HEALTHCARE OVERHAUL:
Impact of SBC Disclosure Requirements on EAPs

Puneet Leekha, J.D.

Senior Associate
Popovits & Robinson, P.C.

Assistant General Counsel
Chestnut Global Partners, LLC

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HEALTH REFORM

Primer on Affordable Care Act

- Patient Protection and Affordable Care Act ("ACA")
  - Signed into law on March 23, 2010
  - Upheld by U.S. Supreme Court on June 28, 2012
- Most significant government expansion and regulatory overhaul of U.S. healthcare system since passage of Medicare and Medicaid in 1965
- Focus:
  - Decreasing number of uninsured Americans
  - Reducing overall costs of healthcare

Primer on Affordable Care Act *(cont'd)*

- Individual mandate
- Medicaid expansion
- Health insurance exchanges
  - Premium and cost-sharing subsidies depending on income
- New insurance regulations
- Employer requirements
  - Penalties on businesses that fail to insure employees in certain circumstances

Primer on Affordable Care Act *(cont'd)*

Triple Aim of Health Reform:

Better healthcare 	Improving **patients**' experience of care within the Institute of Medicine's 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency,* and *Equity.*
Better health 	Keeping patients well so they can do what they want to do. Increasing the overall health of **populations**: address behavioral risk factors; focus on preventive care.
Reduced costs 	Lowering the total cost of care while improving quality, resulting in reduced monthly expenditures for Medicare, Medicaid, and CHIP beneficiaries. Supporting **new models of payment**.

Primer on Affordable Care Act *(cont'd)*

Better healthcare

Improving **patients**' experience of care within the Institute of Medicine's 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency,* and *Equity.*

Strong consumer protections

Consumer tools to help make informed choices about their health

- Vital consumer tool in ACA: Summary of Benefits and Coverage ("SBC")

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Disclaimers (The Fun Stuff…)

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  - The information provided in this presentation is not legal advice, but general educational information based on the sources attributed
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  - Review of this presentation is not a substitute for seeking the advice of legal counsel
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SUMMARY OF BENEFITS AND COVERAGE

Statutory Mandate for SBC

- Public Health Service Act § 2715, added by the ACA, required the U.S. Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, the "Departments") to develop standards for use by a group health plan and a health insurance issuer in compiling and providing a SBC that "*accurately describes the benefits and coverage under the applicable plan*"

- On February 14, 2012, the Departments published final regulations regarding the SBC ("Final Regulations")

What is the SBC?

- One of the most vital consumer tools in ACA
- SBC
  - Document that describes in an easy-to-understand way the benefits and coverage under the applicable plan
- Glossary of Health Coverage and Medical Terms ("Uniform Glossary")
  - ACA also required development of uniform glossary of standard definitions for insurance and medical terms

Who Needs to Provide the SBC?

- Health insurance issuers

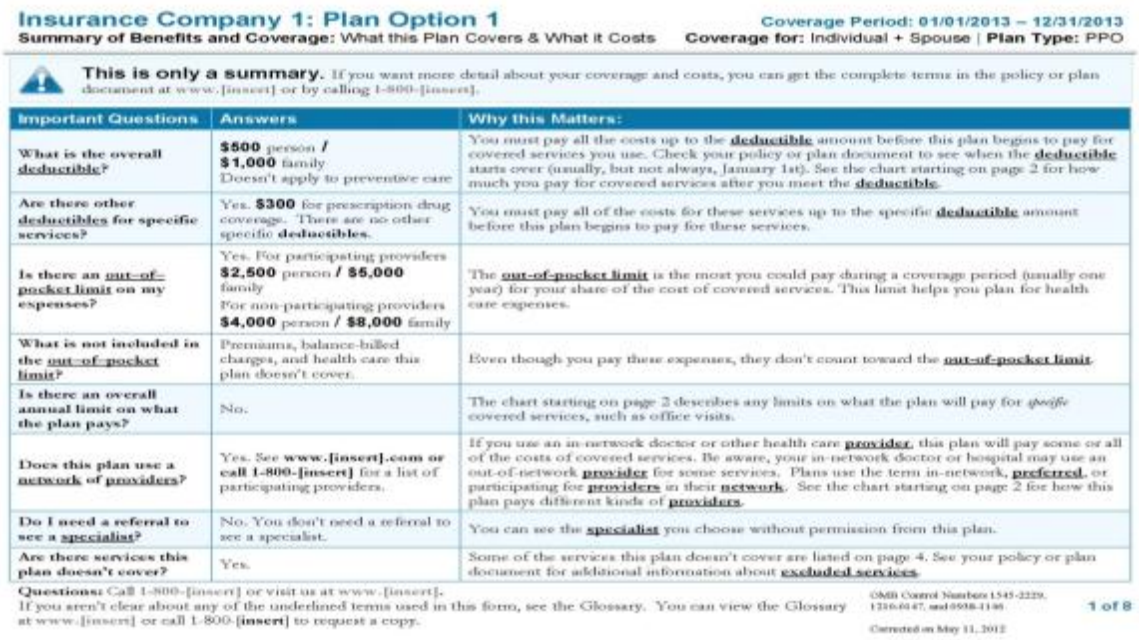
- Group health plans offering group or individual health insurance coverage
  - “Group health plan” is an employee welfare benefit plan established or maintained by an employer or by an employee organization, or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise

What Does the SBC Look Like?

- Final Regulations require insurance companies and group health plans to use a template SBC and Uniform Glossary
  - Published by the Departments on the DOL website
  - Rationale: To facilitate transparency and uniformity across the board so consumers can better understand their health insurance options

What Does the SBC Look Like? *(cont'd)*

- Sample completed SBC for first year of applicability:
  - www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC.pdf



Insurance Company 1: Plan Option 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

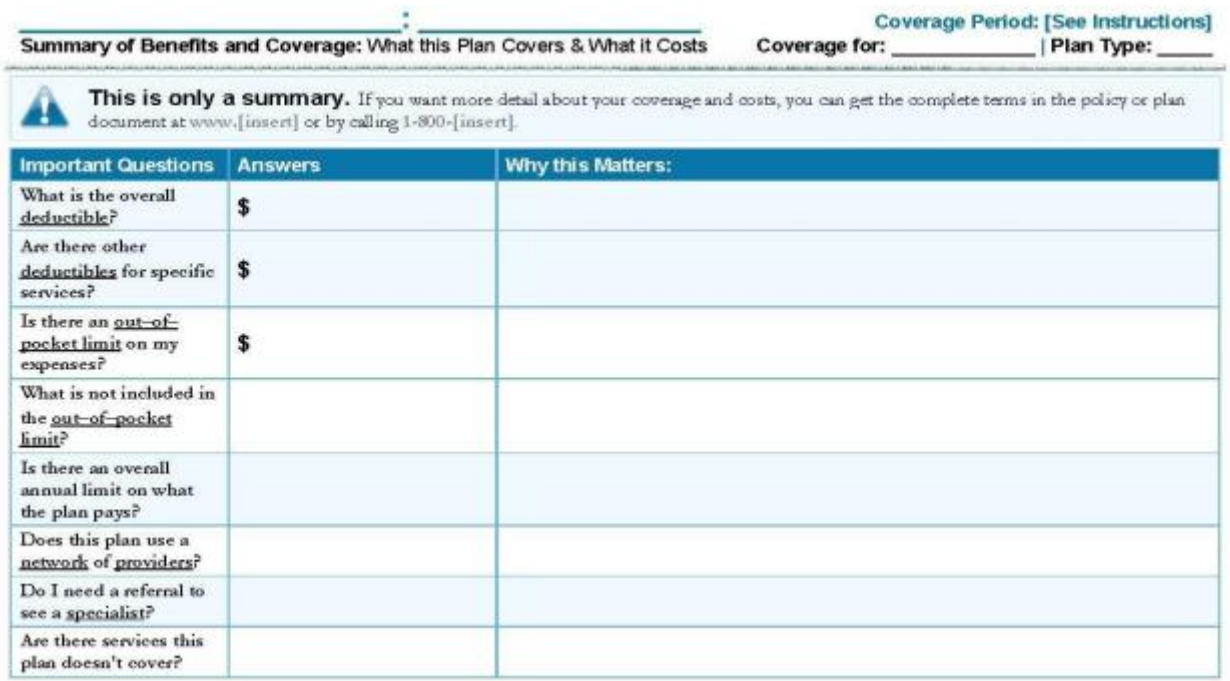
OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

1 of 8

Corrected on May 11, 2012

What Does the SBC Look Like? *(cont'd)*

- SBC template for second year of applicability:
  - www.dol.gov/ebsa/pdf/correctedsbctemplate2.pdf



_____: _____ Coverage Period: [See Instructions]

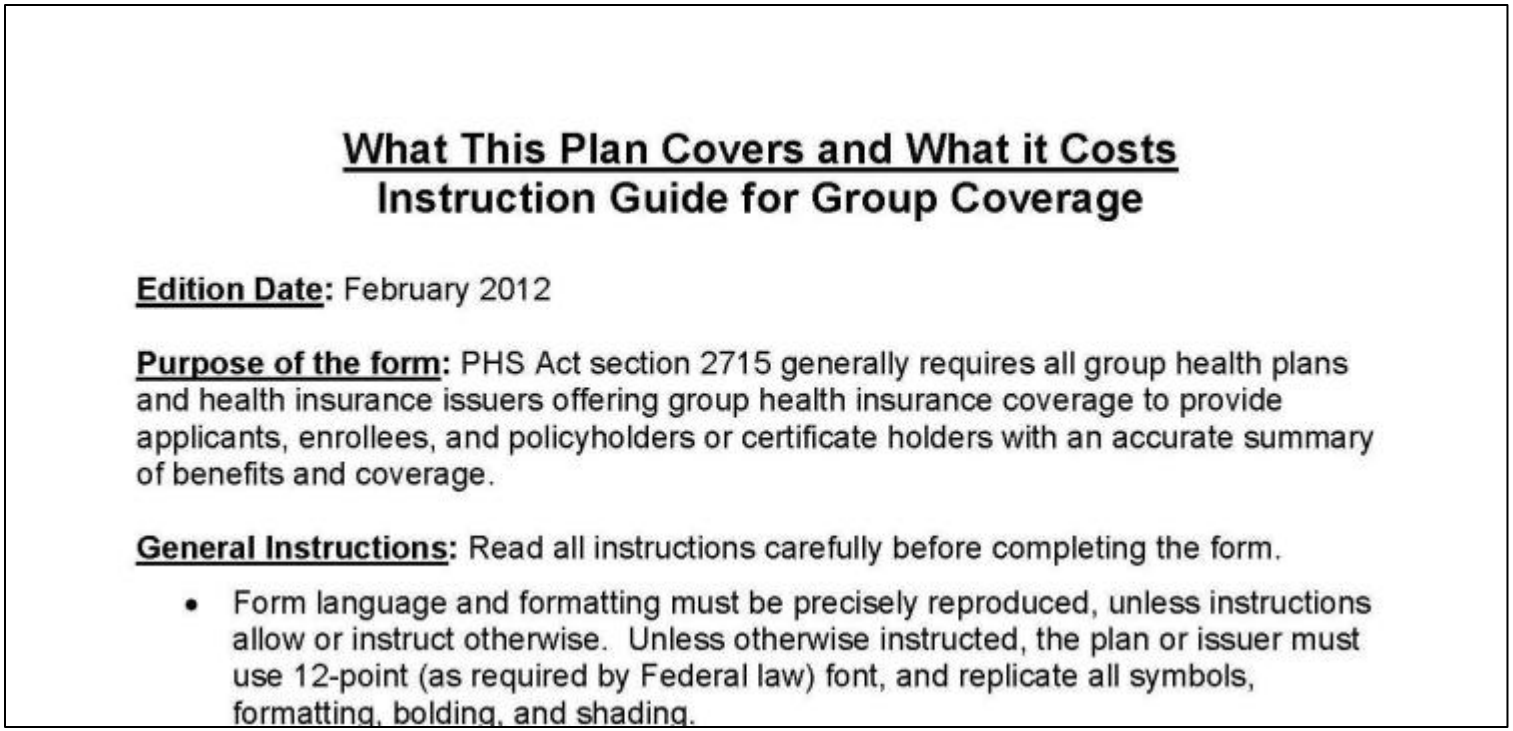
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** _____ | **Plan Type:** _____

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$	
Are there other deductibles for specific services?	$	
Is there an out-of-pocket limit on my expenses?	$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the plan pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

What Does the SBC Look Like? *(cont'd)*

- SBC instructions for group health plans:
  - www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf



What This Plan Covers and What it Costs
Instruction Guide for Group Coverage

Edition Date: February 2012

Purpose of the form: PHS Act section 2715 generally requires all group health plans and health insurance issuers offering group health insurance coverage to provide applicants, enrollees, and policyholders or certificate holders with an accurate summary of benefits and coverage.

General Instructions: Read all instructions carefully before completing the form.

- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the plan or issuer must use 12-point (as required by Federal law) font, and replicate all symbols, formatting, bolding, and shading.

What Does the SBC Look Like? *(cont'd)*

- Uniform Glossary:
  - www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health

Consumer Rights

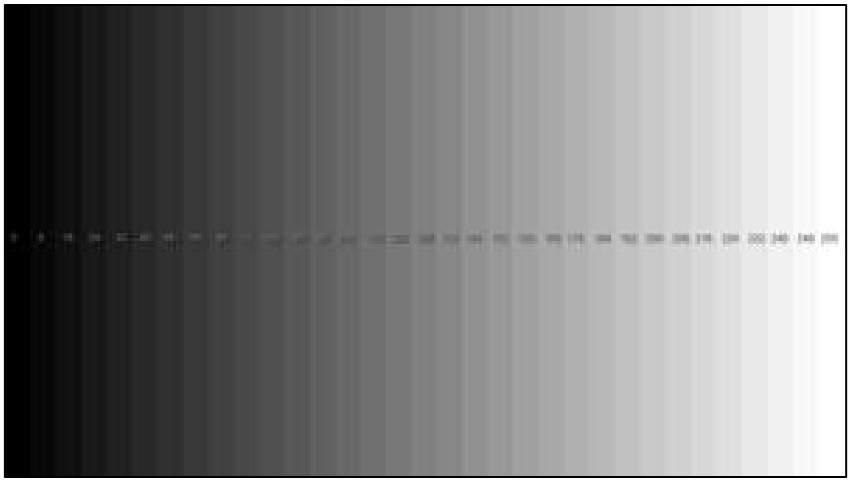
- Every consumer has right to receive SBC and Uniform Glossary when shopping for/enrolling in coverage

- Consumers may also request SBC or Uniform Glossary from health insurer or group health plan

APPLICABILITY OF SBC DISCLOSURE REQUIREMENTS TO EAPS

Do EAPs Need to Comply?

- Whether or not an employee assistance program ("EAP") needs to comply with SBC disclosure requirements is **less of a gray area** now than it was prior to the ACA



Do EAPs Need to Comply? *(cont'd)*

- *Generally*, only EAPs that provide **medical care** are considered **employee welfare benefit plans**, and therefore fall within the meaning of **group health plans** that are subject to SBC disclosure requirements

- **Medical care** includes:
  - Diagnosis, cure, mitigation, treatment or prevention of disease or care that affects any structure or function of the body

Do EAPs Need to Comply?: KEY

- In basic terms, whether an EAP must comply with the ACA SBC disclosure requirements turns on the type of services it provides

IF…	THEN…
Medical Care Provided	SBCs Required
Referral to Medical Care	SBCs NOT Required

Examples

- A group health plan with the following components must comply with ERISA, and therefore with SBC reporting requirements:
  - Wellness program
  - Health risk assessment that provides medical recommendations
  - Onsite health clinic that provides medical care

PRACTICAL IMPACT OF SBC DISCLOSURE REQUIREMENTS ON EAPS: COMMON QUESTIONS

Practical Implications for EAPs

- As clear cut as it might sound, several questions arise about practical impact of ACA SBC disclosure requirements on EAPs

- REMINDER:
  - This information is only relevant to those EAPs that provide **medical services** and are therefore considered **group health plans**

QUESTION 1

Q: *When do/did we have to start complying with the SBC disclosure requirements?*

A: First day of first plan year that begins on or after September 23, 2012

- This is because EAP participants and their beneficiaries are enrolled automatically in an EAP and not through an open-enrollment period

QUESTION 2

Q: *How often do we have to furnish a SBC?*

A: On the following dates:

- On or before the day coverage begins
- Within 7 days of your receipt of a request by a participant or beneficiary
- At least 30 days before start of each new plan year
- Within first 90 days of coverage in the case of special enrollees
  - "Special enrollees" are new participants or newly-eligible participants who become enrolled in the middle of plan year

* Timelines based on date SBC is <u>sent</u>

QUESTION 3

Q: *What if we modify our plan after we furnish a SBC?*

A: If you make a material change to any terms of your plan, you must provide notice of the modification(s) to participants and beneficiaries at least 60 days before the effective date of the modification(s)

- Example: enhancement in covered services or more generous plan or policy terms
  - i.e., reduced cost-sharing or coverage of previously excluded benefits
- Example: Reduction in covered services or more strict requirements for receiving benefits
  - i.e., new referral requirement or increased premiums or cost-sharing

QUESTION 4

Q: *Do we distribute the completed SBC or do our employer-customers?*

A: Onus is on the group health plan, meaning the EAP, to distribute the SBC

- It is the obligation of the EAP to complete and distribute the SBC to the required recipients in accordance with the SBC disclosure requirements
- *However*, Final Regulations contain an "anti-duplication rule"
  - Your obligation to furnish an SBC to an individual is considered satisfied if another party (perhaps your employer-customer) provides a timely and complete SBC to that individual

QUESTION 5

Q: *Who do we distribute the completed SBC to?*

A: To each participant, their beneficiaries, and special enrollees

- Per the anti-duplication rule, a single SBC may be provided to a family unless any beneficiaries are known to reside at a different address

QUESTION 6

Q: *Can we distribute SBCs electronically?*

A: You can distribute SBCs by mail **or** electronically, but electronic distribution has certain restrictions

- Permitted electronic methods:
  - E-mail
  - Intranet posting
  - Password-protected Internet posting
- Must take measures to ensure recipients actually receive
- Must obtain consent to distribute electronically from those who do not have routine work-related access to a computer
  - Requirements for how consent should be obtained and what information consent needs to have
- Must also send notice of significance of SBC and right to request paper copy (see next slide)

QUESTION 6 *(cont'd)*

Departments provided model language to be used in the notice of significance of SBC and right to request paper copy:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

QUESTION 7

Q: *What if my state has a law about SBCs that conflicts with the ACA?*

A: To the extent your state law allows for *less* information to be supplied to consumers, SBC provisions of the ACA will preempt your state law

- So, you must comply with whatever law requires more information to be provided to consumers

QUESTION 8

Q: *What information does a SBC need to contain?*

A: Final Regulations refer to template SBC that all group health plans must use

- Allows for side-by-side comparisons regarding available coverage options
- Viewed as the most comprehensible way to depict plan's coverage
- Found on DOL website: www.dol.gov/ebsa/pdf/correctedsbctemplate.pdf

QUESTION 8 *(cont'd)*

SBC MUST CONTAIN:
Description of coverage for each category of essential health benefits ("EHBs") and other benefits identified by HHS
Coverage exceptions, reductions, and limitations
Cost-sharing provisions (deductibles, co-insurance, co-payments)
Renewability and continuation of coverage provisions
Examples of common benefit scenarios based on clinical practice guidelines
On or after January 1, 2014, statement of whether plan or coverage meets minimum essential coverage and whether plan or coverage meets minimum value requirements
Statement that SBC is only a summary and that the plan document, policy, insurance certificate, or contract should be consulted to determine governing contractual provisions
Contact information
Internet address or similar contact information for obtaining a list of network providers

QUESTION 8 *(cont'd)*

What are EHBs?

- ACA requires "qualified health plans" offered in the individual and small group markets, both inside and outside of health insurance exchanges, to offer a comprehensive package of items and services, or EHBs
- Medicaid benchmark and benchmark equivalent plans will also need to offer EHBs

QUESTION 8 *(cont'd)*

Mandatory EHB categories within which items and services must be offered:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services, preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

QUESTION 8 *(cont'd)*

ACA allows each state to choose a "benchmark plan" from plans currently offered in the state to be the basis for most individual and small market plans sold in that state

- Must include services in all EHB categories
- Plans sold both inside and outside of health insurance exchanges must offer coverage that is of equal or greater value than the "benchmark plan"

QUESTION 9

Q: *Do we need to include in the SBC coverage for services provided to expatriates?*

A: You may list an Internet address or similar contact information to allow participants to obtain information about benefits provided outside the U.S. No need to provide summary of coverage in the SBC.

- To the extent plan provides coverage available within the U.S., however, must include that coverage in your SBC

QUESTION 10

Q: *What should we do if certain fields on the SBC template do not apply to our EAP?*

A: Sometimes, the terms of a group health plan cannot be described in a way that is consistent with the SBC template. Especially true for EAPs. You must still:

- *Accurately* describe your plan terms
- Using your *best efforts*
- In a manner that is *consistent with the instructions and template format* to the extent *reasonably* possible

QUESTION 11

Q: *What if we have not complied with the SBC disclosure requirements under the ACA thus far (in the first year of applicability)?*

A: For the first year of applicability, no penalties will be assessed to group health plans that work in *good faith* to provide the required SBC content

- Penalties are only imposed for *willful* failure to provide required information

QUSTION 12

Q: *What if we don't comply with the SBC disclosure requirements under the ACA in the second year of applicability?*

A: Departments extended several areas of relief to the second year of applicability for group health plans that work in good faith to provide the required SBC content

- Departments are focusing on working together with employers, issuers, states, providers and other stakeholders to come into compliance with the new laws
- Departments' approach to implementation emphasizes assisting, rather than imposing penalties, on plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new laws
- *See* DOL FAQs about the Affordable Care Act Implementation Part XIV, FAQ 5, for areas of extended relief (available at www.dol.gov/ebsa/faqs/faq-aca14.html#footnotes)

QUESTION 13

Q: *What are some additional resources on ACA SBC disclosure requirements?*

A: DOL website (links to regulations, additional FAQs, templates, and instructions) and EAPA website (sample SBC template and additional FAQs)

QUESTIONS?

Puneet Leekha, J.D.

Senior Associate
Popovits & Robinson, P.C.

Assistant General Counsel
Chestnut Global Partners, LLC

20635 Abbey Woods Court
Suite 301
Frankfort, Illinois 60423
(708) 479-3230 (Phone)
(708) 479-3236 (Fax)
puneet@popovitslaw.com

www.popovitslaw.com