Health Care Reform Update

Additional FAQs Released on Summary of Benefits and Coverage

The Affordable Care Act (ACA) requires health plans and health insurance issuers to provide a summary of benefits and coverage (SBC) to applicants and enrollees. The SBC is intended to be a short, simple explanation about the health plan’s benefits and coverage than can help consumers more easily compare plan options.

On April 23, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) issued Frequently Asked Questions (http://www.dol.gov/ebsa/faqs/faq-aca14.html) (FAQs Part XIV) on the SBC requirement for the second year of its applicability. This guidance has been provided in addition to the final regulations (http://www.regulations.gov/#!documentDetail;D=HHS_FRDOC_0001-0442) issued on Feb. 14, 2012 and three prior sets of FAQs related to the SBC rules (FAQs Parts VIII, IX and X).

The new FAQs address issues related to providing SBCs in the second year of applicability, including:

- Changes made to the templates for the SBC and the uniform glossary;
- Transition relief with respect to the minimum essential coverage and minimum value disclosure requirements;
- Extension of certain existing SBC safe harbors and other enforcement relief applicable for first year SBCs; and
- An “anti-duplication” rule for student health insurance coverage.

This Legislative Brief contains the FAQs Part XIV. Please contact BB&T Insurance Services for more information on prior FAQs related to the SBC requirement.

SBC EFFECTIVE DATE

Plans and issuers must start providing the SBC as follows:

- Issuers must provide the SBC to health plans effective Sept. 23, 2012.
- Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first day of the first open enrollment period that begins on or after Sept. 23, 2012.
- For participants who enroll in coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees), plans and issuers must provide the SBC beginning on the first day of the first plan year that begins on or after Sept. 23, 2012.

OVERVIEW OF FAQS PART XIV

In conjunction with the final regulations issued on Feb. 14, 2012, the Departments published a notice announcing the availability of templates, instructions and related materials for use in the first year of applicability (that is, for SBCs...
and the uniform glossary provided with respect to coverage beginning before Jan. 1, 2014). However, these documents do not include language for the required statement in the SBC regarding:

- Whether a plan or coverage provides minimum essential coverage (MEC); and
- Whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value (MV) requirements.

When these documents were first released, the Departments stated that updated materials would be issued for later years. The FAQs Part XIV contain these updated materials that can be used in the second year of applicability. In the FAQs, the Departments explain the changes that have been made and how these documents can be used to comply with the SBC requirement.

Q1: What templates should plans and issuers use for the SBCs and the uniform glossary required to be provided after the first year of applicability?

An updated SBC template (and sample completed SBC) are now available on the Center for Consumer Information & Insurance Oversight (CCIIO) website (http://cciio.cms.gov/) and the DOL website (http://www.dol.gov/ebsa/healthreform/). These documents are authorized for use with respect to group health plans and group and individual health insurance coverage for SBCs provided with respect to coverage beginning on or after Jan. 1, 2014, and before Jan. 1, 2015 (referred to in this document as "the second year of applicability").

The only change to the SBC template and sample completed SBC is the addition of statements of whether the plan or coverage provides MEC (as defined under section 5000A(f) of the Internal Revenue Code) and whether the plan or coverage meets the MV requirements (that is, the plan’s or coverage’s share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs). On page 4 of the SBC template (and illustrated on page 6 of the sample completed SBC), a plan or issuer should indicate in the designated entry on the SBC template that the plan or coverage “does” or “does not” provide MEC and whether the plan or coverage “does” or “does not” meet applicable MV requirements.

There are no changes to the uniform glossary, the Instructions for Completing the SBC (for either group or individual health coverage), “Why This Matters” language for the SBC or the coverage examples.

Q2: Our plan is already working on the process of preparing SBCs for issuance in the second year of applicability and it would be an administrative burden to add the new data element to the template at this point in the process. Is any relief available to provide information about MEC and MV without changing the SBC template?

Yes. To the extent a plan or issuer is unable to modify the SBC template for disclosures required to be provided with respect to the second year of applicability, the Departments will not take any enforcement action against a plan or issuer for using the template authorized for the first year of applicability, provided that the SBC is furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan’s or coverage’s share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV requirement under the ACA. The language for these statements is as follows:

**Does this Coverage Provide Minimum Essential Coverage?**
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy [does/does not] provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**
Q3: A previous FAQ (http://www.dol.gov/ebsa/faqs/faq-aca8.html) stated that the Departments intended to make changes to the SBC template for 2014 to be consistent with the ACA’s requirement to eliminate all annual limits on essential health benefits. Have the Departments made any changes related to this requirement?

No. As stated earlier, the only change to the SBC template and sample completed SBC is the addition of information to indicate whether the plan or coverage provides MEC and whether the plan’s or coverage’s share of the total allowed costs of benefits provided under the plan or coverage meets applicable MV requirements under the ACA.

Plans and issuers should continue to complete the SBC template consistent with the Instructions for Completing the SBC (for either group or individual health coverage, as applicable) for the Important Questions chart that appears on page 1 of the SBC:

- In the Answers column, the plan or issuer should respond “No,” where the template asks, “Is there an overall annual limit on what the plan pays?”, as plans and issuers are generally prohibited from imposing annual limits on the dollar value of essential health benefits for plan years (in the individual market, policy years) beginning on or after Jan. 1, 2014. See 26 CFR 54.9815-2711(a)(2) and (f); 29 CFR 2590.715-2711(a)(2) and (f); and 45 CFR 147.126(a)(2), (d) and (f).

- In the Why This Matters column, the plan or issuer must show the following language: “The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.” (A plan or issuer is not prohibited from placing annual or lifetime dollar limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law. See 26 CFR 54.9815-2711(b); 29 CFR 2590.715-2711(b); and 45 CFR 147.126(b); see also ACA section 1302(b) and its implementing regulations at 45 CFR 156.100 et seq.)

Additionally, as applicable, plans and issuers should continue to include information regarding annual or lifetime dollar limits on specific covered benefits as required in the chart starting on page 2 of the SBC (in the Limitations & Exceptions column), as described in the Instructions for Completing the SBC (for either group or individual health coverage, as applicable).

To the extent a plan or issuer wishes to modify the SBC template for disclosures required to be provided for the second year of applicability to remove this information, the Departments will not take any enforcement action against a plan or issuer for removing the entire row in the Important Questions chart on page 1 of the SBC (with the question: “Is there an overall annual limit on what the plan pays?”).

Q4: A previous FAQ (http://www.dol.gov/ebsa/faqs/faq-aca8.html) stated that the Departments intended to add additional coverage examples for 2014. Have the Departments made any changes related to this requirement?

To help transition to new market changes in 2014, the Departments believe it is prudent to maintain the current coverage examples. Additional coverage examples are not required as part of the SBC at this time. As with the SBC authorized for the first year of applicability, the documents authorized for the second year of applicability continue to require the same two coverage examples authorized for the first year of applicability – having a baby (normal delivery) and managing type 2 diabetes (routine maintenance of a well-controlled condition).

Q5: Safe harbors and other enforcement relief were provided by the Departments related to the requirement to provide an SBC and a uniform glossary for the first year of applicability. Will this relief be extended?

Yes. As stated in previous FAQs, the Departments’ basic approach to ACA implementation is: “[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended.

This Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. Design © 2013 Zywave, Inc. All rights reserved. BK 4/13
Compliance assistance is a high priority for the Departments. Our approach to implementation is, and will continue to be, marked by an emphasis on 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 law. “ (See FAQs Part I, Q1 (http://www.dol.gov/ebsa/faqs/faq-aca.html); FAQs Part VIII, Q2 (http://www.dol.gov/ebsa/faqs/faq-aca8.html); and FAQs Part IX, Q8 (http://www.dol.gov/ebsa/faqs/faq-aca9.html).) In recognition of and to ensure a smooth transition to new market changes in 2014, the Departments believe it is prudent to extend the following enforcement relief to apply through the end the second year of applicability:

- **ACA Implementation FAQs Part VIII**, Q2 (http://www.dol.gov/ebsa/faqs/faq-aca8.html) (regarding the Departments’ basic approach to implementation of the SBC requirements during the first year of applicability);
- **ACA Implementation FAQs Part IX**, Q1 (http://www.dol.gov/ebsa/faqs/faq-aca9.html) (regarding the circumstances in which an SBC may be provided electronically);
- **ACA Implementation FAQs Part IX**, Q8 (http://www.dol.gov/ebsa/faqs/faq-aca9.html) (regarding penalties for failure to provide the SBC or uniform glossary);
- **ACA Implementation FAQs Part IX**, Q9 (http://www.dol.gov/ebsa/faqs/faq-aca9.html) (regarding the coverage examples calculator and related information on use of the coverage examples calculator);
- **ACA Implementation FAQs Part IX**, Q10 (http://www.dol.gov/ebsa/faqs/faq-aca9.html) (regarding an issuer’s obligation to provide an SBC with respect to benefits it does not insure); and
- **ACA Implementation FAQs Part IX**, Q13 (http://www.dol.gov/ebsa/faqs/faq-aca9.html) (regarding expatriate coverage) and FAQs Part XIII (http://www.dol.gov/ebsa/faqs/faq-aca13.html) (which provides broader relief to expatriate coverage that is group health insurance. For self-insured expatriate coverage, this guidance extends the enforcement relief for the SBC to the second year of applicability).

In addition, the following enforcement relief continues to apply through the second year of applicability, consistent with existing guidance:

- **ACA Implementation FAQs Part IX**, Q1 (http://www.dol.gov/ebsa/faqs/faq-aca9.html) (regarding the circumstances in which an SBC may be provided electronically); and

Additionally, ACA Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements) applies “until further guidance is issued.” The relief provided in this ACA Implementation FAQs Part VIII, Q5, continues to apply, and plans and issuers may rely on this relief at least through the end of 2014.

This guidance supersedes any previous subregulatory guidance (including FAQs) stating that enforcement relief for the SBC and uniform glossary requirements is limited to the first year of applicability.
Q6: A previous FAQ [http://www.dol.gov/ebsa/faqs/faq-aca9.html] provided an enforcement safe harbor until Sept. 23, 2013, for plans and issuers with respect to insurance products that are no longer being offered for purchase (“closed blocks of business”). Will this relief be extended?

Yes. The relief provided in this FAQ extends this date to Sept. 23, 2014, for plans and issuers with respect to an insured product that meets three conditions:

- The insured product is no longer being actively marketed;
- The health insurance issuer stopped actively marketing the product prior to Sept. 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and
- The health insurance issuer has never provided an SBC with respect to the insured product.

That is, if a health insurance product is not being actively marketed and the health insurance issuer has not actively marketed the product at any time on or after Sept. 23, 2012, the Departments will not take any enforcement action against the plan or issuer for failing to provide an SBC before Sept. 23, 2014, with respect to a product, provided the SBC is provided for that product no later than Sept. 23, 2014.

However, if an insured product was actively marketed for business on or after Sept. 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the insured product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and the final regulations.

Q7: The final regulations regarding the SBC included an anti-duplication provision for group health coverage clarifying that an entity required to provide an SBC would be considered to have satisfied that requirement with respect to an individual if another party provides a timely and complete SBC. Is a similar anti-duplication rule applicable for student health insurance coverage?

Yes. On March 21, 2012, HHS issued a final rule establishing requirements for student health insurance coverage. See 45 CFR 147.145, published at 77 FR 16453 (March 21, 2012). The final rule defines student health insurance coverage as a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer. See 45 CFR 147.145(a). HHS is extending the anti-duplication rule for group health coverage set forth in the final SBC regulations to student health insurance coverage, as defined in in 45 CFR 147.145(a). Therefore, the requirement to provide an SBC with respect to an individual will be considered satisfied for an entity (such as an institution of higher education) if another party (such as a health insurance issuer) provides a timely and complete SBC to the individual.

Source: Departments of Health and Human Services, Labor and Treasury