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CLIENT ALERT

Obama Administration Seeks Comments on Proposed Changes to Summary of Benefits and Coverage Document and Requirements

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On December 30, 2014, the Departments of Health and Human Services, Labor, and the Treasury (collectively, "Departments") issued a proposed rule ("Proposed Rule") regarding the summary of benefits and coverage ("SBC") for use by group health plans and health insurance coverage in the group and individual markets.[1] The Proposed Rule, which would amend the SBC regulations that were issued in 2012, also includes proposed revisions to materials related to the SBC, such as the SBC templates, an instruction guide, a uniform glossary of certain insurance and medical-related terms, and other supporting materials.[2] The Departments are accepting comments on the Proposed Rule through **March 2, 2015**.

Background

The SBC regulations and supporting materials provide standards by which group health plan and health insurance issuers offering group or individual health insurance coverage communicate certain plan-specific information to the plan, to beneficiaries, or to consumers in the individual market. Final regulations governing the SBC disclosure requirements were issued in February 2012,[3] and the Departments have since provided additional guidance through a series of frequently asked question ("FAQ") publications.[4] The SBC must generally include uniform definitions of standard insurance and medical terms; a description of the coverage of essential health benefits; any exceptions, reductions, and limitation on coverage; the cost-sharing provisions of the coverage; the renewability and continuation of coverage provisions; and examples that illustrate common benefit scenarios, among other things. These uniform standards are designed to help consumers compare coverage and understand the terms of their coverage. The

[1] 79 Fed. Reg. 78578 (Dec. 30, 2014), *available at* https://www.federalregister.gov/articles/2014/12/30/2014-30243/summary-of-benefits-and-coverage-and-uniform-glossary.
[2] Both the existing and the proposed supporting materials are available at http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.
[3] 77 Fed. Reg. 8668 (Feb. 14, 2012).
[4] Affordable Care Act Implementation FAQs, *available at* http://www.dol.gov/ebsa/faqs/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/.

supporting materials, such as the SBC template, are designed to be customized with plan-specific information while containing the required elements.

Changes to the SBC Regulations

The Departments propose to change and clarify the SBC regulations for certain scenarios to reduce unnecessary duplication of SBC disbursement. Specifically, an entity required to supply an SBC to individuals would be able to meet that requirement through contract with another party to provide the SBC, as long as certain conditions are met. Additionally, where a group health plan uses two or more insurance products provided by separate issuers to insure benefits under a single plan offering, the plan administrator, not the issuer, would be responsible for providing the SBC, unless the parties specifically contract for the issuer to do so. Finally, for student health coverage, if the SBC is provided by the issuer, then the requirement to provide the SBC is considered satisfied for the other entity, such as the school. The Departments seek comment on whether or not this section of the SBC regulations should also include a requirement that the provision of the SBC by one of the entities be monitored.

The Departments had previously provided an enforcement safe harbor in published FAQs for group health plans using two or more insurance products provided by separate issuers in a single plan offering.[5] Under the safe harbor, the plan administrator is permitted to issue either a single SBC containing information from the various products or multiple partial SBCs containing the full information in order to ease the burden of combining information from multiple issuers. The Departments now seek comment on codifying this safe harbor in the SBC regulations.

In addition to changes to reduce duplication, the Departments also propose clarifications regarding when the SBCs should be provided. For example, the proposed regulations clarify when an issuer is required to provide an SBC for a second time where the first time was provided prior to application for coverage.

Content of the SBC

The Proposed Rule revises the SBC template as well as its required content. The Departments propose to require that SBCs include a statement both on whether the relevant coverage provides "minimum essential coverage," as defined in Section 5000A(f) of the Internal Revenue Code, and on whether the coverage's share of the total allowed costs of benefits provided meets applicable minimum value requirements. Current regulations allow such statements to be conveyed through a cover letter or separate communication, but this would no longer be permitted under the proposed changes.

The Proposed Rule would also amend the SBC template to add a statement disclosing whether a qualified health plan covers or excludes coverage of abortion services and a statement regarding whether coverage is limited to services for which federal funding is

[5] Affordable Care Act Implementation FAQs Part IX, question 10, *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

allowed.[6] The instruction guide, another SBC supporting document, would be revised to indicate that these statements should be included in sections on "services your plan does not cover" or "other covered services." The Departments seek comment on these proposed changes, including whether this information belongs in a different section of the SBC. This change is designed to increase transparency as well as assist issuers in complying with the Affordable Care Act ("ACA") requirement that issuers providing coverage of abortion services, as described above, disclose such coverage in the SBC.

Proposed revisions to the SBC template also would eliminate certain information that is not required by statute, thus changing the length of the SBC disclosure document from four double-sided pages to two double-sided pages. The Departments believe that this more succinct communication would improve both the document's usefulness to consumers and the ability of issuers to communicate required information within the formatting guidelines. The Departments seek comment on whether this change maintains the proper balance between conveyance of critical information and maintenance of a manageable length. Further, the Departments seek comment on any additional revisions to the SBC document and its supporting materials that could help plans stay within the statutory page limit (four double-sided pages) while conveying the required information.

Coverage Examples

The SBC template currently contains two coverage scenarios that are designed to help consumers understand the coverage they have and to enable them to compare the cost of coverage under different plans, including deductibles, copayments, coinsurance, and other out-of-pocket payments. The scenarios, "having a baby" and "managing diabetes type 2," are two of six coverage scenarios that the Departments are authorized by statute to provide. The Departments propose to add a third scenario of a simple foot fracture with emergency room visit.

In addition to adding a third coverage scenario, the Departments propose to revise the pricing data underlying all three scenarios to improve accuracy and to continue the use of a coverage calculator provided by the Department of Health and Human Services that plans and issuers can use as an way of completing the coverage examples. The Departments seek comment on all aspects of this new, third proposed coverage scenario. When reviewing the proposed changes and submitting comments, issuers should consider whether the new coverage scenario for emergency department services is a useful example or whether a different outpatient, or perhaps out-of-network service scenario, would better serve their enrollees as an alternative coverage scenario.

[6] Absent state law, an individual qualified health plan issuer can make the decision on whether to cover abortion services. Issuers that cover abortion services other than in the case of rape, incest, or danger to the life of the mother must ensure that federal funds (i.e., premium tax credits or cost-sharing reductions) are segregated so as not to be used to pay for such services. *See* Affordable Care Act, § 1303(b)(3)(A) (2010); 42 U.S.C. 18023(b).

Uniform Glossary Revisions

A plan or issuer is required to provide the Uniform Glossary of Coverage and Medical Terms upon request. The uniform glossary contains many terms that are commonly used in the SBC and is designed to provide consumers with consistent definitions for coverage comparison and extent of benefits. The Departments propose to revise the definitions of several medical and insurance-related terms in the uniform glossary, as well as add new terms that are relevant in the context of the ACA. For example, references to preexisting condition exclusions would be removed and a definition of "minimum value" would be added.

The Proposed Rule, revised templates, and other proposed changes would apply to coverage that begins on or after September 1, 2015.

The Departments are accepting comments on the Proposed Rule through **March 2, 2015**.

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