August 1, 2012

7 Overview: Summary of Benefit & Coverage & Uniform Glossary of Insurance Terms

Pursuant to Section 2715 of the PHS Act, the Departments of the Treasury, Labor, and Health and Human Services published on February 14, 2012, final regulations effective on April 16, 2012, for the new Summary of Benefits and Coverage and Uniform Glossary of Insurance Terms (SBC) that all group health plans and health insurance issuers offering group or individual health insurance coverage will be required to distribute. Plan administrators must deliver this four-page (front and back) SBC to plan participants in addition to already-required disclosures such as the summary plan description. The final regulations provide standards that will govern the SBC, including who provides and receives the SBC, when the SBC must be provided, and how the SBC must be formatted and distributed.

The Departments also announced the availability of a template for the SBC and additional guidance containing instructions and sample language for completing the proposed template, as well as the uniform glossary of terms for the disclosure. The template, instructions, sample language and glossary of terms were prepared by the Departments in consultation with the NAIC. The SBC guidance provided by the Departments is not final. (Full text of the guidance for compliance - http://www.regulations.gov/#!documentDetail;D=HHS_FRDOC_0001-0441)

This document summarizes the final rule requirements. MCS staff should review these requirements now to prepare for timely provision of the SBC. (Full text of the final rule visit: http://www.regulations.gov/#!documentDetail;D=HHS_FRDOC_0001-0442)

Effective Date

The requirements to provide an SBC, notice of modification, and uniform glossary apply for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage 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 disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), these requirements apply beginning on the first day of the first plan year that begins on or after **September 23, 2012.**

Providing the SBC

The SBC does not replace any required disclosure documents for group health plan coverage, such as the summary plan description (SPD). The Final Rule sets forth three scenarios under which SBCs must be provided.

1. SBC provided by a Group Health Insurance issuer to a Group Health Plan

a. Upon Application – An insurer must provide the SBC upon the group health plan's application or as soon as practicable after a request for information, but no later than 7 business days after the request. If the plan subsequently applies for coverage, a second SBC must be provided if there has been a change to the SBC. In addition, if there is any change to the SBC before coverage is offered or the first day of coverage, the insurer must provide an updated SBC no later than the date of offer or first day of coverage, as applicable.

b. At Renewal – An insurer must provide an SBC to a group health plan when a policy is renewed or reissued. If a written application is required, the insurer must provide the SBC no later than the date materials are distributed. For automatic renewals, the insurer must provide the SBC at least 30 days prior to the first day of the new policy year. However, if the coverage has not been renewed prior to the 30-day period before the first date of coverage, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the new coverage or the receipt of written confirmation of intent to renew, whichever is sooner.

c. Upon Request – An insurer must provide an SBC to a group health plan as soon as practicable upon request, but no later than 7 business days after the request.

2. SBC provided by a Group Health Insurance issuer and a Group Health Plan to Participants and Beneficiaries

a. At Enrollment - The plan must provide an SBC for all options for which an individual is eligible to enroll with any written application materials distributed by the plan. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first day the participant is eligible to enroll. In addition, if there is any change to the SBC before the first day of coverage, the plan must provide an updated SBC no later than the first day of coverage. The plan also must provide an SBC to HIPAA special enrollees within 7 business days of a request for enrollment. The rule allow a plan to deliver a single SBC to participants and beneficiaries residing at the same address, unless the plan has a different last known address on file for any of the covered individuals.

b. At Renewal – The plan must provide an SBC for the option in which the individual is enrolled at renewal. The plan also must provide SBCs for options in which the participant or beneficiary is eligible, but not enrolled, upon request. If a written application is required for renewal, the plan must provide the SBC no later than the date application materials are distributed. If benefits automatically are renewed, the plan must provide the SBC at least 30 days prior to the first day of the new plan year. However, if the coverage has not been renewed prior to the 30-day period before the first date of coverage, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the new coverage or the receipt of written confirmation of intent to renew, whichever is sooner.

c. Upon Request - If a participant or beneficiary requests, the plan must provide an SBC as soon as practicable, but no later than 7 business days after request.

3. SBC provided by a Health Insurance Issuer to Individuals and Dependents in the individual market.

   a. Upon Application – An insurer must provide an SBC upon application or as soon as practicable after a request for information, but no later than 7 business days after the request. If an individual subsequently submits an application, a second SBC must be provided if there has been a change to the SBC. In addition, if there is any change to the SBC after receipt of the application, the insurer must provide an updated SBC as soon as practicable but no later than the date on which the offer of coverage is made. If an individual accepts an offer of coverage, the insurer must provide a new SBC before the first day of coverage if there has been change to the SBC.

   b. At Renewal – The insurer must provide a new SBC annually to policyholders at least 30 days prior to the first day of a new policy year. However, if the coverage has not been renewed prior to the 30-day period before the first date of coverage, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the new coverage or the receipt of written confirmation of intent to renew, whichever is sooner.

   c. Upon Request - If a policyholder or covered dependent requests, the insurer must provide an SBC as soon as practicable, but no later than 7 business days after request. Finally, unless the health insurance issuer is aware that a dependent lives at a different address than the individual applying for coverage, the obligation to provide an SBC to the dependent is satisfied by sending the SBC to the applicant's address.

To prevent unnecessary duplication with respect to Group Health Coverage, the final regulations states:

1. The requirement to provide an SBC generally will be considered satisfied for all entities if it is provided by any entity, so long as all timing and content requirements are satisfied.
2. The second states that a single SBC may be provided to a participant and any beneficiaries at the participant's last known address. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.
3. SBCs are not required to be provided automatically upon renewal for benefit packages in which the participant or beneficiary is not enrolled, a plan or issuer generally has up to seven business days to respond to a request to provide the SBC with respect to another benefit package for which the participant or beneficiary is eligible.

Preparing the SBC

The SBC must be provided in a standardized format to help provide clear, consistent and comparable information about health plan coverage and benefits. As mentioned above, the Departments have provided a template and a uniform glossary of terms for this purpose.

The SBCs must contain the following provisions:

1. Uniform definitions of standard insurance terms and medical terms, as specified by the Departments;
2. A description of the coverage, including cost-sharing, for each category of benefits identified by the Departments in sub-regulatory guidance;
3. The exceptions, reductions, and limitations of the coverage;
4. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
5. The renewability and continuation of coverage provisions;
6. A "coverage facts label" that includes examples to illustrate common benefits scenarios;
7. A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;
8. Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance;
9. An Internet address for obtaining a list of network providers;
10. An Internet address for obtaining information on prescription drug formulary information; and
11. An Internet address for obtaining the uniform glossary of health-coverage-related terms and medical terms as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.
    a. If the uniform glossary is requested, it must be provided within seven business days of the request.

The final regulation, identify three additional content elements:

- For plans and issuers with one or more provider networks, an Internet address (or similar contact information) for obtaining a list of the network providers;
- For plans and issuers with a prescription drug formulary, an Internet address (or similar contact information) for obtaining information about the prescription drug coverage;
- An Internet address for obtaining the uniform glossary of terms, a contact phone number to obtain a paper copy of the uniform glossary and a disclosure that paper copies of the uniform glossary are available.

As stated in the introduction, the SBC should be relatively short; it cannot be longer than four pages and cannot include print smaller than 12-point font. The final regulations interpret the four-page limitation as four double-sided pages.

The SBC must to be presented in a culturally and linguistically appropriate manner, and use terminology that average enrollees can understand. To provide the SBC in a culturally and linguistically appropriate manner, this requirement is met if the group health plan or health insurance issuer meets the culturally and linguistically appropriate standards set forth in the internal and external claims and appeals regulations at 45 C.F.R. § 147.136(e), as applied to the SBC.

Applicability to Certain Account-Type Arrangements

SBCs are not required for plans, policies, or benefit packages that constitute excepted benefits, including stand-alone dental or vision plans, certain supplemental plans and health FSAs (if the FSA constitutes excepted benefits under HHS regulations). Expatriate plans and health savings accounts (HSAs) are exempt since they are generally not subject to ERISA. However, health reimbursement arrangements (HRAs) are considered group health plans subject to ERISA, and, thus, are generally subject to the SBC requirements.

Modifications

Plans and issuers are required to give at least 60 days advance notice of any material modification in plan terms or coverage, if it is not reflected in most recent SBC and occurs other than in connection with a renewal or reissuance of coverage.

According to the final regulations, a "material modification" includes:

- An enhancement of covered benefits or services, such as coverage of previously excluded benefits or reduced cost-sharing;
- A material reduction in covered services or benefits, such as through increased premiums or cost-sharing; or

- More stringent requirements for receipt of benefits, such as a new referral requirement.

Penalties

The failure by the group health plan or health insurance issuer to provide the SBC in accordance with the Final Rule subjects the applicable group health plan or health insurance issuer to a fine not to exceed $1,000 for each such failure, and a failure with respect to each affected individual constitutes a separate offense.

MCS Plan

1. MCS will develop a master SBC's for groups and individuals products.

2. According to ACA's regulation, the SBC's will be available to employer groups and insured participants during sale processes, renewal periods and upon request..
3. Uniform Glossary, Drug Formulary and Providers Directory will be available through the Internet and upon request.

References

- 45 CFR Part 147, 76 FR 52442 (August 22, 2011), 77 FR 8668 (February 14, 2012)
- http://www.cciio.cms.gov/programs/consumer/summaryandglossary/index.html
- http://www.healthcare.gov