living at that address
- If a participant and beneficiary have different last known addresses, a beneficiary must be provided a separate SBC at the beneficiary’s last known address

Streamlining SBC Disclosures

Multiple Benefit Packages

- In renewal situations, plans or insurers only need to provide a new SBC automatically for the benefit package in which an individual is enrolled
- However, on request, a participant or beneficiary must be provided an SBC:
  - For another benefit package (or packages)
  - If the individual is eligible for the package(s)
- The SBC must be provided as soon as practical, but not more than seven days after the request

Appearance Requirements

An SBC must—

- Be presented in a uniform format
- Use terminology understandable by the average plan enrollee (see later slide on uniform glossary)
- Not be longer than four double-sided pages
  - Note: A significant agency interpretation!
- Not include print smaller than 12-point font
- Be provided as a stand-alone document using an authorized form
  - Detailed instructions must be followed

Form Standards

SBCs provided by the—

- Plan to participants and beneficiaries may be furnished in paper form:
  - Or electronically, if the DOL's electronic disclosure rules are satisfied
- Insurer to the plan/employer may be in paper form, or electronically if:
  - The format is readily accessible by the plan/employer
  - Provided in paper form free of charge on request
  - Notice and a web address are given, in the case of Internet postings

Language Requirements

SBCs must be provided in a "culturally and linguistically appropriate manner"

- Using standards for appeals notices under health care reform, which require plans or insurers to provide—
  - Oral language services and assistance with filing claims and appeals in the applicable non-English languages
  - Notices in the non-English language on request
  - A statement in the English version of all notices, prominently displayed in the non-English language, indicating how to access available language services

Language Requirements

What is an applicable non-English language for purposes of the language requirements?

- Relates to any US county to which an SBC is sent
- A non-English language if—
  - 10% or more of the population residing in the county is literate only in the same non-English language (i.e., Spanish, Chinese, Tagalog, or Navajo), as provided in agency guidance

Content Requirements

SBCs must include the following—

- Uniform definitions of standard insurance and medical terms (see later slide)
  - Permits comparisons of health coverage
  - Addresses terms of coverage, and exceptions
- Exceptions, reductions & limitations of coverage
- Cost-sharing provisions
  - Includes deductibles, co-insurance and co-payments
- Renewability and continuation provisions
- Coverage examples (see later slide)

Content Requirements

SBCs must include the following—

- For coverage beginning on or after 1/1/14, whether "minimum essential coverage" is provided
  - Also, whether the plan's share of total allowed costs of benefits provided satisfies applicable requirements
- A statement that the SBC is only a summary and that the coverage documents should be consulted
- Contact information for questions and obtaining a copy of governing coverage documents
  - E.g., website address, customer service phone number

Content Requirements

Under new guidance, SBCs must also include—

- Web addresses for:
  - Obtaining a list of network of providers, if applicable
  - Finding more information about a plan's prescription drug coverage, if applicable
- Web address for obtaining the uniform glossary
- Premiums
  - For self-insured group health plans, the cost of coverage

Notice of Modifications

Updating the SBC

- Notice of certain changes must be provided at least 60 days before the change is effective
  - Under pre-health care reform law, ERISA required notice of material reductions in health plan services or benefits within 60 days after the change was adopted
- Applies to "material" modifications (as defined under ERISA) in plan or coverage terms affecting SBC content that were not reflected in most recently provided SBC
  - Does not apply to renewal/reissuance changes
- SBC form standards apply (see prior slide)

Notice of Modifications

What is a "Material" Modification?

- Includes changes to plan coverage that, either independently or together with other changes, would be considered—
  - Important changes to covered benefits or plan coverage
  - By an average plan participant
- Examples include:
  - Coverage of previously excluded benefits
  - A material reduction in covered services or benefits
  - More stringent requirements for receiving benefits

Coverage Examples

Coverage Examples Illustrate Cost-Sharing

- SBCs must include examples of how the plan provides benefits in common medical situations
  - Coverage examples provided in new guidance include pregnancy and diabetes (see next slide)
  - The Departments may identify up to six examples
- A benefits scenario is—
  - A sample treatment plan for a specific medical condition based on recognized clinical practice guidelines
  - Simulated claims processing for estimating cost-sharing for individuals under the benefit package

Coverage Examples

Coverage Examples Illustrate Cost-Sharing

- Excel spreadsheets from HHS include scenarios for maternity, diabetes and breast cancer
- Hypothetical treatment summaries include:
  - A brief description of major services related to the condition (e.g., for maternity, routine obstetric care).
  - Sample care costs and related categories (e.g., hospital charges for baby and mother).
  - Standard assumptions (e.g., medical necessity).
  - Specific medical condition information, including dates of service, diagnosis and billing codes, and allowed charges associated with each scenario.

Uniform Glossary

Defined Terms and Disclosure Requirements

- Proposed regulations require plans and insurers to make available a uniform glossary of terms—
  - On request
  - Within seven days of the request
  - In either paper or electronic form, as requested
- Glossary includes uniform definitions for—
  - Health-care-related terms (e.g., co-insurance, deductible)
  - Medical terms (e.g., emergency room care)
  - Other terms may be added (e.g., external review)

Penalties and Enforcement

Substantial penalties

- Plans and insurers that fail to provide an SBC can be fined up to $1,000 for each failure
  - A failure as to each participant or beneficiary is a separate offense
- DOL has enforcement authority over ERISA plans
  - Additional DOL regulations will address penalties
- HHS has enforcement authority over—
  - Insurers
  - Non-federal governmental plans

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