Published: January 23, 2014

Proposed Regulations on Summary of Benefits & Coverage

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On December 22, 2014, the Departments of Labor, the Internal Revenue Service and Health and Human Services issued proposed regulations and supporting documents addressing the SBC requirement. The majority of the proposed regulations incorporate the guidance previously published in numerous FAQs, but some new information is provided. Key items in the proposed regulations, if adopted, would (a) clarify when and how a plan administrator or insurer must provide an SBC, (b) shorten the length of the SBC, (c) amend the uniform glossary and (d) add a third coverage example regarding "simple foot fracture with emergency room visit." If finalized, the new requirements would be effective for plan years and open enrollment periods beginning on or after September 1, 2015. Below you will find pertinent information found in the proposed regulations.

Types of Plans to which SBCs Apply

The proposed regulations confirm that SBCs are not required for expatriate health plans, Medicare Advantage plans, health savings accounts, or plans that qualify as excepted benefits. Excepted benefits include (when certain requirements are met) employee assistance programs, dental and vision coverage and health FSAs. SBCs are required for health reimbursement arrangements; however, an HRA integrated with other major medical coverage under a group health plan does not need to separately satisfy the SBC requirements. The SBC is prepared for the other major medical coverage and the effects of employer allocations to an account under the HRA can be denoted in the appropriate spaces on the SBC.

Shortened SBC

The regulations propose to shorten the sample SBC template from four double-sided pages to two and a half double-sided pages. The proposed regulations would remove a significant amount of information that is not required by law and that has been identified as not useful to consumers in choosing a plan.

Content Changes to New SBC Template

Other changes to the SBC template include:

- Adding a cost example for a simple foot fracture treated in an emergency room
- Authorizing the continued use of the coverage example calculator
- Removing references to annual limits for essential health benefits and preexisting condition exclusions
- Revising minimum essential coverage and minimum value information and requiring it to be included in the SBC
- Allowing (but not requiring) premium information to be included in an SBC
- Clarifying that for contact information, only issuers must include an Internet web address where a copy of the actual individual coverage policy or group certificate coverage can be reviewed and obtained
- Some definitions in the uniform glossary have been changed and new medical terms have been added. Additional terms related to health care reform such as minimum value and cost-sharing reductions have also been added.

Clarification on Providing the SBC

Issued by Issuer: When a health insurance issuer offering group health insurance provides the SBC to the employer before application for coverage, the requirement to provide an SBC upon application would be deemed satisfied unless there is a change to the information required to be in the SBC. If the information changes, a new SBC that includes the correct information would have to be provided upon application. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the issuer would not be required to provide an updated SPD (unless requested) until the first day of coverage. The updated SBC would have to reflect the final coverage terms under the contract, certificate or policy of insurance that was purchased.

Issued by Employer: If a plan provides an SBC to employees prior to application for coverage, the plan is not required to automatically provide another SBC upon application if there is no change to the information required to be in the SBC. However, if there is any change to the information by the time the application is filed, the plan must update and provide a current SBC as soon as practicable following receipt of the application, but in no event later than 7 business days following receipt of the application. If the terms of coverage are not finalized after an application has been filed and the information changes, the plan is not required to provide an updated SBC (unless requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate or policy of insurance that was purchased.

Elimination of Duplication

The proposed regulations clarify prior guidance and would help prevent unnecessary duplication where (a) a group health plan contracts with another party who agrees to assume responsibility to provide the SBC,(b) a group health plan uses two or more insurance products from different issuers to insure benefits under a single group health plan, and (c) the SBC for student health insurance coverage is provided by another party, such as an institution of higher education.

Employer Action

No employer action is required at this time until final regulations are issued.

For templates, instructions and related materials, visit: http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html