



# Guidance on “Mini Summaries” and 60-Day Advance Notice of Changes

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Federal health care reform (also called PPACA) mandates the preparation and delivery of a new mini plan summary, often called the four-page mini summary. The federal agencies overseeing implementation jointly issued proposed regulations governing this requirement. The new disclosure rule adds another layer of compliance for most employers. ERISA requires more extensive Summary Plan Descriptions (SPDs); this new item does not replace that document.

Health care reform law also requires an employer to provide 60-day advance notice of plan changes. Congress used very broad wording, stating that any change to information in the mini plan summary would require notice to plan participants and beneficiaries 60 days before the change could be implemented. Now, in a very welcome, more narrow interpretation, the government indicates the 60-day advance notice is only required for mid-year, off-renewal changes. This clarification is quite a relief for employers who must get renewal figures, market coverage, and finalize changes for each plan year. (See our previous article on this topic at the following link: <http://bit.ly/qM53Ro>)

The new disclosure rules apply regardless of grandfathered status.

## Executive Summary

This *Client Bulletin* describes content requirements, distribution rules (including electronic distribution), and disclosure timeframes for this new mini plan summary, known as the “Summary of Benefits and Coverage.” Coming as no surprise, the required information does not fit on the four pages required by Congress, so the government expanded the format to four double-sided pages.

Along with the new rules, the government issued the following compliance materials:

- Model Summary of Benefits and Coverage template
- Instructions, sample language, and a guide for “coverage example calculations” to be used in completing the template
- Other supplemental materials for use by insurance carriers and group health plans to achieve compliance (See detailed content discussions and the numerous links below.)

This *Client Bulletin* emphasizes issues of particular interest to plan sponsors, along with other practical considerations when using these new documents. (The new regulations also affect individual coverage, but that topic area is not addressed in this *Bulletin*.)

## Content, Distribution and Timing

### What disclosure needs to be sent?

Employers must distribute two new items intended to help employees understand and evaluate their health insurance choices:

- A Summary of Benefits and Coverage
- A uniform glossary of terms commonly used by the plan

For the Summary of Benefits and Coverage, a standardized template stipulates the exact wording and precise format to be used. Plans and insurance carriers will simply use the template document to plug in plan-specific details. Although the 2010 law specified a four-page document, the regulations allow for up to four *double-sided* pages. A separate glossary to be provided with the Summary of Benefits and Coverage means the final document is substantially larger than originally allowed. Although the regulations did not address paper size, a good faith interpretation dictates that a “page” for this purpose is no larger than 8-1/2 × 11 inches, with normal margins. Print size must be 12-point font or larger.

For now, an employer must disclose using a separate written document. The HHS may later allow the mini plan summary to be incorporated into to other employer information (such as the longer ERISA Summary Plan Description or an employee handbook).

### Are any plans exempt?

As with other PPACA provisions, the new disclosure requirement does not apply to “excepted benefits” such as retiree-only plans and stand-alone vision or dental programs. Grandfathered plans do not escape these new disclosure rules.

### Effective date

Group health plans and health insurance carriers must comply with the new requirements for plan years starting April 1, 2012 – a mere seven months away for some plans. The federal agencies have requested comments on “the feasibility of implementation within this timeframe.” Some hope the government may postpone compliance.

### Who sends the material?

For self-insured plans, the plan sponsor (typically the employer) must prepare and distribute the new disclosure. For insured programs, insurance carriers and employers are jointly responsible for distributing the new mini summary. Many carriers will prepare and send the summary to the plan sponsor, which in turn will distribute it to the appropriate persons.

### Who receives a Summary of Benefits and Coverage? How many must be sent?

A group health plan (or insurance carrier) must provide a mini plan summary to a participant or beneficiary. A plan sponsor may send a single Summary of Benefits and Coverage when an employee and any covered family members or other beneficiaries are known to reside at the same address. If they do not reside at the same address, the plan or its carrier must send the disclosure material to that address. (See discussion of electronic disclosure, below, for those rules.)

If an employer offers multiple options for group health plan coverage, such as an HMO, a PPO, and a High Deductible Health Plan, the number of required disclosures depends on the timing:

- For the first year the new rule is in effect (in 2012 through 2013 depending on plan year), the plan or its carrier must provide a copy of the summary for each benefit option that person is eligible to elect.
- After the first year, the plan or insurance carrier is only required to provide a new disclosure for the selected plan option, unless the individual requests other plan option Summaries. (In other words, a Summary of Benefits and Coverage need not be provided automatically for benefit options the individual did not select.) If someone does request a Summary of Benefits and Coverage for any other benefit option for which he or she is eligible, the plan or carrier must provide that disclosure within seven days.

### Detailed Content Requirements

Apart from the surprising expansion of the four-page summary into eight pages, the proposed regulations closely parallel the content elements as enacted by Congress:

- Uniform definitions or a glossary of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage. For example, mandated definitions include co-insurance, copayment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network copayments, and out-of-pocket limit. A plan can simply refer to an Internet link where an individual may review and obtain the glossary. Most plans will use this approach for compliance.
- A meaningful coverage description, including cost sharing, for each category of benefits
- Exceptions, reductions, and limitations on coverage
- Cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations
- Renewability and continuation of coverage provisions
- “Coverage facts label” **Note:** The “coverage facts label” is analogous to the standardized nutrition label on most foods. An employer’s plan disclosure must include prescribed examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions)
- Minimum essential coverage statement, and an explanation of whether the plan’s share of the total allowed costs of benefits meets applicable requirements (these two requirements are delayed until 2014 plan years)
- A statement that the Summary of Benefits and Coverage 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 number to call with questions and an Internet web address where a copy of the actual plan document or group certificate of coverage can be reviewed and obtained

The regulations also add four *additional* elements to the Summary of Benefits and Coverage based on recommendations submitted by the National Association of Insurance Commissioners (NAIC):

- **Network provider directory link:** For plans that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers
- **Prescription drug formulary link:** For plans 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
- **Glossary link:** An Internet address where an individual may review and obtain the uniform glossary (see first bullet point in previous bulleted items)
- **Plan cost:** A statement addressing required premiums (or cost of coverage for self-insured group health plans)

### General Timing Rules

A plan sponsor or its carrier or administrator must deliver the Summary of Benefits and Coverage within specific time frames.

- When an employee is first eligible to enroll, usually a recent hire, the disclosure is required by the date the person is eligible to enroll.
- If a participant or beneficiary requests that information, within seven days following the request.
- Within seven days following notice of a HIPAA special enrollment.
- With enrollment materials for an employee at open enrollment, but only the summary for the option covering that person is required. Individuals may request summaries for other options, to be provided within seven days of the request. (Plan sponsors may provide the summary for each option, just to facilitate choice and to cut down on responding to requests. Also, providing complete information is arguably a fiduciary obligation.)
- If there is any change to the information required to be in the disclosure between the date provided and before the first day of coverage, the plan or carrier must update and provide a current Summary of Benefits and Coverage to a participant or beneficiary no later than the first day of coverage.
- A group health plan or health insurance carrier also must provide participants with a new summary each year when the policy is renewed (if renewal is automatic, the Summary of Benefits Coverage must be provided at least 30 days prior to renewal).

Although this rule appears geared towards insurance carrier operations, the implication is that for any benefit plans that automatically renew (whether insured or self-funded), the plan must provide the Summary of Benefits Coverage at least 30 days prior to the first day of the new plan year.

## 60-Day Advance Notice of Plan Changes – Relief under New Guidance

A troubling health reform provision requires 60-day *advance* notice of plan changes that affect the Summary of Benefits and Coverage. As passed, the law would have applied to annual plan changes at group health plan renewal, or after marketing, severely compressing the timeframe for receiving carrier renewals and for plan design or carrier change decisions to be made.

The proposed regulations provide relief from that impractical rule. The 60-day advance notice only applies to material modifications not made in connection with renewal or reissuance of coverage. In other words, only mid-year changes trigger the advance notice rule. If a change is made at renewal or when coverage is reissued (the most common times for plan changes), the 60-day advance notice is not required. (Although comments are still being solicited on this point, the implication is that this rule applies for both insured and self-funded programs.) The welcome result of this regulatory interpretation is that a 60-day advance notice of changes will only be required, for example, if there is a mid-year plan change, or an actual change of policy year or plan year.

All existing ERISA disclosure rules continue to apply, such as the Summary of Material Modification (SMM) to be provided within 60 days after plan changes that might be characterized as benefit reductions.

### Manner of delivery

Summaries may be delivered in paper and/or electronic format.

**ERISA plans and electronic disclosure.** Plans subject to ERISA may use the DOL's electronic disclosure rules to distribute the Summary of Benefits and Coverage. Although an explanation of those DOL rules exceeds the scope of this discussion, the electronic disclosure rules generally require meaningful proof of receipt of electronic delivery, evidence of the validity of the target individual's e-mail addresses, and assurance that all recipients are notified of their right to request a traditional hard copy version of the materials. In some cases, plan sponsors must also first obtain permission from the individual before using electronic disclosure. The Summary of Benefits and Coverage must reach beneficiaries as well as employees, and satisfying the criteria for compliant electronic distribution for those individuals could be especially daunting.

**Non-ERISA plans and electronic disclosure.** For programs not subject to ERISA, the regulations allow the Summary of Benefits and Coverage to be provided electronically if the "substance" of the provisions of the Department of Labor's electronic disclosure rules is satisfied.

The proposed regulations also specifically allow the Summary of Benefits and Coverage to be distributed along with other employer notifications. So, it could be included in the same envelope as other items or as an attachment or link provided with other electronic documents. However, even when sending the Summary of Benefits and Coverage with other materials, the Summary of Benefits and Coverage should be treated as a separate, free-standing electronic file or document.

### **Readability and the language rule: “culturally and linguistically appropriate”**

The Summary of Benefits and Coverage must use language that the “average” plan enrollee will understand – a standard that closely corresponds to the long-standing ERISA requirement that SPDs be “calculated to be understood by the average plan participant.” The Summary of Benefits and Coverage is designed to deliver information at a far more simplified reading level than the typical ERISA Summary Plan Description.

The new Summary of Benefits and Coverage also must be presented in a “culturally and linguistically appropriate manner.” This requirement refers to non-English languages. A group health plan (or insurance carrier) must both provide interpretive services (translators) and provide written non-English versions of the Summary of Benefits and Coverage upon request. These requirements apply if an employee or beneficiary resides\* in specified counties where ten percent or more of the county’s resident population is literate only in the same non-English language. In these counties, English versions of the new disclosure must state the availability of language services in the relevant, non-English language. As a result, in designated counties in which there are a significant number of Spanish-speaking residents, for example, the Summary of Benefits Coverage must include a statement in the appropriate language disclosing interpretive and translation services available. (The new Summary of Benefits and Coverage language rules require more than ERISA, which has traditionally required minimal translation assistance and statements in foreign languages offering assistance.)

\*Although the language rule appears to be triggered depending on county of worker residence, the agencies requested comments on whether and how translations of the Summary of Benefits Coverage should be made available. Further clarification of this point may be forthcoming. In addition, the government published a chart with county-by-county measures of locations that would be affected by the rule. See, at page 37221: <http://1.usa.gov/kaHMpL>

### **Compliance risk areas**

The new disclosure rule needs to be managed carefully. ERISA duties will still require Summary Plan Descriptions (SPD) and Summary Material Modifications (SMM). Plan sponsors should ensure that the new mini summary is exactly “in sync” with provisions reflected in the SPD and plan document (if separate). If a legal challenge erupts over interpretation of an ambiguous plan provision, a court or arbitrator can be expected to examine all relevant documents (including the new Summary of Benefits and Coverage) and may selectively apply wording from among those documents that most closely supports the participant’s point of view. (Courts categorize plan disclosures as contracts, which often are interpreted to favor the party that did not have the opportunity write or negotiate the contract – the employee or covered family member in the context of benefit plans.)

### Applicable penalties

A penalty of up to \$1,000 per failure can be assessed on insurance carriers and plan sponsors (for self-insured health plans) who do not provide the new summaries on a timely basis. The fine cannot be passed along to participants or paid from plan assets.

**Example:** Acme sponsors the Acme Group Health Plan, a self-insured plan with 1,000 enrollees. Acme fails to distribute new summaries to ten enrollees (a mere one percent failure rate). Acme is subject to a penalty of up to \$10,000 for these failures (\$1,000 for ten separate failures).

Other employer penalties may apply, particularly for ERISA plans. Moreover, individuals may also have a cause of action for breach of fiduciary duty under ERISA on the basis of the plan sponsor's failure to satisfy the PPACA rule.

### Conclusion

The new disclosure requirement creates a new paperwork burden on affected plan sponsors. However, the requirement should, at least theoretically, provide plan participants and beneficiaries with clear and consistent information about health care coverage and choices.

The HUB International compliance team will continue to closely monitor and provide additional commentary on this proposed rule.

### Helpful links

More information about the proposed regulation is available at: <http://1.usa.gov/qjOaR8>

To view the proposed template for the Summary of Benefits and Coverage, visit: <http://1.usa.gov/qCmYkh>

To view the Notice of Proposed Rulemaking or learn how to submit public comment, visit Summary of Benefits and Coverage and Uniform Glossary (PDF -385 KB) <http://bit.ly/qnIiYL>

Other technical information is available at: <http://cciio.cms.gov/>

For general information about complying with the language rules, HHS cites the following link: <http://1.usa.gov/4FzUo7>

The HHS relied heavily on the NAIC proposed draft Summary of Benefits and Coverage in formulating its regulations. The NAIC document may be found at the following links <http://bit.ly/jVZxIL>

The sample uniform glossary will be posted at the following links [www.HealthCare.gov](http://www.HealthCare.gov) and [www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/)

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