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Employee Benefits & Executive Compensation ADVISORY ■

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Agencies Issue New Proposed Rules for the Summary of Benefits and Coverage

On December 30, 2014, the Departments of the U.S. Treasury (Treasury), Labor (DOL) and Health and Human Services (HHS) (the "agencies") jointly published proposed rules (the "Proposed Rules") that update and clarify the final regulations regarding the Summary of Benefits and Coverage (SBC) published in 2012.

Practice pointer: The new regulations are only proposed regulations, so some aspects could change before they are finalized. If finalized, however, the new SBC rules, template and glossary should be used for all SBCs issued on or after September 1, 2015.

The Proposed Rules incorporate previous subregulatory guidance issued in the form of Frequently Asked Questions (FAQs), as well as make some new changes. The proposed template and the proposed glossary can be found on the DOL's website.[1]

Changes to the SBC Template and Glossary

A template and glossary for the SBC were issued in connection with the 2012 final regulations. The Proposed Rules make a number of additions and deletions to these form documents and the glossary. First, the Proposed Rules would require the SBC to state whether the coverage offers minimum essential coverage and minimum value. This would end the current safe harbor that allows this information to be delivered through a separate letter.[2] The Proposed Rules would also require the SBC to add a third coverage example, an emergency room visit for a simple foot fracture, to the two previously required examples involving a routine delivery and the management of type 2 diabetes.

Despite these new additions, the Proposed Rules actually shorten the completed SBC template to two and a half pages from the original four pages. This is accomplished by removing some information that is not required by statute. For example, references to annual limits for essential health benefits and pre-existing condition exclusions would be removed. Conversely, the glossary is expanded from four to six pages. The Proposed Rules will add definitions for several new terms, including "claim," "cost sharing" and "individual responsibility requirement." Several existing

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1 The proposed template can be found at http://www.dol.gov/ebsa/pdf/sbctemplateproposed.pdf. The proposed glossary is at http://www.dol.gov/ebsa/pdf/sbcuniformglossaryproposed.pdf.

2 As found in FAQ XIV, Q2. http://www.dol.gov/ebsa/faqs/faq-aca14.html.

definitions are also changed slightly. Furthermore, changes are proposed to the SBC instruction sheet and the "Why This Matters" language.

In addition, the continuation of coverage, minimum essential coverage and minimum value disclosures are revised in an effort to provide more useful information.

Changes to the SBC Delivery Requirement

Plan and/or insurer's requirement to provide SBCs to participants

The Proposed Rules make several clarifications regarding the provision of the SBC to participants, all of which are discussed in previous FAQs issued by the agencies. For instance, the Proposed Rules state that an SBC must be provided to participants upon automatic re-issuance or re-enrollment.[3] They also codify the safe harbor providing for electronic delivery of SBCs in connections with online enrollment, renewal or online request from a participant or beneficiary.[4]

The Proposed Rules also extend previous safe harbors in an attempt to streamline the SBC delivery process to participants and reduce duplication issues that may arise when SBCs are delivered by a third party.[5] A plan or issuer that contracts with a third party to provide an SBC will be considered to satisfy the requirement to provide an SBC if the plan or issuer monitors the performance of the contract, corrects noncompliance with the contract "as soon as practicable" and communicates with participants and beneficiaries affected by the noncompliance and takes "significant steps as soon as possible to avoid future violations."

Furthermore, if a group health plan contracts with more than one issuer to provide benefits for a single plan, the Proposed Rules require the plan administrator to provide a consolidated SBC for the plan.[6] An issuer has no obligation to provide an SBC containing information for benefits that it does not insure, but a plan administrator may contract with an issuer to do so. In addition, the safe harbor allowing plan administrators to either synthesize information into a single SBC or provide multiple SBCs is left in place.[7]

The antiduplication rules cover individual student health insurance plans as well.[8] The Proposed Rules state that a higher education institution's requirement to provide an SBC to an individual will be considered satisfied if another party, such as a health insurance issuer, provides a timely and complete SBC.

Insurer's requirement to provide SBCs to a plan

The Proposed Rules make several clarifications regarding the provision of the SBC to plans by insurers, all of which were discussed in previous FAQs. First, insurers will not be required to provide updated SBCs during coverage negotiations.[9] If a plan sponsor is still negotiating coverage terms following the application for coverage, the issuer is

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3 Codified from FAQ VIII, Q9. http://www.dol.gov/ebsa/faqs/faq-aca8.html.

4 Codified from FAQ VIII, Q10. http://www.dol.gov/ebsa/faqs/faq-aca8.html and FAQ IX, Q1. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

5 Codified from FAQ VIII, Q5. http://www.dol.gov/ebsa/faqs/faq-aca8.html.

6 Codified from FAQ IX. Q10. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

7 Codified FAQ IX, Q10. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

8 Codified from FAQ XIV, Q7. http://www.dol.gov/ebsa/faqs/faq-aca14.html.

9 Codified from FAQ IX, Q2. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

not required to provide an updated SBC to the plan until the first day of coverage. However, a plan sponsor's request for an updated SBC must otherwise be honored at any time.

In addition, the rules reaffirm that insurers will not be required to provide new SBCs upon application if they were provided prior to application.[10] If a plan or issuer provides an SBC prior to an application for coverage, such as part of its pre-enrollment materials, the plan or issuer is not required to provide another SBC upon application if there is no change to the information.

Summary for Plan Administrators

The Proposed Rules codify many existing SBC practices that plan administrators are probably already taking to deliver the SBC to participants. No new proposed rules would change existing delivery practices. The biggest change for plan administrators will be the use of the new template and glossary, which should be used exclusively after September 1, 2015.

Practice pointer: Many of the delivery practices discussed in the Proposed Rules simply codify delivery practices provided in previous agency FAQs. The FAQs can be found here. The Proposed Rules would make the FAQ guidance permanent.

Penalties for Noncompliance

The 2012 regulations provided that a willful failure to provide an SBC can result in a fine of $1,000 for each such failure, which can be enforced by the DOL, HHS or IRS. The Proposed Rules provide some clarity about DOL and IRS enforcement. For instance, in assessing fines against plans, the Proposed Rules clarify that the DOL will use the same process and procedures it currently uses to enforce the Form 5500 filing rules. The Proposed Rules further clarify that the DOL is not authorized to assess this fine against a health insurance issuer, per ERISA § 502(b)(3). Furthermore, the Proposed Rules state that the IRS will enforce the SBC rules using a process consistent with Internal Revenue Code Section 4980D for failure to meet the Code's group health plan requirements.

The agencies are accepting comments through March 2, 2015, including through www.regulations.gov.

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[10] Codified from FAQ IX, Q3. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

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If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.239.3366
bob.bauman@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Stacy C. Clark
404.881.7897
stacy.clark@alston.com

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Meredith Gage
404.881.7953
meredith.gage@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

Emily C. Hootkins
404.881.4601
emily.hootkins@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Johann Lee
202.239.3574
johann.lee@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Emily W. Mao
202.239.3374
emily.mao@alston.com

Steven Mindy
202.239.3816
steven.mindy@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

Thomas G. Schendt
202.239.3330
thomas.schendt@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Richard S. Siegel
202.239.3696
richard.siegel@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Jahnisa P. Tate
202.239.3670
jahnisa.tate@alston.com

Daniel G. Taylor
404.881.7567
dan.taylor@alston.com

Elizabeth Vaughan
404.881.4965
beth.vaughan@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON&BIRD

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.1111
DALLAS: 2828 North Harwood Street ■ 18th Floor ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213.576.1100
NEW YORK: 90 Park Avenue ■ 15th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RESEARCH TRIANGLE: 4721 Emperor Blvd. ■ Suite 400 ■ Durham, North Carolina, USA, 27703-85802 ■ 919.862.2200 ■ Fax: 919.862.2260
SILICON VALLEY: 1950 University Avenue ■ 5th Floor ■ East Palo Alto, California, USA, 94303-2282 ■ 650.838.2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333