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Legal Advice for Health Plans

HEALTH LAW ALERT
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Final Summary of Benefits Rule Published

Plans Must Use Standard Summaries and Glossaries Beginning September 23

On Tuesday, the Department of Health and Human Services (HHS) formally published a final rule, adopting standards for a four-page summary of benefits and coverage (SBC) and a glossary of terms that health plans must begin to make available in September. The Rule requires health insurers to provide the SBCs to group customers, plan participants and beneficiaries, and (in the individual market) to individuals and beneficiaries. Group health plans must provide the SBCs to plan participants and beneficiaries. The SBCs must be furnished (1) upon request, (2) upon application, (3) upon renewal, and, (4) if the final SBC is different from an SBC previously provided, by the first day of coverage. The SBCs must include an Internet address and telephone number for individuals to obtain a copy of a "uniform glossary of health coverage and medical terms," which insurers and group health plans must make available (in paper or electronic form) within 7 business days.

Click here to see the SBC Rule incorporated into my compilation of Selected Federal Health Insurance Provisions (*see* first line under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com). Guidance for the summary of benefits and coverage and glossary of terms was published at 77 *Federal Register* 8706 (click here). Additional guidance, including a copy of a sample completed SBC and instructions for completing the SBC, are available on the Center for Consumer Information and Insurance Oversight's website (click here).

Content Changes from Proposed Rule

For now, the SBC Rule will require SBCs to include only two coverage examples, rather than the three initially proposed. Accordingly, SBCs will need to include estimated out-of-pocket costs for a particular "sample treatment plan for a specified medical condition during a specific period of time." The medical conditions will be for having a baby (normal delivery) and managing type 2 diabetes (routine maintenance of a well-controlled condition). The proposed coverage example for breast cancer was eliminated because of "high variability in treatment plans." But, the Rule permits HHS to designate up to six coverage examples that must be included in an SBC as required in future guidance.

SBCs will not need to include premium. HHS determined that premium amounts would be too difficult to include. For example, insurers would not know how much of a plan participant's premium an employer would cover.

Delivery of SBCs

Under the SBC Rule, insurers may deliver SBCs to group customers in paper or electronic form, provided that the electronic format is readily accessible to the customer and a paper SBC is available upon request at no charge. If the electronic copy is provided on the Internet, the insurer must timely advise the customer, using e-mail or paper, that the SBC is available and provide the Internet address.

An insurer in the individual market may deliver an SBC by hand, by mail, or by "any other method that can reasonably be expected to provide actual notice." The insurer may deliver an SBC by e-mail after the individual agrees to receive SBCs (or electronic disclosures generally) by e-mail. An SBC may be posted on the Internet, provided that the insurer notifies the customer in a timely manner that the SBC is available and provide the Internet address.

The insurer for a group or the group health plan may provide a plan participant or beneficiary the SBC in paper form. Alternatively, they may furnish the SBC in electronic form, provided that the insurer or group health plan meets the requirements for electronic delivery established for the individual market or the ERISA requirements for electronic delivery of documents.

An insurer is deemed to comply with the requirement to furnish SBCs to individuals upon request with respect to requests made prior to an application for coverage, provided that the insurer has complied with requirements to provide applicable information to the federal health reform web portal (*see* 45 C.F.R. Part 159).

An SBC must be published in a foreign language in the same circumstances (and based on the same rules) as notices of adverse benefit determinations. Thus, insurers and group health plans must provide SBCs in non-English languages in counties in which 10%

FSAs, HRAs and Wellness Programs

The preamble to the SBC Rule explains that group health plans that provide only excepted benefits are not required to furnish SBCs. Thus, Flexible Spending Arrangements (FSAs) generally are not subject to the SBC requirements. (*See* 45 C.F.R. § 146.145(c)(3)(v). But, Health Reimbursement Arrangements (HRAs) "generally do not constitute excepted benefits, and thus HRAs are generally subject to the SBC requirements."

HRAs (and FSAs that do not qualify as "excepted benefit" plans) "must accurately describe the relevant plan terms while using [the plan sponsor's] best efforts to do so in a manner that is still consistent with the [SBC] instructions and template format as reasonably possible."

This same "best efforts" requirement applies to a plan that "provides different cost sharing based on participation in a wellness program." Thus, for example, health plans that waive out-of-pocket costs for enrollees who participate in a wellness program must use their best efforts to accurately describe how participation in the wellness program affects out-of-pocket costs in a manner that is, to the extent possible, consistent with the SBC instructions and template.

or more of the population is literate only in a non-English language (as identified by HHS). (Click here to read my Health Law Alert addressing the issue.)

By providing a participant (or, in the individual market, a policyholder) an SBC at the participant's (or policyholder's) last known address, an insurer meets its requirement to provide an SBC to each dependent at that address. But, an insurer (or group health plan) must provide a separate SBC to a beneficiary at the beneficiary's last known address, if that address is different that the participant's (or policyholder's) address.

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For more information, please contact Tom Bixby at (608) 661-4310 or TBixby@tbixbylaw.com

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