HEALTH & WELFARE PLAN LUNCH GROUP

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Employee Benefits & Executive Compensation ADVISORY

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Health Care Reform Update: Final Regulations Impose Reinsurance "Contribution" on Fully Insured and Self-Insured Plans Starting in 2014

The Affordable Care Act (ACA) provides for a State-based transitional reinsurance program to help stabilize premiums for coverage in the individual health insurance market during the first three years of operation of the Exchanges (2014-2016). The program is designed primarily to transfer risk from the group market to the individual market. The program is funded through "contributions" from fully insured and self-insured plans. The statute sets forth the aggregate amount to be collected—$12 billion in 2014, $8 billion in 2015 and $5 billion in 2015. The aggregate amount is divided among plans subject to the fee as provided by the Department of Health and Human Services (HHS).

On March 16, 2012, HHS issued final regulations regarding the reinsurance program (the "Final Regulations").[1] Among other provisions, the Final Regulations provide that the contribution requirement will be imposed on a per capita basis based on the number of enrollees and that the contribution is payable to HHS by health insurance issuers and third-party administrators on behalf of self-insured plans (called "contributing entities" in the Final Regulations). The per capita amount, as well as other details relating to the program, will be set forth in future guidance that is scheduled to be issued by HHS no later than October of this year in the form of federal "benefit and payment parameters."

This advisory focuses on the contribution requirement, particularly as applied to self-insured group health plans.

Background—The Reinsurance Program

The transitional reinsurance program is one of three risk-spreading mechanisms that are provided under the ACA that together are designed to mitigate the potential impact of adverse selection and provide stability for health insurers that issue individual and small group health insurance policies. Adverse selection occurs when each new health insurance purchaser understands his or her own potential health risks better than health insurance issuers do, and health insurance issuers are therefore less able to accurately price their products. As described by the HHS, the reinsurance program is designed to reduce the uncertainty of insurance risk in the individual market by making payments to insurers for high-cost enrollees in the individual market. Theoretically, this will reduce individual market rate increases that might otherwise occur because of the immediate enrollment of individuals with unknown health status, potentially including those currently in State high-risk pools.

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[1] The final regulations were published in 77 Fed Reg17220 (March 2, 2012) and may be found at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf.

Payments under the reinsurance program are funded by contributions payable by health insurance issuers and third-party administrators on behalf of self-insured group health plans. Under the statute, a total of $25 billion will be collected for the three-year period 2014-2016, $20 billion of which will be used to fund the reinsurance program and $5 billion of which will be paid into the general funds of the U.S. Treasury.[2] In addition to these statutory amounts, States may impose additional contribution requirements to fund administrative expenses associated with the reinsurance program and/or to provide for additional reinsurance payments.

Each State decides whether to establish a reinsurance program or whether to have HHS administer the reinsurance program for the State. If a State establishes a reinsurance program, the program must be operated through a reinsurance entity that meets certain requirements.

Application of the Contribution Requirement to Group Health Plans

Contribution amount

Under the Final Regulations, the contribution requirement will apply on a per capita basis with respect to each individual covered by a plan subject to the contribution requirement (such individuals are referred to in the Final Regulations as a "reinsurance contribution enrollee"). As noted above, the amount of the per capita contribution, as well as other details, will be set forth in future guidance to be issued by HHS in the form of "benefit and payment parameters." The HHS benefit and payment parameters are expected to be issued by October 2012.

Plans subject to the contribution requirement

The contribution requirement is imposed on health insurance issuers in the case of fully insured individual and group health plan coverage and on third-party administrators on behalf of self-insured plans, including governmental plans. The contribution requirement does not apply with respect to plans that provide coverage solely of "excepted benefits" as defined under HIPAA (e.g., coverage for a specified disease or stand-alone vision or dental coverage). The per capita requirement will impose an especially onerous administrative and financial burden on plans such as employee assistance programs (EAPs) and health reimbursement arrangements (HRAs) that do not qualify as excepted benefits if the program or arrangement does not currently keep track of covered dependents and/or provides limited reimbursement benefits. There is no exception to the contribution requirement for grandfathered plans.

Payment process and timing

In the case of self-insured plans, the third-party administrator is responsible for paying the contribution on behalf of the group health plan. When an insurer is acting as a third-party administrator under an ASO contract, the insurer should be responsible for payment of the contribution as a third-party administrator on behalf of the plan, not as an insurer.

The proposed regulations defined "third-party administrator" to mean the claims processing entity for a self-insured group health plan. The preamble to the proposed regulations provided that, if a self-insured group health plan processes its own claims, the self-insured plan will be considered a third-party administrator for

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[2] During Congressional consideration of the ACA, the Congressional Budget Office (CBO) allocated the $5 billion payable to the U.S. Treasury as a revenue offset for the Early Retiree Reinsurance Program (ERRP) established under ACA. However, there is no direct link between the $5 billion and funding of the ERRP. Further information on the ERRP may be found at www.ERRP.gov.

purposes of the reinsurance program. The final regulations do not define the term "third-party administrator," leaving this to future guidance.

The final regulations provide that the required contribution is to be paid as follows:

- Contributions on behalf of self-insured plans are paid by the third-party administrator directly to HHS.
- If a State does not establish a reinsurance program (so that the reinsurance program is run by HHS), all contributions (including by insurers for fully insured plans) are paid directly to HHS.
- If a State establishes a reinsurance program, then the State determines how contributions with respect to fully insured plans will be collected—i.e., the State can provide that contributions with respect to fully insured plans will be paid by the insurer to the reinsurance entity that administers the State program or paid to HHS.
- Special rule for additional contributions: The final regulations authorize States to impose additional contributions in excess of those required under the statute either for administrative costs or for additional reinsurance payments. Additional contributions for administrative costs are paid either to HHS or to the applicable State reinsurance entity in the same manner as the contributions specified in the statute. If a State imposes additional contributions to fund additional reinsurance payments, such additional amounts (whether imposed on fully insured or self-insured plans) must be paid to the applicable State reinsurance entity (that is, HHS will not collect any additional contributions to fund additional reinsurance).

The Final Regulations provide that contributions payable to HHS must be paid on a quarterly basis beginning January 15, 2014. States have flexibility to determine the timing of contributions payable to applicable reinsurance entities. Insurers and third-party administrators are required to provide to HHS or to the applicable State reinsurance entity data required to substantiate the contribution amounts in the manner and timeframe specified by the State or HHS.

If contributions are paid to HHS, HHS is responsible for determining the proper amount to apply to reinsurance payments for a State, the amount to be transferred to the U.S. Treasury and the amount, if any, to be used by a State for administrative expenses of the reinsurance program. If contributions are paid to a State reinsurance entity, the reinsurance entity is responsible for making these determinations.

Enforcement of the contribution requirement

The proposed regulations provided that all contributions, including those on behalf of self-insured plans, would be paid to the applicable State reinsurance agency. The preamble to the Final Regulations indicates that the final rule requires payments on behalf of self-insured plans directly to HHS due to concerns regarding the States' lack of authority and oversight over self-insured plans. The Final Regulations do not address enforcement mechanisms that HHS may use with respect to self-insured plans. For example, it is not clear what action HHS may take regarding a third-party administrator that does not collect a contribution from a self-insured plan or a self-insured plan that does not pay the contribution to the third-party administrator for remitting to HHS.

This advisory was written by Carolyn Smith and John Hickman.

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Employee Benefits & Executive Compensation ADVISORY

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When Is a Summary More than a Summary, Part Two: Agencies Issue Final Guidance on the ACA's Uniform Summary of Benefits and Coverage Requirement

On February 14, 2012, the Departments of the U.S. Treasury ("Treasury"), Labor (DOL) and Health and Human Services (HHS) (collectively, the "Agencies") jointly published final regulations[1] that identify the standards for completing and delivering the uniform explanation of coverage ("Summary of Benefits," or SBC) required by the Patient Protection and Affordable Care Act of 2010 (ACA).[2] The final regulations clarify and revise the SBC requirements first proposed by the Agencies in the proposed regulations issued on August 22, 2011.[3]

Group health plan sponsors and health insurance carriers must act quickly. With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rule described in the final regulations is effective *on the first day of the first annual enrollment period beginning on or after September 23, 2012.* With respect to participants and beneficiaries enrolling other than during an annual enrollment period (e.g., newly eligible individuals and special enrollees), the SBC rule is effective for such enrollments that occur *on or after the first day of the plan year beginning on or after September 23, 2012.*

Practice Pointer: Applying the effective date of the SBC rules can be tricky. For some plans with fiscal years, the SBC rules may first apply to newly eligible individuals and special enrollees. See "When are SBCs required to be provided?" below for a more detailed discussion of the effective dates.

The following is the *who, what, when, where and how* of the SBC rules, as described in the final regulations. For those who simply want to know the differences between the proposed and final rules, we have attached to this advisory a quick reference chart that highlights the differences between the proposed regulations and the final regulations. We will highlight issues arising from the template and the corresponding instructions in a subsequent advisory.

NOTE: The SBC requirements also apply to health insurance issuers who issue coverage in the individual market; however, the focus of our overview below is solely on group health plans.

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1 *See* 77 Fed. Reg. 8668 (Feb. 14, 2012) at http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf. *See* also our prior advisory at http://www.alston.com/employee_benefits_SBC_regulations.

2 PHSA Section 2715, as added by Section 1001 of the ACA. This requirement is also incorporated into ERISA (ERISA Section 715) and the Internal Revenue Code (Section 9815) by reference.

3 *See* 76 Fed. Reg. 52442 (Aug. 22, 2011) at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf.

Who is required to provide an SBC?

The final regulations obligate the group health plan (including the plan administrator) **and**, if applicable, the health insurance issuer offering coverage in connection with a group health plan (i.e., if the plan is fully insured) to provide the SBC in accordance with the standards described below.

Practice Pointer: The SBC requirement applies to all self-insured and fully-insured group health plans that are otherwise subject to the health insurance reforms in Sections 1001 and 1201 of the ACA, *including grandfathered plans.* Thus, the SBC rules do not apply to benefits that qualify as "excepted benefits" under HIPAA's portability rules (e.g., non-integral dental and vision coverage, Health FSAs funded solely with employee's pre-tax salary reductions, certain specified disease and hospital indemnity insurance) and stand-alone retiree health plans.

While many Health FSAs and some health reimbursement arrangements will be excepted benefits, and thus exempt from the SBC requirements, Health FSAs and HRAs that are not excepted benefits are subject to the SBC requirements. The preamble clarifies that separate SBCs must be prepared where such arrangements are stand-alone plans (although many of the provisions applicable to traditional fee for service plans would not apply). However, for a non-exempt health FSA or HRA that has been integrated into other major medical coverage, an SBC prepared for the other major medical coverage can note the effects of the health FSA or HRA.

If the group health plan is self-insured, the obligation to provide an SBC lies solely with the plan. If the plan is fully insured, the obligation to provide an SBC lies with *both* the plan and the health insurer; however, both are deemed in compliance to the extent one of the responsible parties timely provides an SBC. Plan sponsors of fully insured plans and their health insurers must cooperate with one another to ensure an SBC is timely provided as required.

Practice Pointer: Unlike HIPAA's portability rules regarding certificates of creditable coverage, the plan or insurer will *not* avoid liability under the statute simply by entering into a written agreement with the other party that the other party will provide the SBC.

To whom must the SBCs be provided?

The final regulations indicate that a plan or insurer must generally provide an SBC in accordance with the SBC rules to a "participant" and "beneficiary" as defined in ERISA Sections 3(7) and 3(8). The terms "participant" and "beneficiary" are defined broadly by ERISA and include not only those individuals who are currently enrolled in the plan (i.e., covered employees/former employees *and* their covered dependents), but *anyone who is eligible to enroll.* Thus, a plan or insurer must provide an SBC generally to employees (including former employees) *and* dependents that are *eligible to enroll* or are enrolled in the group health plan.

Practice Pointer: The regulations indicate that a single SBC provided to participants and beneficiaries at the participant's last known address satisfies the requirement to send an SBC to all beneficiaries who reside at that address. See "How must the SBC be delivered?" below for more information.

In addition, "participant" and "beneficiary" would also appear to include self-employed individuals and their dependents that are eligible for or enrolled in the plan. ERISA's definition of "participant" does not specifically include self-employed individuals, such as independent contractors or partners covered under a plan; however, cases have held that self-employed individuals covered under an ERISA-covered plan should be treated as participants.[4]

Practice Pointer: Although both participants and beneficiaries are each entitled to receive an SBC, plans are not always required to send an SBC to both. See "How must the SBC be delivered?" below for more information.

A group health plan is also entitled to receive an SBC from a health insurer.

When are SBCs required to be provided?

Generally, plans or insurers must provide the requisite SBCs participants or beneficiaries in the following instances ("triggers"):

- upon "application" for coverage,
- upon "renewal,"
- following a request for a special enrollment (as defined by HIPAA),
- upon request by a participant or beneficiary, and
- following a material modification in the information contained in the SBC.

An SBC must also be provided by a health insurer to a plan at certain times.

See "What SBCs must a plan or insurer provide?" below for more detail on the number and the contents of the SBCs required to be provided.

Practice Pointer: The number of SBCs that a plan or insurer must provide to each participant and beneficiary is based, at least in part, on the number of "benefit options" maintained by the plan and the applicable trigger. See "What SBCs must a plan or insurer provide?" below for a more detailed discussion of the requisite SBCs.

The SBC triggers and the specific time frames for providing the SBC as a result of those triggers are discussed below.

A. From Plan to Participant/Beneficiary

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4 *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 32 EBC 1097 (2004) (citing DOL Opinion 99-04A).

The First SBCs

The SBC rules have two different effective dates, depending on the type of enrollment period. With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rules are effective on the first day of the first annual enrollment period beginning on or after September 23, 2012.

For all other participants and beneficiaries enrolling during an enrollment period other than annual enrollment (e.g., newly eligible individuals and special enrollees), the SBC rules are first effective with any enrollment occurring on or after the plan year that begins on or after September 23, 2012.

Practice Pointer: The SBC rule will apply to the plan's first annual enrollment period based on the date that the annual enrollment period begins—not the date the plan year starts. For example, if your annual enrollment period typically begins September 1 of each year, then the first annual enrollment period to which the SBC rules apply is the annual enrollment period beginning September 1, *2013*, even if your plan year begins prior to that date. However, that does not mean you necessarily get a pass from the rules until then. Depending on when your next plan year and enrollment period start, the SBC rule applicable to all other enrollments may apply *before* your next annual enrollment period.

Consider the following examples to illustrate application of SBC effective date.

> **Example #1:** ABC sponsors a health plan that has a calendar plan year. Each year it begins the annual enrollment period for the following plan year on October 1. ABC must comply with the SBC rules with respect to individuals enrolling in the annual enrollment period that begin October 1, 2012. Thereafter, the SBC rules will apply to all initial and special enrollments that occur on or after January 1, 2013.
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> **Example #2:** XYZ sponsors a health plan that has a calendar year; however, unlike ABC Plan, XYZ typically begins annual enrollment for the following plan year on September 1 of each year. For XYZ, the first annual enrollment period to which the SBC rule will apply is the annual enrollment period beginning September 1, 2013 (for the 2014 plan year). However, the SBC rules will apply to all initial and special enrollments that occur on or after January 1, 2013.

Enrollments Other than Annual and Special Enrollments Occurring after the Effective Date (Application)

Plans and insurers must provide the requisite SBCs to individuals who become eligible to enroll (except during a special enrollment period) with any written (or electronic) enrollment materials distributed by the plan as part of the enrollment process. If the plan does not provide written or electronic enrollment materials as part of the initial enrollment process, the plan must provide the SBC *no later than the first day on which the individual is otherwise eligible to enroll.* If any of the information required to be in the SBC that was provided changes before the first day of coverage (e.g., prior to the effective date of coverage), then an updated SBC must be *provided no later than the first day of coverage.*

Practice Pointer: Plans that typically do not provide written enrollment materials in connection with the initial enrollment will nevertheless have to provide an SBC in accordance with the SBC rules. This could pose administrative issues if the enrollment period for newly eligible individuals begins shortly after the individual becomes eligible for coverage.

Consider the following examples to illustrate the application of this rule:

> **Example #3:** Bob is hired by ABC on October 1, 2013, and he becomes eligible for coverage under ABC's group health plan on that date. ABC's plan administrator sends Bob written enrollment materials on October 5, 2012. ABC satisfies the SBC rules if ABC provides the requisite SBCs (or a postcard with a link to the SBCs, as permitted by the SBC rules) with the written enrollment materials sent to Bob on October 5, 2012.
>
> **Example #4:** This example presents the same facts as Example #3, except that ABC does not send written enrollment materials. Instead, ABC typically instructs new employees on the enrollment process, which begins immediately, during the employee orientation. In that case, ABC would need to provide the requisite SBCs in accordance with the SBC rules on the date of the employee's orientation.

Special Enrollments Occurring after the Effective Date

Plans must provide the requisite SBCs to special enrollees during a special enrollment period, as defined by HIPAA's portability rules, within 90 days of becoming covered under the plan (i.e., the date that a Summary Plan Description is otherwise required to be provided under ERISA). Unlike the other enrollment periods, a plan and insurer are not required to provide an SBC at the beginning of a special enrollment period. This seems to be the applicable rule without regard to whether the employee was previously enrolled in the plan prior to requesting a special enrollment.

Practice Pointer: Special enrollments under HIPAA's portability rules are not the only situations in which an individual may be able to enroll him/herself or a beneficiary in a plan during the plan year. For example, an employee's election for a group health plan benefit offered through a cafeteria plan may, to the extent permitted by a cafeteria plan, be changed mid-year to add a spouse whose coverage period under the spouse's employer's plan is different than the employee's plan, or where the spouse's employer significantly increased the cost of the spouse's coverage. These events that enable an individual to request mid-year enrollment are not special enrollment events as defined by HIPAA. Unfortunately, it isn't clear which SBC rules apply to such mid-year enrollments. Are such enrollments treated as "applications," which require plans or insurers to provide an SBC automatically, or would they be subject to the request rule (see below), which requires an SBC only if an SBC is specifically requested?

Annual Enrollment (Renewal)

If a written annual enrollment is required, the Plan or insurer must provide the requisite SBCs with the written enrollment materials provided in connection with annual enrollment. If annual enrollment is automatic, the Plan or insurer must provide the requisite SBCs no later than 30 days prior to the first day of the new plan year. With insured plans, however, if the policy, certificate or contract of insurance has not been issued or

renewed before this 30-day period, the SBC must be provided as soon as practicable, but no later than seven *business* days after issuance of the new policy or receipt of written confirmation of intent to renew, whichever is earlier.

Practice Pointer: Many plans utilize a "negative" or "passive" enrollment process where affirmative elections are made by participants only if the participant wishes to change his/her prior election. Are these enrollments considered "automatic" enrollment? We all would like to treat them that way, but conservative plan sponsors should carefully consider this issue with counsel absent further favorable clarification on this point from the agencies.

Unlike the SBC rules applicable to other enrollments, the final regulations do not specifically require plans and insurers to issue a new SBC for annual and special enrollments if there are changes to the information in the SBC before the first day of coverage.

Upon Request by a Participant or Beneficiary

A plan or insurer must provide the requisite SBCs to a participant or beneficiary upon request as soon as practicable, but no later than seven *business days* following the receipt of the request.

Practice Pointer: May plans and insurers charge for requested SBCs? Neither the statute nor the regulations address charges for requested SBCs. Absent guidance that specifically permits plans and insurers to charge for requested SBCs, plans and insurers would be wise to provide them free of charge.

Material Modifications

The SBC rules affect the timing for providing a summary of material changes (i.e., a summary of modification, or SMM) to participants. For covered plans, the revised process will subsume the process for distributing SMMs for covered plans. The timing will vary depending on whether the change is effective during the plan year or on the first day of the next plan year. Where a material modification (as defined in ERISA Section 102) is made to the terms of the plan that would impact the information in the most recently distributed SBC, and such change is effective during the plan year (i.e., prior to the first day of a subsequent plan year), a plan or insurer must provide notice of the material modification to "enrollees" at least 60 days prior to the effective date of the change. If it is a change effective as of the first day of the next plan year, a plan or insurer must provide an updated SBC in accordance with the SBC rules applicable to annual enrollment (see above).

Practice Pointer: Although the statute uses the term "enrollee," the section of the regulations explaining material modifications is the only time in the regulations in which the term "enrollee" is used. The isolated use of this term raises questions with respect to the scope of individuals to whom a plan or insurer must provide the notice of material modification: Does this requirement apply only to those enrolled in the benefit package affected by the material modification or everyone who previously received an SBC for that benefit package? The preamble to the regulations indicates that "enrollee" is interpreted by the agencies to mean "participant" and "beneficiary"; therefore, a plan or insurer must arguably send an SBC notice of material modifications for a benefit package to everyone who previously received an SBC for that benefit package.

A "material modification" is generally any modification that, standing alone or in conjunction with other modifications, an average plan participant would consider an important change. A material modification could include an enhancement to coverage or a reduction in services.[5]

The preamble to the final regulations states that the mid-year notice of material modifications can be in the form of a stand-alone notice that describes the material modification or an updated SBC. In either case, a plan or insurer must provide the notice of material modification in accordance with the SBC rules.

Practice Pointer: The preamble indicates that an updated SBC or notice of modification provided in accordance with SBC rules will satisfy ERISA's SMM requirements as well.

B. From Health Insurance Issuer to Plan

Beginning September 23, 2012, an insurer must provide an SBC to a group health plan (or its sponsor) at the following times:

- With the plan's application or as soon as reasonably practicable, but no later than seven business days following receipt of the application by the group health plan.
- If there is a change in the information required to be in the SBC provided upon application or before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.
- If written application for renewal is required, then the SBC must be provided when the written application materials are provided.
- If renewal is automatic, then the SBC must be provided to the plan no later than 30 days prior to the first day of the new policy year. However, if the policy, certificate or contract of insurance has not been issued or renewed before this 30-day period, the SBC must be provided as soon as practicable, but no later than seven business days after issuance of the new policy or receipt of written confirmation of intent to renew, whichever is earlier.
- As soon as practicable, but no later than seven business days following receipt of a request by a plan for an SBC or summary information about a health insurance product.

What SBCs must a plan or insurer provide?

As noted above, the number of SBCs a plan or insurer must provide to a participant or beneficiary is based on the number of "benefit packages" maintained under the plan that are otherwise subject to the ACA's health insurance reforms and the specific triggers identified above.

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[5] *See* DOL Information Letter, Washington Star/Washington-Baltimore Newspaper Guild to Munford Page Hall, II, Baker & McKenzie (February 9, 1985).

Practice Pointer: The regulations clarify that stand-alone HRAs are generally required to provide an SBC and the effects of an "integrated" HRA must generally be noted on the SBC for the health plan into which the HRA is "integrated." No guidance is provided regarding (i) the time period for providing an SBC for a stand-alone HRA, which typically has no enrollment period, and (ii) the definition of an "integrated" HRA.

The final regulations do not define "benefit package"; however, the special enrollment regulations under HIPAA's portability rules (the same subpart in ERISA, the PHSA and the Code to which the health insurance reforms were added by the ACA) define a benefit package as any coverage arrangement with a difference in benefits or cost sharing (e.g., deductibles or out-of-pocket maximum).

Practice Pointer: From a practical perspective, any option that can be elected separately by a participant is presumably a "benefit package." For example, assume employees may elect any of the following benefit options maintained by the employer: (i) a PPO with a $1200 deductible, (ii) a self-insured PPO with a $2,000 deductible and (iii) an HMO. Presumably, each option is a separate benefit package.

The triggers identified above also determine the number of SBCs a plan or insurer must provide to a participant and beneficiary.

Enrollments Other than Annual and Special Enrollments (Application)

With respect to individuals enrolling during an enrollment period other than an annual or special enrollment period, a plan or insurer must provide to the participant and beneficiary an SBC for each benefit package for which the participant or beneficiary is eligible.

> **Example #5:** Bob is hired by Acme, Inc., on January 5, 2013, and he is sent written enrollment materials on January 10, 2013. Acme, Inc., maintains a PPO, HMO and indemnity option, and Bob is eligible for each one. Acme, Inc., must provide three SBCs to Bob with the written enrollment materials: one each for the PPO, HMO and indemnity options.

Annual Enrollment (Renewal)

With respect to individuals enrolled in a benefit package, a plan or insurer must only provide an SBC during annual enrollment for the benefit package in which the individual is actually enrolled. A plan or insurer is not required to automatically provide an SBC to an enrolled individual for any benefit package in which the individual is not enrolled, but the participant or beneficiary may request an SBC for the other benefit packages for which the individual is otherwise eligible.

Practice Pointer: What if the employee is enrolled in a benefit package under the plan, but the employee's spouse is not? Must a plan or insurer provide the employee with an SBC for the benefit package in which the employee is enrolled and an SBC to the spouse for each benefit package for which the spouse is eligible? Presumably, the plan or insurer is only obligated to send an SBC for the benefit package in which the participant is enrolled; however, the participant or spouse may request an SBC for the other benefit packages for which they are eligible. Further guidance from the agencies on this issue would be helpful.

Special Enrollment

The final regulations do not clearly define the scope of SBCs that plans or insurers must provide to special enrollees. As noted above, a plan or insurer must provide an SBC to a special enrollee no later than the date an SPD is required to be provided, which is 90 days after the individual becomes covered under the plan. This strongly suggests that a plan or insurer must only be provided an SBC for the option in which the special enrollee actually enrolls; however, additional guidance would be welcomed.

Material Modifications

Plans or insurers must provide a notice of material modification or an updated SBC only for the benefit package affected by the material modification. However, as noted above, the regulations do not clearly indicate to whom the notice of material modification should be provided (i.e., only those currently enrolled in the affected option or all eligible employees).

How must the SBC be delivered?

At a minimum, a plan or insurer must provide the requisite SBCs in paper form. However, plan or insurers may provide an SBC electronically according to the following rules:

- For plans and issuers subject to ERISA (plans sponsored by private employers) and/or the Internal Revenue Code (e.g., church plans), a plan or insurer may provide the SBC electronically to individuals *covered* by the plan, but only if the requirements of the DOL's electronic disclosure safe harbor at 29 CFR Section 2520.104b-1(c) are met.

Practice Pointer: ERISA's electronic disclosure safe harbor currently set forth in its regulations imposes strict requirements on plan administrators. For example, while SBCs may automatically be provided to employees who have routine access to the electronic medium as part of their job function, plans or insurers may generally provide the SBC electronically to employees who do not have routine access and non-employees (e.g., retirees, spouses, COBRA continuees) only if such individual provides affirmative electronic consent. Obtaining consent may pose administrative difficulties for plans or insurers. Perhaps the agencies will relax this rule in the future to more closely align with the rule noted below for distributing SBCs to non-enrollees.

For those who are *eligible* for coverage but *not enrolled*, a plan may provide an SBC electronically if the following requirements are satisfied:

- the format is readily accessible;

- a paper copy is available free of charge upon request; and
- if the electronic form is an internet posting, the individual is notified (by paper or email) that the documents are available online, informed of the web address and notified that paper copies are available upon request.

Practice Pointer: The final regulations provide much-needed relief for plans and insurers who desire to send the SBCs electronically, but only with respect to those who are not currently enrolled.

Nonfederal governmental plans may comply with either ERISA's electronic disclosure safe harbor requirements or, alternatively, the requirements applicable to insurers in the individual market. Nonfederal governmental plans that wish to comply with the electronic disclosure requirements for insurers in the individual market may provide the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosure by email, or post the SBC on the Internet if they advise the individual or dependent in paper or electronic form that the SBC is available online and provide the applicable web address. However, a nonfederal governmental plan cannot disclose an SBC electronically unless the format is accessible; the SBC is placed in a prominent, accessible location; the electronic form can be electronically retained and printed; the SBC appearance, content and language requirements are satisfied; and the recipient is informed a paper copy is available free of charge.

The preamble to the final regulations states an SBC may be provided as either a stand-alone document or in combination with other summary materials (e.g., an SPD), if the SBC information is displayed prominently at the beginning of the materials (after the table of contents in an SPD) and in accordance with the timing requirements for SBCs.

Like the proposed regulations, the final rules contain a "single notice" rule that allows plans or insurers to satisfy the SBC requirement for a participant and beneficiary with a single notice sent to the participant and beneficiaries at the participant's last known address, *unless the beneficiary is known to reside at a different address*. However, the proposed regulation seemed to limit application of the single notice rule to situations where the plan or insurer *knew* the participant and beneficiaries resided at the same address. The final regulations clarify that an SBC sent to the participant and beneficiaries at the participant's last known address satisfies the requirement with respect to all beneficiaries residing at the participant's address, even if the plan or insurer does not know that they reside there. However, like the proposed rule, the final regulations indicate that a plan or insurer must send a separate SBC to a beneficiary it knows resides at a different address.

Practice Pointer: The single notice rules does not appear to go so far as to say that a plan or insurer does not have to send an SBC to a beneficiary who is enrolling subsequent to a participant solely because that SBC has already been provided to that address. For example, if a spouse is enrolled via special enrollment *subsequent* to the participant, then the plan or insurer arguably has to send an SBC to that spouse, in accordance with the SBC rules for special enrollment, even though that SBC has already been provided to that address as part of the participant's initial enrollment.

For an SBC provided by an issuer to a plan, the SBC may be provided in paper form or electronically. For electronic forms, the format must be readily accessible by the plan, the SBC must be provided in paper form upon request free of charge, and if the electronic form is an Internet posting, the issuer must notify the plan the documents are available online and provide the web address.

What are the format and content requirements for an SBC?

An SBC must satisfy the following format requirements:

- four double-sided pages (i.e., a total of eight printed pages, front and back); and
- no less than 12-point font (and the instructions to the draft template reflect that the font must be Times New Roman).

An SBC must generally satisfy the following content requirements:

- uniform definitions of standard insurance terms and medical terms, so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
- a description of the coverage, including cost-sharing, for each category of benefits identified by the Agencies;
- the exceptions, reductions and limitations on coverage;
- the cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;
- the renewability and continuation of coverage provisions;
- coverage examples that illustrate common benefits scenarios (a normal childbirth, diabetes management) and related cost-sharing based on recognized clinical practice guidelines;
- a statement about whether the plan provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements (this information does not have to be provided until on or after January 1, 2014);
- a statement that the SBC is only a summary and that the plan document, policy certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;
- a contact number to call with questions and an Internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;
- for plans and issuers that maintain more than one network of providers, an Internet address (or similar contact information) for obtaining a list of network providers;
- for plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage; and

- an Internet address where an individual may review and obtain the uniform glossary, as well as a phone number to obtain a paper copy and a disclaimer that paper copies are available.

Practice Pointer: The SBC must be completed in accordance with the instructions to the template provided by the agencies. The instructions to the template are very rigid and generally instruct the plan or insurer to use language and formatting precisely as required by the instructions, except where otherwise permitted by the instructions. However, if a plan's terms required to be described in the template cannot be reasonably described in a manner consistent with the template's instructions, then plans or insurers must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is as consistent with the instructions as possible.

For items and services provided outside the United States, the final regulations allow a plan or issuer to provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. However, an SBC that summarizes benefits and coverage available within the United States still must be provided.

In addition, if at least 10 percent of the population in the county are literate only in the same non-English language, as determined by the American Community Survey data published by the United States Census Bureau, then each SBC sent to a recipient with an address in that county must include a one-sentence statement in that non-English language about the availability of language services provided by the plan.

What happens if I don't comply?

Potential penalties for failure to comply with the SBC requirement are severe, including agency-induced fines of up to $1,000 for each failure to distribute an SBC and the self-reported excise tax applicable to group health plans (other than governmental plans) under Section 4980D of the Internal Revenue Code. The Department of Labor (which has enforcement authority over ERISA plans) has indicated that it will issue separate enforcement penalty regulations in the near future.

This advisory was written by Ashley Gillihan *and* John Hickman.

Chart of Differences Between Proposed Rules and Final Rules

For those familiar with the guidance in the proposed regulations and only want to understand the differences between the final and proposed rules, a summary is provided below.

Item	Proposed Regulations	Final Regulations
Effective date	Enrollments occurring on or after March 23, 2012	With respect to participants and beneficiaries enrolling during an annual enrollment period, the SBC rules are effective on the first day of the first annual enrollment period beginning on or after September 23, 2012. For all other participants and beneficiaries enrolling during an enrollment period other than annual enrollment (e.g., newly eligible individuals and special enrollees), the SBC rules are first effective with any enrollment occurring on or after the plan year that begins on or after September 23, 2012.
Stand-alone document	SBC must be provided as a stand-alone document.	The final regulations eliminate the requirement that an SBC be provided as a stand-alone document to the extent certain conditions are satisfied.
Time period to respond to request for an SBC	Within seven (7) calendar days	Within seven (7) business days
Changes to SBC prior to first day of coverage	If there is any change before the coverage is offered or before the first day of coverage, an updated SBC must be provided no later than the date of the offer, or the first day of coverage, as applicable.	The final regulations state if there is any change to information required to be in the SBC that was provided upon application and before the first day of coverage, an updated SBC must be provided no later than the first day of coverage.
SBCs for automatic renewals	SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.	The final regulations state that if renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. However, with an insured plan coverage, if the policy, certificate or contract of insurance has not been issued or renewed before this 30-day period, the SBC must be provided as soon as practicable, but in no event later than seven business days after issuance of the policy, certificate, or contract of insurance, or receipt of written confirmation of intent to renew, whichever is earlier.
Special enrollment	SBC must be provided within seven days of requesting enrollment.	The final regulations state that special enrollees must be provided an SBC no later than when an SPD is required to be provided under the timeframe set forth in ERISA Section 104(b)(1)(A), which is 90 days from enrollment.
Contents-premium information	Required	Not required
Coverage and services outside the United States	Required to be described in SBC	Instead of summarizing coverage for items and services provided outside the United States, the final regulations indicate that a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. Of course, the plan or insurer must still provide an SBC that summarizes benefits and coverage available within the United States.
Electronic disclosure	All plans subject to ERISA and the Code must provide SBC electronically according to ERISA safe harbor.	Special, less burdensome rules apply to individuals that are eligible but not enrolled.

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