

## **Summary of Benefits and Coverage and Uniform Glossary Disclosure Requirements**

On August 22, 2011, the Departments of Health and Human Services, Labor and Treasury published proposed regulations on the health reform provision requiring group health plans and health insurance issuers to distribute two new disclosure documents – a Summary of Benefits and Coverage (“SBC”) and a Uniform Glossary of common terms. At the same time, the agencies released draft versions of the SBC and Uniform Glossary, along with instructions, sample language and related materials (*note that these drafts were prepared by the National Association of Insurance Commissioners primarily for use by health insurance issuers, and future guidance will likely modify these drafts for use by group health plans*). The new SBC and Uniform Glossary disclosure requirements are scheduled to become effective March 23, 2012, but the agencies may well decide to extend that compliance date in future guidance. This memorandum summarizes the portions of the proposed regulations applicable to group health plans and health insurance issuers providing group coverage – additional requirements apply to health insurance issuers selling individual health insurance coverage.

***Appearance, Content and Language.*** The SBC must satisfy specific requirements regarding appearance, content and language. With respect to appearance, the SBC must be a stand-alone document, use a uniform format, use understandable terminology, not exceed four double-sided pages in length, use at least a 12-point font and be completed in accordance with agency instructions. With respect to content, the SBC must include:

- Uniform definitions of standard insurance and medical terms (presumably, this is a reference to the Uniform Glossary but the proposed regulations are unclear on this point)
- A description of coverage, including cost-sharing, for each category of benefits
- List of exceptions, reductions and limitations
- Cost-sharing provisions, including deductibles, coinsurance and copayments
- Renewability and continuation of coverage provisions
- Coverage examples illustrating benefits for up to six hypothetical benefit scenarios (the draft version of the SBC includes coverage examples for “having a baby”, “treating breast cancer” and “managing diabetes”)
- A statement that the SBC is only a summary and that the plan document, policy or certificate should be consulted to determine the contract provisions
- Contact information to ask questions and obtain a copy of the plan document, policy or certificate (such as a telephone number or internet address)

- For plans or policies using networks, an internet address for obtaining a list of network providers
- For plans or policies using formularies, an internet address for obtaining information on prescription drug coverage
- Internet address for obtaining the Uniform Glossary
- Premiums (for fully-insured plans or policies) or cost of coverage (for self-insured plans)
- For coverage beginning on or after January 1, 2014, a statement indicating whether the coverage is “minimum essential coverage” and satisfies other applicable requirements

With respect to language, the SBC must be provided in a culturally and linguistically appropriate manner in accordance with the regulations issued earlier this year regarding claim procedure notices. In general, those regulations require group health plans and health insurance issuers to make documents available (and provide interpretive services) in one or more non-English languages in certain U.S. counties where at least ten percent of the residents are literate only in the same non-English language.

***Distribution responsibilities.*** Health insurance issuers and group health plans have slightly different distribution responsibilities. Health insurance issuers must distribute the SBC to group health plans or sponsors of those plans *and* to participants and beneficiaries. Group health plans must distribute the SBC *only* to participants and beneficiaries. The proposed regulations include special rules to prevent unnecessary duplication – for example, an HMO could distribute an SBC on behalf of a group health plan.

***Form of distribution.*** A group health plan or health insurance issuer may provide the SBC in paper form. A group health plan may provide the SBC to participants and beneficiaries electronically, as long as the distribution satisfies the DOL’s rules for electronic distribution of ERISA documents. A health insurance issuer may provide the SBC to plan sponsors electronically (either via email or an internet posting) if certain conditions are satisfied.

***Distribution to participants and beneficiaries.*** A health insurance issuer and group health plan must provide an SBC to participants and beneficiaries for each benefit package for which those individuals are eligible, in accordance with the following rules:

- As part of any application or enrollment materials (and if any information changes prior to the first day of coverage, an updated version of the SBC must be provided no later than the first day of coverage)
- Upon request, but in no event later than seven days following the request

- Within seven days after a special enrollee requests enrollment under a special enrollment right
- Upon renewal of coverage (if renewal is automatic, the SBC must be provided at least 30 days prior to the first day the coverage will renew; if renewal is not automatic, the SBC must be provided with the renewal application or enrollment materials)

***Distribution to group health plan sponsors.*** A health insurance issuer must provide an SBC to a group health plan sponsor within seven days of the date the sponsor either applies for coverage, requests information about coverage or simply requests a copy of an SBC (and an updated SBC must be provided if the sponsor applies for coverage and there is a change to the SBC prior to the first day of coverage). A health insurance issuer must also provide an SBC when a policy is renewed – if the renewal is automatic, the SBC must be provided at least 30 days prior to the first day the coverage will renew; if the renewal is not automatic, the SBC must be provided with the renewal application materials.

***Advance Notice of SBC Modifications.*** If a group health plan or health insurance issuer makes a material modification to an SBC (using the ERISA definition of a material modification), the plan or issuer must provide at least 60-days advance notice of the modification to enrollees. This notice is required only if the material modification affects the content of the SBC, is not reflected in the most recently-provided SBC and occurs at any time other than in connection with a renewal of coverage. The proposed regulations do not provide any model notice language.

***Uniform Glossary.*** Group health plans and health insurance issuers must also make the Uniform Glossary available to participants and beneficiaries upon request. The Uniform Glossary must include uniform definitions of various coverage and medical terms as specified in agency guidance. The Uniform Glossary must be provided within seven days of a request, and can be provided under the same distribution methods applicable to the SBC (via paper or electronic distribution). The preamble acknowledges that the definitions in the Uniform Glossary are not plan-specific

***Penalties.*** Willful failures to provide an SBC are subject to fines of up to \$1,000, and the proposed regulations indicate that a failure with respect to each participant or beneficiary is a separate offense. In addition, the preamble notes that other failures may be subject to excise tax penalties under §4980D of the Internal Revenue Code and reportable on Form 8928.