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“Meeting employee needs is a challenge.
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Employer Compliance Alert

AGENCIES FINALIZE GUIDANCE ON SUMMARY OF BENEFITS AND COVERAGE

As explained in our [August 2011 article](#), the health care reforms enacted in March of 2010 will require employer health plans to provide a uniform "summary of benefits and coverage" (SBC) to all plan participants and beneficiaries. The agencies charged with implementing this requirement have now finalized the regulations they proposed in August of 2011. The [final regulations](#) ease certain of the more onerous requirements, and they also grant a six-month delay in the statutory effective date.

Compliance Deadlines

As enacted, this SBC requirement was to apply as of March 23, 2012. This recent guidance allows compliance to be deferred until the first open enrollment period beginning on or after September 23, 2012. For participants who are not a part of the open enrollment process (such as new hires or special enrollees), the compliance deadline is the first day of the first plan year beginning on or after September 23, 2012.

To comply with this requirement, an SBC must be included in any application materials provided as a part of the open enrollment process. If there are no such materials, the deadline for providing an SBC is the first day on which a participant is eligible to enroll. Plans have additional time to provide an SBC to any special enrollee. The deadline in that case is 90 days after the participant's enrollment date (i.e., the same as the deadline for providing a summary plan description).

Covered Plans

These SBC rules apply to both insured and self-funded plans. The plan administrator (typically, the sponsoring employer) is responsible for providing the SBC. In the case of an *insured* plan, however, the insurer is equally responsible. Moreover, if an insurer provides a timely and accurate SBC, the plan administrator is not required to do so.

This is another health care reform requirement to which even "grandfathered" plans are subject. The same is true for even stand-alone health reimbursement arrangements, as well as "mini-med" plans that have received a waiver from the prohibition on annual benefit limitations.

Certain employer plans are *exempt* from this SBC requirement, however. These include HIPAA "excepted benefits," such as stand-alone dental and vision plans and most flexible spending arrangements. Health savings accounts are also exempt. The agencies

note, however, that even *exempt* FSAs or HSAs may need to be referenced in an SBC for a comprehensive medical plan, as a way of explaining that plan's deductibles and other co-payment features.

Recent Changes

Although the final regulations track most of the August 2011 proposals, certain changes should make it somewhat easier to comply with this SBC requirement. These include the following:

- An SBC need not disclose information concerning premiums.
- An SBC may be combined with other plan materials, such as a summary plan description, so long as the SBC is prominently displayed. In the case of an SPD, the agencies suggest that the SBC immediately follow the SPD's table of contents.
- Although the agencies continue to emphasize the importance of using the published template when preparing an SBC, they now acknowledge that certain modifications are permissible. These might be needed to describe discounts available through provider networks, benefits that vary with the type of facility, multi-tier drug formularies, or incentives for participation in wellness programs.
- The proposed regulations described three examples to be included in the "Coverage Facts" portion of each SBC: maternity care, management of type 2 diabetes, and treatment of breast cancer. Responding to concerns raised by various commenters, the breast cancer example has now been removed. However, the agencies have specifically reserved the right to require up to *six* different examples, so future guidance may require examples of more acute medical conditions.
- The version of the SBC template issued in August of 2011 was drafted by a task force organized by the National Association of Insurance Commissioners. Perhaps for that reason, it spoke in terms of a "policy" or "insurer." Recognizing that these terms are not appropriate for self-funded plans, the revised template substitutes "coverage" and "plan" for these two terms.
- The final regulations make it somewhat easier to distribute an SBC via electronic means, rather than on paper. The rules have not changed for participants and beneficiaries who are currently enrolled in the plan (for whom electronic delivery is permissible only in accordance with the DOL's stringent requirements), but somewhat more liberal rules now apply to individuals who are merely *eligible* to enroll. Assuming an SBC is in a "readily accessible format," it may be posted on the Internet. The plan or its insurer would then notify the eligible individual (either on paper or via e-mail) that the document is available online, providing both the Internet address and a statement that the SBC will be provided in paper form upon request.

The penalty for failing to comply with this SBC requirement is \$1,000 for each participant and beneficiary who fails to receive a timely and accurate SBC. Plan administrators should therefore take immediate steps to prepare appropriate SBCs (one for each benefit option), well in advance of the upcoming open enrollment season. Administrators of insured plans will want to coordinate with their insurers, but self-funded plans should familiarize themselves with both the final regulations and numerous pieces of [related guidance](#).

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