2012-14

March 22, 2012

BENEFIT NEWS BRIEFS

DOL Releases 24 FAQs on the SBC

The DOL released 24 new FAQs aimed specifically at the new Summary of Benefits and Coverage (SBC) required by the *Affordable Care Act (ACA).* As reported on in *Client Bulletin 2012-08*, the SBC regulation has a delayed compliance date of the first Plan Year beginning on or after September 23, 2012.

> Individuals who are responsible for the preparation of SBCs will want to read each of these FAQs as they provide welcome guidance on distribution, formatting and other matters.

The FAQs provide helpful details regarding the preparation an SBC. The FAQs reinforce that "compliance" not "enforcement" will be the DOLs focus the first year that the SBC requirements are in place. This attitude of "helpfulness" should bring some calm to nervous plan sponsors. FAQ 2 asks: "*What is the Departments' basic approach to implementation of the SBC requirement during the first year of applicability*?"

> The Departments' basic approach to ACA implementation, as stated in a previous FAQ (see http://www.dol.gov/ebsa/faqs/faq-aca.html), 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. 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. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices."*

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> In addition to the general approach to implementation, in the instructions for completing the SBC, we stated: *"To the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms. This may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program."*
>
> Consistent with this guidance, ***during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations***. The Departments intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community.
> FAQ 2 (emphasis added)

The FAQs are available at: *http://www.dol.gov/ebsa/pdf/faq-aca8.pdf*. A specially prepared version of the FAQs with a Table of Contents for ease of use is available by: *"clicking here." We have provided a list of the FAQs below. For the answers to these questions, see the aforementioned documents.*

Q1: When Must Plans And Issuers Begin Providing The SBC?

Q2: What Is The Departments' Basic Approach To Implementation Of The SBC Requirement During The First Year Of Applicability?

Q3: Are Plans And Issuers Required To Provide A Separate SBC For Each Coverage Tier (e.g., Self-Only Coverage, Employee-Plus-One Coverage, Family Coverage) Within A Benefit Package?

Q4: If The Participant Is Able To Select The Levels Of Deductible, Copayments, And Co-Insurance For A Particular Benefit Package, Are Plans And Issuers Required To Provide A Separate SBC For Every Possible Combination That A Participant May Select Under That Benefit Package?

Q5: If A Group Health Plan Is Insured And Utilizes "Carve-Out Arrangements" (Such As Pharmacy Benefit Managers And Managed Behavioral Health Organizations) To Help Manage Certain Benefits, Who Is Responsible For Providing The SBC With Respect To The Plan?

Q6: If A Plan Offers Participants Add-Ons To Major Medical Coverage That Could Affect Their Cost Sharing And Other Information In The SBC (Such As A Health Flexible Spending Arrangement (Health FSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), Or Wellness Program), Is The Plan Permitted To Combine Information For All Of These Add-Ons And Reflect Them In A Single SBC?

Q7: The Final Regulations Require The SBC To Be Provided In Certain Circumstances Within 7 Business Days. Does That Mean The Plan Or Issuer Has 7 Business Days To Send The SBC, Or That The SBC Must Be Received Within 7 Business Days?

Q8: Are Plans And Issuers Required To Provide SBCs To Individuals Who Are COBRA Qualified Beneficiaries?

Q9: What Circumstances Will Trigger The Requirement To Provide An SBC To A Participant Or Beneficiary In A Group Health Plan? In Particular, How Do The Terms "Application" And "Renewal" Apply To A Self-Insured Plan?

Q10: What Are The Circumstances In Which An SBC May Be Provided Electronically?

Q11: Are Issuers Who Have Provided Individual Market Plan Information To Healthcare.Gov In Compliance With PHS Act Section 2715 And Its Implementing Regulations Already?

Q12: Can The Departments Provide Model Language To Meet The Requirement To Provide An E-Card Or Postcard In Connection With Evergreen Website Postings?

Q13: The Regulations State That In Order To Satisfy The Requirement To Provide The SBC In A Culturally And Linguistically Appropriate Manner, A Plan Or Issuer Follows The Rules In The Claims And Appeals Regulations Under PHS Act Section 2719. Does This Mean That The SBC Must Include A Sentence On The Availability Of Language Assistance Services?

Q14: Where Can Plans And Issuers Find The Written Translations Of The SBC Template And The Uniform Glossary In The Non-English Languages?

Q15: Is An SBC Permitted To Simply Substitute A Cross-Reference To The Summary Plan Description (SPD) Or Other Documents For A Content Element Of The SBC?

Q16: Can A Plan Or Issuer Add Premium Information To The SBC Form Voluntarily?

Q17: Must The Header And Footer Be Repeated On Every Page Of The SBC?

Q18: For Group Health Plan Coverage, May The Coverage Period In The SBC Header Reflect The Coverage Period For The Group Plan As A Whole, Or Must The Coverage Period Be The Period Applicable To Each Particular Individual Enrolled In The Plan?

Q19: Can Issuers And Plans Make Minor Adjustments To The SBC Format, Such As Changing Row And Column Sizes? What About Changes Such As Rolling Over Information From One Page To Another, Which Was Not Permitted By The Instructions?

Q20: Can Plan Names Be Generic, Such As "Standard Option" Or "High Option"?

Q21: Can The Issuer's Name And The Plan Name Be Interchangeable In Order?

Q22: Can Barcodes Or Control Numbers Be Added To The SBC For Quality Control Purposes?

Q23. Is The SBC Required To Include A Statement About Whether The Plan Is A Grandfathered Health Plan?

Q24. My Plan Is Moving Forward To Implement The SBC Template For The First Year Of Applicability. Are Significant Changes Anticipated For 2014?

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