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UPDATE
Employee Benefits and Compensation

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2012 Health Care Reform Update: Final Rules Released for Summary of Benefits and Coverage

On February 9, 2012, the US departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (Departments) issued final regulations implementing the summary of benefits and coverage (SBC) requirement applicable to insured and self-insured group health plans and individual health plans under health care reform. The SBC is designed to be a short, uniform, plain-English explanation of health coverage, which should make it easier for participants to compare coverage among various health care options.

The SBC must be presented in a uniform format, cannot exceed four double-sided pages, and must not include print smaller than 12-point font. An SBC need not be provided for any benefit plan that is an excepted benefit. Generally, the rules do apply to HRAs but not to HSAs, although the SBC can mention the impact of the employer contributions to HSAs in the appropriate spaces on the SBC.

The final regulations include a delayed compliance date for the distribution of SBCs. Under health care reform, SBCs were to be provided beginning March 23, 2012. Under the guidance, for disclosures to participants and beneficiaries who enroll or reenroll in plan coverage through an open enrollment period, SBCs must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures to participants and beneficiaries who do not enroll through an open enrollment period (that is, new hires and special enrollees), the rules apply beginning on the first day of the first plan year beginning on or after September 23, 2012 (that is, January 1, 2013, for calendar year plans).

SBCs must be included in any application materials provided as a part of the open enrollment process. If there are no such materials, the deadline is the first day on which a participant is eligible to enroll. For special enrollees, the deadline is 90 days after the participant's open enrollment date. There is a $1,000 penalty for each willful failure to distribute an SBC.

With the final regulations, the Departments released multiple documents to assist in compliance, including an SBC template with instructions, samples, a guide for coverage example calculations to be used in completing the SBC template, and a uniform glossary of coverage and medical terms.

SBCs must contain certain elements, including the following:

- Uniform definitions of standard insurance 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 requirements, such as deductibles, coinsurance, and copayments, for each category of benefits
- 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 to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines
- A statement about whether the plan provides minimum essential coverage as defined under Code Sec. 5000A(f) 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
- A contact number to call with questions and an Internet web 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 one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the 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
- Information for obtaining copies of the uniform glossary, including an Internet address where an individual may review the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available

Dropped from the final version of the regulations was a provision in the proposed rules that would have required the SBC to include premiums or cost of coverage for self-insured group health plans.

An SBC can be provided either as a stand-alone document or in combination with other summary materials (including SPDs), so long as the SBC information is intact and prominently displayed at the beginning of the materials (for example, after an SPD's Table of Contents) and provided consistent with the timing rules for SBCs.

SBCs can be distributed electronically (1) for those already covered under the plan, if the requirements of the DOL's safe harbor for electronic disclosure are satisfied and (2) for those eligible for coverage but not enrolled in a plan, if the format is readily accessible, and a paper copy is provided free of charge on request. If the electronic form is an Internet posting, the plan or issuer must advise the individual in paper form (such as a postcard) or by e-mail that the documents are available on the Internet, provide the Internet address, and notify the individual that the documents are available in paper form upon request.

The delay in the effective date of SBCs also delays the effective date of the requirement to provide a 60-day advance notice of material modifications to the content of the SBC.

OTHER RECENT HEALTH CARE REFORM NEWS

The 1099 reporting requirements under health care reform were repealed last year before they went into effect.

The DOL has indicated that the automatic enrollment guidance will not be ready to take effect by 2014, as previously indicated by the DOL. Until final regulations are issued and become applicable, employers are not required to comply with automatic enrollment for health plans.

Starting with 2012 W-2s (to be issued in 2013), large employers (those required to file at least 250 W-2s) must disclose the cost of employer-provided health benefits. The reportable cost generally equals the sum of employer and employee contributions, whether pre- or post-tax, for all individuals covered as of December 31.

Under the guidelines on women's preventive services, nongrandfathered group health plans are generally required to cover contraceptive services for plan years beginning on or after August 1, 2012. Final regulations have been issued that give HHS the discretion to exempt group health plans of qualifying religious employers. Nongrandfathered, nonexempted nonprofit organizations with religious objections to covering contraceptive services will have a one-year safe harbor from agency enforcement, during which time further guidance should be issued.

HHS has also issued a set of frequently asked questions (FAQs) intended to provide additional guidance on defining what are essential health benefits (EHB) under health care reform. Among other things, the FAQs address how employers determine which benefits are EHB when they offer coverage to employees residing in more than one state.

The effective date of the nondiscrimination regulations for fully insured plans under health care reform has been delayed until after final regulations are released.

Robinson & Cole's Employee Benefits and Compensation Practice Group is available to assist clients in complying with their obligations under health care reform. If you have any questions, please contact any of the following attorneys:

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