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BENEFITS MARKETPLACE

Final SBC Rules Issued

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As background, the Affordable Care Act ("ACA") requires a summary of benefits and coverage ("SBC") and uniform glossary to be provided to plan participants at time of enrollment. Significant penalties (up to $1,000) may be imposed for each individual who does not receive this summary. If any material changes are made to the document outside of renewal, the participant must be notified 60 days prior to the effective date of the change.

On December 22, 2014, the Departments of Labor ("DOL"), the Internal Revenue Service ("IRS"), and Health and Human Services ("HHS") (collectively, "the Departments") issued proposed rules and supporting documents addressing the SBC requirement.

On June 12, 2015, final rules were issued. These final rules largely follow the proposed rules.

The regulations provide new information and also incorporate several FAQs that have been issued since the final SBC regulations were issued in 2012. The rules clarify when and how a plan administrator or insurer must provide an SBC and shorten its length.

The new requirements are effective for plan years and open enrollment periods beginning on or after September 1, 2015. The updated SBC templates and related documents will apply to coverage that begins on or after January 1, 2017.

Additional information follows.

SBC from the Issuer to the Employer

The regulations:

- Clarify that when a health insurance issuer offering group health insurance coverage provides the SBC to the employer before application for coverage, the requirement to provide an SBC upon application is deemed satisfied unless there is a change to the information required to be in the SBC. If there has been a change in the information required, a new SBC that includes the correct information would have to be provided on application.

- Clarify how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized. If

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the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the issuer would not be required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage. The updated SBC would have to reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

SBC from the Employer to Employees

The regulations:

- Clarify when a plan must provide the SBC to employees again if the plan already provided the SBC prior to application. If the plan provides the SBC prior to application for coverage, the plan is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. However, if there is any change to the information required to be in the SBC by the time the application is filed, the plan must update and provide a current SBC as soon as practicable following receipt of the application, but in no event later than 7 business days following receipt of the application.

- Clarify how to satisfy the requirement to provide an SBC to employees when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan is not required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

Online Posting by Insurers

- Insurers must include an Internet address where a copy of the actual certificate of coverage is "easily available" to individuals shopping for coverage. Because the actual certificate will not be available until the plan sponsor has negotiated the terms of coverage, insurers should post a sample group certificate of coverage for each product and make the actual certificate (once executed) available to the plan sponsor, participants, and beneficiaries via an Internet address.

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Elimination of Duplication

The regulations:

- Add a provision to prevent unnecessary duplication with respect to a group health plan that uses 2 or more insurance products provided by separate issuers to insure benefits under the plan. The regulations place responsibility for providing complete SBCs with respect to the plan in such a case on the group health plan administrator. Under the rule, the group health plan administrator may contract with one of its issuers (or other service providers) to provide the SBC; however, absent a contract to perform the function, an issuer has no obligation to provide an SBC containing information for benefits that it does not insure.

- State that, under circumstances where an entity required to provide an SBC with respect to an individual has entered into a binding contract with another party to provide the SBC to the individual, that the entity would be considered to satisfy the requirement to provide the SBC with respect to the individual if specified conditions are met:
  - The entity monitors performance under the contract;
  - If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and
  - If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

New SBC Template

Revisions to the SBC, coverage examples, and uniform glossary are anticipated to be finalized by January 2016 after the Departments utilize consumer testing and receive additional input from the public. The SBC will be shorter in length and clearer and will apply to coverage that would renew or begin on the first day of the first plan year that begins on or after January 1, 2017 (including open enrollment periods that occur in 2016 for coverage beginning on or after January 1, 2017).

Effective Date

The changes apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. For disclosures to participants and beneficiaries who enroll in group health coverage other than through an open enrollment period (including those newly eligible for coverage), the revised requirements would apply beginning on the first day of the first plan year that begins on or after September 1, 2015.

Employer Action

Employers should be ready to comply with the new rules for the 2016 plan year and be ready for the revised template to be used for 2017 plan year.

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