



HHS Issues Guidance on Uniform Summary of Benefits

LEGISLATIVE BRIEF

September 13, 2011

HHS on August 17 finally issued long-awaited guidance on PPACA's **Uniform Summary of Benefits and Coverage (SBC)**, which health plans and health insurers will be required to provide to eligible employees and enrollees as of **March 23, 2012**. The Uniform Summary is intended to provide plan participants and potential enrollees with clear, consistent and comparable information about health plan benefits and coverage under different plans and policies to allow them to reasonably compare different coverage options. A plan or carrier that fails to comply with the SBC requirements could be fined up to \$1,000 per affected individual, and could also be subject to state fines.

The HHS guidance includes not only proposed regulations, but also two model documents:

1. A proposed template for the Summary of Benefits and Coverage, click [here](#), which also includes an additional 2-page "Coverage Examples" plus instructions for completing these documents; and
2. A uniform "Glossary of Health Insurance and Medical Terms" (from "Allowable Amount" to "Urgent Care") click [here](#).

Background

PPACA (the Health Care Reform law) requires that insurers and group health plans provide applicants and enrollees/employees with a uniform "Summary of Benefits and Coverage" (SBC). This must be provided before enrollment or re-enrollment, to help people understand what their plan (or different options) will cover and exclude, so they can make comparisons and choices among benefit options. This new SBC requirement applies in addition to ERISA's SPD and SMM requirements. The requirement **applies to both grandfathered and non-grandfathered plans, and to all size plans and employers** (no "small-employer" exception for those under 50 or under 100).

The Summary of Benefits and Coverage

PPACA required HHS to develop these standards in consultation with the National Association of Insurance Commissioners (NAIC) and to issue them by March 23, 2011. HHS missed the March 23rd deadline, but now the guidance and the model template are out.

The SBC requirement applies to both insurers and to health plans. This article focuses on the SBC requirement on employer plans. If an employer offers more than one benefit option under its health plan, a separate SBC must be provided for each option. If the plan offers *insured* options, the SBC could be provided by either the insurer or the plan, but not by both. The SBC must be in at least 12-point font. The template for the SBC includes five sections:

1. What this Plan Covers and What it Costs
2. Excluded Services & Other Covered Services
3. Your Right to Continue Coverage
4. Your Grievance and Appeals Rights
5. Examples of how the plan might cover medical expenses in three standard situations: having a baby, treating breast cancer, and managing diabetes.

Additional detail on each of these five sections is included later in this article.

When the SBC Must Be Provided

The plan or carrier (but not both) must provide an SBC to eligible employees:

1. With enrollment materials, prior to enrollment or re-enrollment;
2. As soon as possible, but no longer than seven days after an employee requests special enrollment due to a change in status (e.g., due to marriage or birth of a baby);
3. As soon as possible, but no longer than seven days after an employee requests a copy of the SBC (no limit on how many requests per year);
4. At least sixty days *before* a *material* change would become effective, if the plan makes a change in benefits during the plan year.

How the SBC Must Be Provided

The SBC may be provided in paper or in electronic form (in compliance with the DOL's electronic disclosure rules). The proposed regulations require that the SBC be provided as a stand-alone document; however, the Departments requested comments as to whether and how plan sponsors should be allowed to incorporate the SBC into the SPD or other enrollment materials.

Additional Detail on Each of the SBC Sections

- 1) **What This Plan Covers and What it Costs:** This is the first 3 pages of the 4-page SBC. Each page has 3 columns: "*Important Questions*" (e.g., "What is a premium?"), "*Answers*" (the dollar amount), and "*Why this matters*" (e.g., "The premium is the amount paid for health insurance."). In this section, the SBC provides plan-specific information such as: overall and specific deductible amounts; out-of-pocket limits; does this plan use a network of providers; cost differences to use a participating versus non-participating provider- for office visits, tests, drugs, surgery, etc; costs for urgent or emergency care; costs for mental health or substance abuse services; costs for eye exams, glasses and dental checkups for children;
- 2) **Excluded Services & Other Covered Services:** Once this information is included for the plan or benefit option, the SBC will probably be at least one page longer. It does say "This isn't a complete list. Check your policy...."

- 3) **Your Rights to Continue Coverage:** Surprisingly, this is not about COBRA or other continuation coverage. Instead, it says "You can keep this insurance as long as you pay your premium unless. . . you commit fraud, the insurer stops offering services in the state, or you move outside the coverage area."
- 4) **Your Grievance and Appeals Rights:** The SBC defines these terms and must include the phone number and website an individual would use if they have a grievance or appeal.
- 5) **Coverage Examples:** (This is the additional two pages at the end of the four-page SBC.) As noted above, the three examples are having a baby, treating breast cancer, and managing diabetes. Each example includes a hypothetical amount that would be owed to providers, and how much of this amount would be paid by the plan and by the patient. The example lists "sample care costs" such as office visits, lab tests, hospital charges, pharmacy, etc., and then breaks down the patient's costs into deductibles, co-pays, co-insurance, and limits or exclusions. The insurer or plan must insert applicable dollar amounts. The SBC also includes caveats such as "This is not a cost estimator!" and warns that this is how this plan *might* cover medical care in three situations.

Next Steps for Employers

You probably want to familiarize yourself with the SBC, the 2-page Examples, and the Glossary. This is what you or your carrier(s) will be providing to plan participants and eligible enrollees as of March 23, 2012.

If you have a calendar year plan, you do **not** have to provide this with enrollment materials for January 1, 2012, but you might want to.

You will no doubt receive information and sample SBC from your carrier(s), if you have insured health benefits.

If you are self-funded, you should talk with your TPA and/or broker to find out what they will provide for you on and after March 23, 2012.

If you currently offer several benefit options under your plan and you provide a side-by-side comparison, you might want to keep doing that. It is likely participants will refer back to that more often than to the SBC.

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