DOL and the Treasury Release FAQ Regarding Implementation of SBC Provisions

PARKER | SMITH | FEEK

March 2012

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (the Departments) have released Frequently Asked Questions (FAQs) regarding implementation of the summary of benefits and coverage (SBC) provisions of the Affordable Care Act. The FAQ contains answers to 24 questions received by the Departments regarding implementation of the SBC rules.

Background

Beginning later in 2012 the ACA requires health plans to provide participants with a uniform summary of benefits and coverage (SBC). On February 9, 2012, the Departments released the final rules regarding the SBC. The final regulations and the requirements to provide the new standardized SBC are effective for group health plans on the following dates:

- Requirements that apply to communications to participants during an annual enrollment period are effective for open enrollment periods that begin on or after September 23, 2012.
- Requirements that apply to participants who enroll in a plan other than during an open enrollment period (e.g. new enrollees, and HIPAA special enrollees) are effective beginning on the first day of the first plan year that begins on or after September 23, 2012.

For example, an employer with a plan year that begins October 1, 2012, but starts their open enrollment period on September 1, 2012, would not be required to provide the SBC during open enrollment, but would be required to use the SBC for new enrollees beginning on the first day of the new plan year.

The final regulations confirmed that, in the case of fully insured plans, the insurance carrier is responsible to produce and provide a valid SBC to employers who sponsor group health plans. Self-funded employers are technically responsible to produce their own SBCs, however, it is anticipated that third party administrators (TPAs) will assist with the development of required SBCs. Employers will be responsible for the distribution of the SBC to participants, both during open enrollment periods, and to new participants.

Highlights of the FAQ

- The departments stressed that during the first year of implementation their approach to compliance will 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."… and that during the first year "the Departments will not impose penalties on plans and issuers that are working…in good faith to provide the required SBC content…consistent with the final regulations."
- Separate SBCs are not required for different tiers (i.e. single vs. family) of coverage,
- Plans can combine coverage provided under separate plans, such as a high deductible health plan combined with a health reimbursement arrangement (HRA) into a single SBC.
- SBCs may be provided electronically,
  - SBCs provided electronically to participants must meet the requirements of the existing DOL safe harbor rules related to electronic communications of plan information.
  - SBCs may also be provided electronically to an individual eligible, but not yet participating in a plan, as long as those individuals are notified where and how to access the information. The departments also provided sample language for this notification.

Summary of when the SBC must be provided to participants

The FAQ also provides a summary of when the SBC must be provided to participants. These distribution rules are covered in greater detail in the final regulations. The SBC must be provided:

- *Upon application*. If a plan (including a self-insured group health plan) or an issuer distributes written application materials for enrollment, the SBC must be provided as part of those materials.

For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage.

- *By first day of coverage* (if there are any changes). If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC no later than the first day of coverage.
- *Special enrollees*. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment).
- *Upon renewal*. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season (open enrollment), or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.
- *Upon request*. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practicable but in no event later than seven business days following receipt of the request.

Providing the SBC in a culturally and linguistically appropriate manner

If the SBC is sent to an address in a county in which ten percent or more of the population is literate only in a non-English language the plan must meet the language requirements contained in the claims and appeals regulations released last year. Current county-by-county data can be accessed at http://www.cciio.cms.gov/resources/factsheets/clas-data.html.

These rules outline three requirements that must be satisfied for notices sent in these counties. The plan is generally required to:

- Provide oral language services in the non-English language.
- Provide notices upon request by an individual in the non-English language.
- Include in all English versions of the notices a statement in the non-English language clearly indicating how to access the language services provided by the plan.
    - Sample language for this statement is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc.

Version of SBC language is available on the HHS website for a number of languages. Written translations in Spanish, Chinese, Tagalog and Navajo will be available at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

Summary

Employers must begin planning to add the SBC to their current employee communication processes. Additional guidance is expected this year as the departments continue to receive questions about this process. Employers with fully insured plans can expect to see SBCs from their carriers soon. Self-funded employers should discuss who will be responsible for SBC creation with their claims administrators. The full text of the Departments' FAQ is available on the DOL website at: http://www.dol.gov/ebsa/faqs/faq-aca8.html