Benefit Comply
Employee Benefit Compliance Support Services

Issue Brief

SBC Distribution Rules for Employer Sponsored Health Plans
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Summary

The Affordable Care Act (ACA) expands ERISA's disclosure requirements by requiring that a "summary of benefits and coverage" (SBC) be provided to applicants and enrollees. The SBC must accurately describe the benefits and coverage under the applicable plan. The SBC rules apply to both group health plans and individual health insurance.

Terms used in guidance issued by the regulatory agencies (the agencies) often uses language more common to the individual health insurance market, such as "applicants" instead of common group health plan terms such as "employees" or "participants".

This summary focuses on the SBC distribution requirements that affect employer sponsored health plans, and does not address issues specific to insurance company obligations for individual health insurance policies.

Which Plans Are Required to Provide the SBC?

The SBC requirement applies to group health plans (both insured and self-insured) and insurers but not to certain "excepted benefits." Grandfathered group health plans must comply with this mandate.

Excepted Benefits

Benefits treated as excepted benefits under existing HIPAA rules are not subject to the SBC requirements. Common benefits not subject to the SBC rules include:

- Limited Scope dental and vision plans
- Health FSAs funded with only participant contributions
- Coverage only for accidents (including accidental death and dismemberment coverage);
- Disability income coverage
- Workers' compensation or similar coverage
- Automobile medical payment insurance
- Health Savings Accounts
    - The SBC requirement does not apply to HSAs. However, the SBC would apply to the underlying high-deductible health plan (HDHP). According to the preamble to the final regulations, the effects of employer contributions to an HSA can be mentioned in an SBC for the HDHP.

Application to Heath Reimbursement Accounts (HRAs)

HRAs may create additional obligations on the part of many employers.

- Information about HRAs (and health FSAs that are not excepted benefits) can be included in the appropriate spaces on the major medical plan SBC.
- The FAQs refer to account-based coverage as an "add on" to major medical coverage that could affect the participant's cost-sharing and other information on the SBC. In such circumstances, the agencies explain that the SBC coverage examples should note the assumptions used in creating them.

Important Note for HRA Plans
HRAs that are "integrated" with other coverage may satisfy the SBC requirement by providing a single combined SBC that describes the HRA and any underlying health coverage. Agency guidance does *not*, however, define what it means for an HRA to be "integrated" with other coverage. Fortunately plan administrators can safely choose to either distribute a single integrated SBC or prepare a stand-alone SBC for the HRA coverage, at least for the first year that SBCs are required.

However, whether incorporated into the primary plan SBC or not, the HRA plan administrator should ensure that the HRA's provisions are covered by an SBC. Agency guidance confirms that the responsibility to distribute an SBC for an HRA remains with the plan administrator. In fact, the guidance states that the plan or insurer must accurately describe the relevant plan terms while using its "best efforts" to do so in a manner that is still consistent with the instructions and template format as reasonably as possible.

Consequently, employers need to choose to incorporate the HRA coverage into a "combined SBC" or produce and distribute a separate SBC for the HRA coverage.

Application to Wellness Programs

Depending on the types of benefits provided, a wellness program may be considered a group health plan. The FAQs refer to a wellness program as an "add on" to major medical coverage that could affect the participant's cost-sharing and other information on the SBC. In such circumstances, the agencies explain that the coverage examples should note the assumptions used in creating them.

Application to Employee Assistance Programs (EAPs)

The SBC rules do not explicitly address EAPs, but whether the SBC requirements apply would depend on if the EAP is considered a group health plan. Given the limited nature of benefits under an EAP, it would not traditionally fit within the SBC template. Thus, these programs may take advantage of a special rule. It states that to the extent a plan's terms that are required to be in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or insurer must accurately describe the relevant plan terms while using its "best efforts" to do so. Until further guidance is provided it is expected that employers who offer EAP coverage will simply denote that fact in the health plan SBC.

Who Must Provide the SBC?

For self-funded plans the obligation to provide the SBC clearly rests with the plan administrator (usually the plan sponsor/employer unless another entity is named as such in the plan documents). However, one source of confusion among employers stems from the fact that for fully insured plans the rules apply to both the plan administrator (usually the employer) and the insurance company.

Allocating Contractual Responsibility

The regulations contain a special rule regarding the "joint liability" situation. The plan's obligation is satisfied so long as any entity has provided the SBC. Thus, if the insurer provides a timely and compliant SBC, the plan administrator's obligation is satisfied.

The FAQ guidance recognizes that different combinations of plans, insurers, and service providers may have different information needed to satisfy the SBC requirement. The rules provide that, until further guidance, a plan or insurer generally will not be subject to enforcement action if it enters into a binding contractual arrangement under which another party assumes responsibility for the SBC.

Some insurance carriers have begun to add language to group insurance contracts specifically making the employer responsible for the distribution of the SBC to employees.

Responsibility for Combining Information from Multiple Insurers

The FAQ guidance provides that plan administrators are responsible for providing complete SBCs with respect to a plan, even when two or more insurers provide benefits under the plan. For example, a plan administrator that uses two or more insurance products (e.g., a major medical policy and a separate "carved-out" prescription drug coverage) provided by separate insurers under a single plan may combine the information into a single SBC or may contract with one of the insurers (or other service provider) to perform that function.

The departments have indicated that during the first year, for employers that use two or more insurers, distributing multiple SBCs that together provide all the relevant information, will meet the SBC content requirements.

Who Must Receive an SBC?

Generally, the SBC must be distributed to all applicants (at the time of application), and enrollees (at initial enrollment and annual enrollment). The plan administrator and/or the insurer must automatically provide an SBC to participants and beneficiaries with respect to each "benefit package" offered.

Important Note: Multiple "Benefit Packages"
Neither the statute nor the regulations define "benefit package" but different coverage tiers may be considered part of the same benefit package. Thus, separate SBCs would not be required for differences between self-only, employee-plus-one, and family coverage.

COBRA

Plans are also required to provide SBCs to COBRA qualified beneficiaries. During an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary.

When Must the SBC Be Distributed?

From Plan or Insurer to Participants and Beneficiaries

Group health plans and/or insurers are required to provide an SBC to a participant or beneficiary with respect to each "benefit package" offered for which the participant or beneficiary is eligible. The SBC must be distributed at various times, as outlined below.

- At Open Enrollment (Renewal)
    - The SBC must be included with open enrollment materials. The regulations use the term "renewal" as opposed to "open enrollment".
    - If a plan or insurer requires participants and beneficiaries to actively elect to maintain coverage during open enrollment, or provides them with the opportunity to change coverage options during that time, the SBC must be provided at the same time the open enrollment materials are distributed.
    - If there is no requirement to renew (often referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic, and the SBC must be provided no later than 30 days prior to the first day of the new plan year.
    - For insured plans, if the new policy has not yet been issued 30 days prior to the beginning of the plan year, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the policy.

    - For employers that offer multiple benefit packages, in connection with renewal, the regulations provide that the plan only need to automatically provide a new SBC with respect to the benefit package in which a participant or beneficiary is enrolled.
        - However, if a participant or beneficiary requests an SBC with respect to another benefit package for which the participant or beneficiary is eligible, the SBC must be provided as soon as practicable, but in no event later than seven business days following the request.

- At Initial Enrollment
    - The SBC for each benefit package offered, for which the participant or beneficiary is eligible, must be provided as part of any written application materials that are distributed by the plan (including a self-insured plan) or insurer for initial 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.
    - If there is any change to the information required to be in the SBC before the first day of coverage (e.g., prior to the end of the plan's waiting period), the plan or insurer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

- At Special Enrollment
    - The plan must provide the SBC to special enrollees (employees and dependents with the right to enroll in coverage midyear upon specified circumstances) within 90 days after enrollment pursuant to a special enrollment right.

- Upon Request
    - The plan or insurer must provide the SBC to a participant or beneficiary upon request, as soon as practicable, but in no event later than seven business days following the request.

From Insurer to Plan

In the case of an insured plan, an insurer is required to provide an SBC to the group health plan (in this case, the employer/plan sponsor):

- Upon an application or request for information the SBC must be provided as soon as practicable following the request, but in no event later than seven business days following the request.
- If there is a change to the information in the SBC before the coverage is offered, or before the first day of coverage, the insurer must update and provide a current SBC to the plan no later than the date of the offer (or no later than the first day of coverage, as applicable).
- If written application for renewal is required, the SBC must be provided no later than the date the materials are distributed.
- If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year. If the new policy has not yet been issued 30 days prior to the beginning of the plan year, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the policy.
- Upon request from the group health plan, the SBC must be provided as soon as practicable but no later than seven business days following the request.

Form and Manner to Distribute the SBC

Distribution to Participants and Beneficiaries

An SBC may be provided in paper form to participants and beneficiaries covered under the plan, or can be provided electronically if the requirements of the electronic disclosure regulation under ERISA are met.

- The FAQ guidance provides important relief relating to distribution requirements by noting that unless the plan or insurer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the other beneficiary (e.g. spouses and dependents). This deemed notice to beneficiaries applies even in the case of electronic delivery of the SBC.

Important Note - Deemed Disclosure to Beneficiaries.
From an administrative standpoint, the clarification in the FAQ regarding electronic delivery of the SBC to the participant on behalf of the beneficiary provides important relief. The agencies' position is also a sensible recognition that employees will share information about coverage options with family members living under the same roof. This relief from not having to directly notify a beneficiary would not apply if the employer has information that a beneficiary lives at an address different from the participant/employee.

- The agencies have adopted another important safe harbor for electronic delivery of the SBC. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or renewal of coverage under the plan.
    - It appears that the safe harbor would only be satisfied for those *actually* enrolling online. In other words, it would not be available for those who choose to enroll via another means.
- For participants and beneficiaries who are eligible but not enrolled, the SBC may be provided electronically if the format is readily accessible and a paper form is provided free of charge upon request.
    - For these participants and beneficiaries, the SBC may be provided via Internet posting if the individuals are notified in paper form (such as a postcard) or via email that the documents are available on the Internet.
    - The postcard or email must provide the Internet address and indicate that the documents are available in paper form upon request.

Language Requirements for the SBC

Plans must include a one-sentence statement indicating how to access the language services in the English versions of SBCs sent to an address in specified counties of the United States.

- 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. HHS provides a list, which is applicable for 2012, of counties which meet or exceed this threshold at: http://www.cciio.cms.gov/resources/factsheets/clas-data.html**.** .
- Most employers sending SBCs to counties where this rule applies will simply include the sentence in all SBCs sent rather than attempt to send different SBCs to specific counties.
- Upon request from an individual, written translations of the SBC must be provided in the four applicable non-English languages. Written translations for the SBC template and the uniform glossary are now available in all four applicable languages—Spanish, Chinese, Tagalog, and Navajo—on the HHS website.