

August 19, 2011



Legislative Update

Forest Financial Group is pleased to offer updates focusing on legislation changes and decisions that impact our clients. It is important to us that our clients are kept abreast of changes in both Washington and Springfield that apply to employee benefits.

FFG aims to provide you with a better understanding of our healthcare system, our federal and statutory laws, and our industry regulations. We hope you find this information valuable to the administration of your benefits program.



HHS Announces Proposed Rule for Uniform Benefit Summaries

On August 17, the Department of Health and Human Services (HHS) released a Notice of Proposed Rulemaking for Uniform Benefit Summaries under the Patient Protection and Affordable Care Act (PPACA).

The intent of Uniform Benefit Summaries is to provide individuals with standard information so they can review medical plans, compare insurers and make decisions about which medical plan to choose. The proposed rule provides additional guidance on the information that must be provided to all individuals enrolling in a medical plan on or after March 23, 2012.

This provision applies to individual and employer-sponsored medical plans, regardless of grandfathered status or funding. It does not apply to retiree-only plans or to standalone dental and vision plans.

What Information Must be Included

Insurers and self-insured employers must provide a Summary of Benefits and Coverage (also referred to as an 'SBC' in the proposed rule) to individuals who apply for and enroll in medical plans. The Summary of Benefits and Coverage is a required document that must be provided in the standard format.

There are four standard components:

- A four-page Benefit Summary (double sided)
- Medical Scenarios called "Coverage Examples" that are patterned after the Food and Drug Administration food labels. They estimate customer costs based on the specific plan's benefits for three medical scenarios – Maternity, Breast Cancer Treatment and Managing Diabetes
- A standard glossary of medical and insurance terms
- A phone number and website where individuals can get additional information including documents such as Certificates, Summary Plan Descriptions (SPDs) and policies

HHS asked the National Association of Insurance Commissioners (NAIC) to propose a format for the four components in the Summary of Benefits and Coverage. Here is a link to the documents proposed by NAIC: http://www.naic.org/committees_b_consumer_information.htm

The information on the NAIC website is not a guideline or example. It is the exact wording, format and layout that must be used. Insurers and employers will just insert plan details into the predetermined rows and columns.

The Benefit Summary must be a freestanding document and may not be incorporated into any other document. Supplemental communication materials may be provided with it. Currently produced documents will not satisfy the requirements of the regulation.

The Coverage Examples must include three pre-defined medical scenarios: Maternity, Breast Cancer Treatment and Managing Diabetes. These scenarios are intended to show typical services and cost sharing under the plan. The numbers would be based on client-specific plans and costs. The estimates are based on national average costs and in-network benefit levels.

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Who is Responsible for Providing the Information

For fully insured plans and HMOs, the insurer is responsible for producing and distributing the summaries. For self-insured plans, the responsibility lies with the employer.

What is the Required Timing

Summaries must be provided when an employer or individual requests information about a plan, applies for coverage or enrolls in a plan. They must also receive a summary if there are plan changes or if the individual has a HIPAA special enrollment event that prompts a new enrollment opportunity.

People enrolled in a health plan must be notified of any significant changes to the terms of coverage reflected in the Summary of Benefits and Coverage at least 60 days prior to the effective date of the change. This timing applies only to changes that become effective during the plan or policy year but not to changes at renewal (the start of the new plan or policy year).

How Benefit Summaries will be Delivered

Summaries are required both before and after enrollment and may be delivered in paper and/or electronic format. There are specific requirements for group vs. individual plans.

Penalty for Non-Compliance

The penalty for 'willful' non-compliance is up to \$1,000 per enrollee for each failure to comply.

Next Steps

Comments on this proposed rule – including the specific request for expatriate plans – are due 60 days from the publish date.

Source: Cigna