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Summary of Benefits and Coverage Requirements Under the PPACA

On August 17, 2011, federal regulators released long-awaited **guidance** on the requirement that health plans provide "uniform summary of benefits and coverage" (SBC) to participants, under the Patient Protection and Affordable Care Act (PPACA, i.e., federal health care reform legislation). The PPACA requires plans and insurers to begin distributing SBCs no later than **March 23, 2012**. This deadline has not been extended in the proposed rule despite the fact that federal regulators issued guidance nearly five months after their intended deadline (August 17, 2011, instead of March 23, 2011). However, the regulatory agencies acknowledged that this sort of mid-plan-year change could challenge employer plans, and therefore requested comment about the deadline.

The proposed rule and accompanying **template SBC** set forth content requirements, delivery rules, required recipients and other specifications for group health plans (whether grandfathered or not) to provide the SBCs. The rule also requires plans to provide covered individuals with at least 60 days *advance* notice of any mid-year material modifications affecting SBC content, such as plan changes. **Annual conference health plans (insured and self-insured) are subject to these summary benefits and coverage regulations.**

The intent is that health plan benefit summaries across the U.S. will be consistent in look, language and content.

Required Materials

Under the proposed rule, all SBCs must be four pages (double-sided) and use 12-point Times Roman font. The SBC must include the following:

- Uniform definitions of standard insurance and medical terms;
- Description of coverage, including cost sharing, for certain benefit categories;
- Exceptions, reductions and limitations on coverage;
- Cost-sharing provisions, including deductibles, co-insurance and co-payments;
- Renewability and continuation of coverage provisions;
- Coverage **examples** explaining common benefit scenarios (with estimated plan and participant costs), such as the birth of a child, cancer treatment and managing diabetes;
- Statement that the SBC is only a summary and the plan documents should be consulted;
- Contact information, including a website;
- Directions and Internet address for obtaining a list of network providers, if applicable;
- Directions and Internet address for finding the prescription drug formulary, if applicable;
- Internet address for accessing the uniform glossary;
- Premium information for insured plans, or cost of coverage for self-insured plans; and

- Beginning **January 1, 2014**, a statement of whether the plan provides affordable coverage that qualifies under the PPACA's individual mandate.

SBCs must be "readily accessible" and written in a "culturally and linguistically appropriate manner." The readily accessible requirement raises questions about whether summaries can be posted only on password-protected websites, without other avenues of distribution to participants (see "Required Delivery" below). Additionally, the SBC must include a **glossary** with uniform (standard) definitions for 44 specific medical and coverage-related terms, as provided in the government's template. Plans may not use their own definitions in the SBC.

Non-Duplication of Efforts

The plan administrator of an annual conference health plan will be required to distribute the SBCs to participants. This is typically the conference board of pensions. For HealthFlex plan sponsors, Wespath will distribute SBCs to participants, in cooperation with plan sponsors. For fully insured plans, the insurance company is also responsible for distributing SBCs. The regulators have attempted to reduce duplication of efforts by allowing the requirement to be met if *either* the insurance company or plan administrator delivers the SBC.

Premium or Cost of Coverage

Annual conference plans should be able to satisfy most of these SBC requirements without much difficulty. However, the requirement to disclose the cost of coverage or premium may present challenges. Under the proposed rule, insurers of group plans—such as the insurance company issuing the policy to a fully-insured annual conference plan—may direct participants to their employer for premium information, which will take the form of a rate sheet or table of applicable premium rates. Fully insured annual conferences will need to work closely with their insurers to determine who will distribute the SBCs and who will supply the premium information: the insurer, the annual conference or the local churches.

Self-funded annual conference plans (including those in HealthFlex) may have to wait for further guidance from the regulators. Self-funded plans must provide the "cost of coverage" (rather than premium) in the SBC. The regulators have asked for comment about whether this amount should reflect employer subsidies (i.e., whether it should be the *full* contribution or just the *employee's share*). Whether self-insured multiple employer plans (like most self-funded annual conferences) can similarly rely on employers to supply cost of coverage to participants through an addendum remains to be seen in further guidance.

In many annual conference plans, the plan administrator does not know the amount a local church charges a participant for coverage. The amounts often do not match the amount the annual conference charges local churches. In annual conferences that blend or cross-subsidize insurer or HealthFlex premiums or self-funded contributions (e.g., by charging large churches higher rates than small churches), the plan and employers may have some difficulty determining what to disclose on the SBC. In annual conferences that add premiums or contributions to other apportionments, the plan and employers may face greater challenges. For example, having the full contribution amount (in self-funded annual conference plans) or the full premium (from the insurer or HealthFlex) appear directly on SBCs could generate questions from participants. All annual conferences will have to determine who should supply the premium information in an addendum, be it the plan administrator (which bears the ultimate legal responsibility),
the insurer, or the local churches and other employers (which often lack sufficient resources).

The regulators are expected to issue additional guidance for employer plans about the cost of coverage in SBCs. Wespath will provide additional information about this requirement as it becomes available from the regulators.

Required Recipients

All individuals eligible for plan coverage (including family members) are entitled to receive an SBC for *every benefit option* available to them. However, individuals *currently covered* are only required to receive the SBC for the benefit option in which they are enrolled. Currently covered individuals may request SBCs for other available benefit options, and a plan must send them within seven days of such a request.

Required Delivery

The SBC generally must be provided to participants and other eligible persons as a separate stand-alone document with any written open enrollment materials (not as part of a summary plan description, SPD). If written open enrollment materials are not distributed, the plan must provide the SBC no later than the first day an individual is eligible to enroll. If there is any change to the SBC after the open enrollment period, an updated version would have to be provided by the start of the plan year. Individuals who enroll in a plan under a HIPAA special enrollment right—such as marriage or birth or adoption of a child—must be sent an SBC within seven days of the date they request special enrollment.

SBCs may be delivered in paper form, e.g., via U.S. postal delivery. Alternatively, plans may deliver the summaries electronically if certain criteria are met. The electronic delivery criteria are established by the U.S. Department of Labor (DOL) and the Internal Revenue Service (IRS). The current criteria are under review and public comment with these regulators, and are expected to be eased in the coming year. Generally, the DOL and IRS require plans to take necessary steps to ensure that the method of delivery results in actual receipt by participants.

The proposed rule also applies standards recently issued under another PPACA provision (the claims and appeals rules) that would require certain support and translation services if notices are being sent to a participant in a state county where the U.S. Census Bureau has determined that 10 percent or more of the population is literate only in Chinese, Spanish, Tagalog or Navaho.

Plans failing to provide timely SBCs, or 60-day advance notice of a material modification, could be fined up to $1,000 for each affected individual.

Public Comment

Regulators are seeking comments by **October 21, 2011**, including input on special considerations for group health plans and the feasibility of meeting the **March 23, 2012**, deadline for SBCs. The template SBC was developed by the National Association of Insurance Commissioners and is likely to be revised. The initial template was designed primarily for individual and group health insurers. Anticipated revisions may make the template more user-friendly for self-insured plans, including some church plans. Regulators also will need to clarify exactly what type of cost information should be provided under an employer plan where there may be employer subsidies for different tiers of coverage.

Impact on Annual Conferences

Annual conferences should ensure that their plans are ready to incorporate these new rules for SBCs by **March 23, 2012**. Unless the regulators extend the deadline, annual conference health plans will be required to begin delivering SBCs to health plan participants by March 2012. Annual conferences should watch for additional guidance from the regulators about the cost of coverage and other clarifying details. If the rules for electronic delivery are liberalized after public comment, electronic delivery of SBCs beginning in spring 2012 could become more cost effective. In adapting the template SBC to its health plan, annual conferences should work closely with their third-party administrators, insurers or Wespath, and inform participating local churches and employers to be sure they are aware of the content, particularly with respect to cost/premium information.

Questions and Information

If you have questions or would like additional information, please send your inquiries to **healthcarereform@gbophb.org**. You also can learn more about health care reform through the federal government's website: **www.healthcare.gov**.
