United Actuarial Services, Inc.
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CLIENT BULLETIN

Proposed Regulations on the Affordable Care Act's "4-Page" Summary of Benefits and Coverage and Uniform Glossary Released by IRS, EBSA and HHS

"4-pages" means "4-double-sided pages"

The Internal Revenue Service (IRS), Employee Benefits Security Administration (EBSA) and the Department of Health and Human Services (HHS) (the Departments) jointly released proposed regulations for the *Affordable Care Act's (ACA)* "4-Page" Summary of Benefits and Coverage (SBC) and Uniform Glossary of health care terms requirement. See *Benefit News Briefs 2011-34* for more on the required summary and glossary.

This new summary requirement is in ADDITION TO the requirement for health plans to provide a Summary Plan Description (SPD). These regulations apply to <u>both</u> *grandfathered* and *non-grandfathered* health plans.

The proposed regulations are open for comment on several items and are currently set to be effective March 23, 2012. This is different from the effective date method used for earlier *ACA* regulations which were premised on a plan year start date. In this case, unless modified later, the effective date is March 23, 2012 NOT the first plan year beginning on or after March 23, 2012.

The below is a listing of documents released by the Departments and available at *http://www.dol.gov/ebsa/*:

<u>Summary of Benefits and Coverage (SBC) and Uniform Glossary (Glossary)</u>

News Release
Fact Sheet

<u>Regulations</u>

Proposed Regulations (SBC and Glossary regulations)

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NAIC Documents

SBC Template
Sample Completed SBC - Individual Health Insurance Coverage
Instructions for Completing the SBC - Group Health Plan (GHP) Coverage
Instructions for Completing the SBC - Individual Health Insurance Coverage
Why This Matters language for "Yes" Answers
Why This Matters language for "No" Answers
Guide for Coverage Examples Calculations
Uniform Glossary of Coverage and Medical Terms

Before discussing the materials, let's take a look at the outline of the regulation, as shown below. A copy of the proposed regulation is available by "*clicking here*."

OUTLINE OF SECTION 2590.715-2715
SUMMARY OF BENEFITS AND COVERAGE
AND UNIFORM GLOSSARY

(A) Summary of benefits and coverage
(1) IN GENERAL
(2) CONTENT
(3) APPEARANCE
(4) FORM
(5) LANGUAGE
(B) Notice of modifications
(C) Uniform glossary
(1) IN GENERAL
(2) HEALTH-COVERAGE-RELATED TERMS AND MEDICAL TERMS
(3) APPEARANCE
(4) FORM AND MANNER
(D) Preemption
(E) Failure to provide
(F) Applicability date

Overview of the Proposed Regulations and Sample SBC Templates And Instructions

SBC

Section 2715 of the Public Health Service Act (PHSA), as added by the *ACA*, directs the Departments to develop standards for use by a GHP in compiling and providing a SBC that "accurately describes the benefits and coverage under the applicable plan or coverage." The proposed regulations interpret the *ACA's* four-page summary requirement to mean **four double-sided pages**, in order to ensure that this information is presented in an understandable and meaningful way.

Sample SBC Templates And Instructions - Definitions and Glossary

In conjunction with these proposed regulations, the Departments are publishing a document that provides the proposed template for the SBC (with proposed instructions and sample language for completing the template) and the proposed uniform glossary that are identical to the documents that were developed and agreed to by the National Association of Insurance Commissioners (NAIC). Note, that the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers and self-insured plans may need to modify the format as allowable.

Specifically, the *ACA* requires plans to include in the SBC "uniform definitions" of common health insurance terms including specified insurance-related terms and medical terms.

The NAIC adopted a two-part approach to the definitions. First, it drafted a consumer-friendly uniform glossary, which includes definitions of health coverage terminology, to be provided in connection with the SBC. The NAIC's uniform glossary provides simple, general, descriptive definitions designed to help consumers understand terms and concepts commonly used in health coverage.

In these proposed regulations, the Departments propose that the NAIC uniform glossary be used to satisfy the requirements of *ACA*.

In addition to the uniform glossary, the NAIC also developed a "Why this Matters" column for the draft SBC template (with instructions for plans and issuers to use in completing the SBC template). The instructions specify how plans must describe each coverage component in the SBC. For example, the instructions indicate what information must be provided about a plan's out-of-pocket limit on cost sharing, including whether copayments, out-of-network coinsurance, and deductibles are subject to this limit.

Discussion Of The Regulations

We will limit our discussion to the requirement for GHPs even though the same requirements may (or may not) apply to insurance issuers also.

What Must be Distributed, To Who and How

Subsection (a) of the proposed regulations require a GHP (and its administrator) to provide a ***written SBC*** for each benefit package that is offered by the plan or issuer for which the participant or beneficiary is eligible. This SBC must be provided without charge.

The SBC must be provided as **part of any written application materials** that are **distributed** by the plan or issuer **for enrollment**. *If the plan does not distribute written application materials for enrollment*, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant or any beneficiaries.

If there is any change to the information required to be in the SBC *before the first day of coverage*, the plan must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

The plan must provide the SBC at the following times:

- to participants and beneficiaries at each new plan year, no later than 30 days prior to the first day of coverage under the new plan year.
- to special enrollees within seven days of a request for enrollment pursuant to a special enrollment right.
- to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request.
- to a participant or beneficiary who may be shopping for coverage or enrolling in coverage.
- to a participant or beneficiary when coverage is renewed, if the plan requires participants or beneficiaries to renew to maintain coverage.

Special Distribution Rules

In order to prevent unnecessary duplication of notices, if a participant and any beneficiaries are known to *reside at the same address*, and a *single SBC is provided to that address*, the requirement to provide the SBC is satisfied with respect to all individuals residing at that address. If a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

With respect to a GHP that offers *multiple benefit packages*, the plan is required to provide *a new SBC automatically upon renewal only with respect to the benefit* package in which a participant or beneficiary is enrolled; SBCs are not required to be provided automatically with respect to benefit packages in which the participant or beneficiary are not enrolled. *However, if a participant or beneficiary requests an SBC with respect to another benefit package* (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided as soon as practicable, but in no event later than seven days following the request.

Content of SBC

The SBC must include the following:

- 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 Secretary in guidance;

- The exceptions, reductions and limitations of the coverage;

- The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

- The renewability and continuation of coverage provisions;

- Coverage examples;

- With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage 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;

- A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;

- Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance);

- For plans that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

- For plans that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage;

- An Internet address for obtaining the uniform glossary; and

- Premiums (or in the case of a self-insured GHP, cost of coverage).

Examples

The examples must illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) that are identified by the Departments. Up to six coverage examples *may be required* in an SBC.

A benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines available through the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Departments will specify, in guidance, the types of services, dates of service, applicable billing codes, and allowed charges for each claim in the benefits scenario.

To demonstrate benefits provided under the plan, a plan will simulate how claims would be processed under the required scenarios and generate an estimate of cost sharing a consumer could expect to pay under the benefit package. The demonstration of benefits will take into account any cost sharing, excluded benefits, and other limitations on coverage, as described in guidance.

Appearance of SBC

The SBC must be provided as a stand-alone document in the form authorized by the regulations and completed in accordance with the instructions for completing the SBC that are authorized in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than **12-point font**.

Provision of SBC

An SBC provided by a plan to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically if the requirements of ERISA Regulation Section 2520.104b-1 are met.

Language of SBC

A GHP must provide the SBC in a culturally and linguistically appropriate manner. These proposed regulations provide that, to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan shall follows the rules for providing appeals notices in a culturally and linguistically appropriate manner, as was discussed in *Benefit News Briefs 2011-50*. In general, those rules provide that, in specified counties of the United States, plans must provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages. In addition, in such counties, English versions of the SBC must disclose the availability of language services in the relevant language. The counties in which this must be done are those in which at least 10% of the population residing in the county is literate only in the same non-English language, as determined in guidance.

At the time of publication of this amendment, 255 U.S. counties (78 of which are in Puerto Rico) meet or exceed this 10% threshold. The overwhelming majority of these non-English language speakers speak Spanish; however, Chinese, Tagalog, and Navajo are present in a few counties in five states (specifically, Alaska, Arizona, California, New Mexico, and Utah). A full list of the affected U.S. counties in 2011 is available by "*clicking here*."

This guidance will be updated annually if there are changes to the list of the counties determined to meet this 10% percent threshold that are literate only in the same non-English language The annual updates can be found at: *http://www.dol.gov/ebsa/healthreform* and *http://cciio.cms.gov/*.

Notice of Modifications

Subsection (b) of the proposed regulations state if a GHP makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

Uniform Glossary

Subsection (c) of the proposed regulations state a GHP must make the uniform glossary described in the regulations available to participants and beneficiaries.

Contents

The uniform glossary must provide uniform definitions as prescribed by regulations and guidance for the following 44 health-coverage-related and medical terms:

- allowed amount
- appeal
- balance billing
- co-insurance
- complications of pregnancy
- co-payment
- deductible
- durable medical equipment
- emergency medical condition
- emergency medical transportation
- emergency room care
- emergency services
- excluded service
- grievance
- habilitation services
- health insurance
- home health care
- hospice services
- hospitalization
- hospital outpatient care
- in-network co-insurance
- in-network co-payment
- medically necessary
- network
- non-preferred provider
- out-of-network co-insurance
- out-of-network co-payment
- out-of-pocket limit
- physician services
- plan
- preauthorization
- preferred provider
- premium
- prescription drug coverage
- prescription drugs
- primary care physician
- primary care provider
- provider
- reconstructive surgery
- rehabilitation services
- skilled nursing care
- specialist
- usual customary and reasonable (UCR)
- urgent care

The Departments are considering whether glossary definitions of any of the following terms would also be helpful:

- claim
- external review
- maternity care
- preexisting condition
- preexisting condition exclusion period
- specialty drug

Appearance
The uniform glossary must be presented with the appearance authorized in guidance, ensuring that the uniform glossary is presented in a uniform format and utilizes terminology understandable by the average plan enrollee.

Distribution of Glossary
A plan must make the uniform glossary available upon request, in either paper or electronic form (as requested), within seven days of the request. (Under the rules in subsection (a) of these regulations, the SBC will disclose to participants and beneficiaries their rights to request a copy of the uniform glossary.)

Preemption to State Law

Subsection (d) of the proposed regulations preempts State laws that require a health insurance issuer to provide an SBC that supplies less information than required under the regulation. Such laws would already be preempted by ERISA for self-funded plans.

Failure To Provide

Subsection (e) of the proposed regulations states that if a GHP willfully fails to provide information required under this section to a participant or beneficiary it is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph.

Applicability Date

Subsection (f) of the proposed regulations states the regulations are **applicable beginning March 23, 2012** and **apply to grandfathered and non-grandfathered plans**.

Other Considerations

It is advisable to read all applicable documents. For example the instructions for filling out the SBC state, among other things:

Formatting / Page Layout
Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the insurer must use 12-point (as required by federal law) Times New Roman font, and replicate all symbols, formatting, bolding, colors, and shading exactly. *"Click here"* for an example of a blank chart.

The items shown on Page 1 must always appear on Page 1, and the rows of the chart must always appear in the same order. The chart starting on page 2 shown in the example must always begin on Page 2, and the rows shown on this chart must always appear in the same order. However, the chart rows shown on Page 2 may extend to Page 3 if space requires, and the chart rows on Page 3 may extend to the beginning of Page 4 if space requires. The *Excluded Services and Other Covered*

Services section may appear on Page 3 or Page 4, but must always immediately follow the chart starting on page 2. The Group – 7-28-11 *Excluded Services and Other Covered Services* section must be followed by the *Your Rights to Continue Coverage* section, the *Your Grievance and Appeals Rights* section, and the *Coverage Examples* section, in that order.

Variable Benefit Structures
If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used. For example, if the policy uses the terms “preferred provider” and “non-preferred provider” and the annual deductible is $2,000 for a preferred provider and $5,000 for a non-preferred provider, then the Answer column should show “$2000 preferred provider, $5,000 nonpreferred provider”.

General Reminder
The details listed above are just a few of the many instructions that need to be followed.

Individuals responsible for implementing these new regulations will want to review the materials carefully and in detail. While there may be some changes made in the final regulations, it is not expected that any drastic changes will be made, so one should not wait to act just because these regulations are “proposed”.

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