Employment, Labor & Benefits Advisory

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# HHS, DOL, and Treasury Issue FAQs Under the Affordable Care Act's "Summary of Benefits and Coverage" Requirement

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The Affordable Care Act (the Act) requires group health plans and health insurance issuers[1] to provide group health plan participants and beneficiaries with:

- A summary of benefits coverage that describes the benefits and coverage available under the plan; and
- A uniform glossary of terms.

These requirements are collectively referred to as the Act's "Summary of Benefits and Coverage" or "SBC" rules. The particulars of final regulations issued February 14, 2012 implementing the SBC rules are explained in our advisory of March 2, 2012. In response to questions from stakeholders, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) recently issued a set of Frequently Asked Questions (FAQs) regarding implementation of the SBC rules. The FAQs are available at http://www.dol.gov/ebsa/pdf/faq-aca8.pdf. This advisory summarizes the FAQs.

## Effective Dates

The FAQs confirmed the following effective dates:

### *Enrollment or re-enroll through an open enrollment period*

For disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012.

### *Enrollment or re-enroll other than through an open enrollment period*

For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

The Departments emphasized that their 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."

According to the FAQs, during the 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."

## Compliance Issues

Regarding the substance of SBC compliance, the Departments offered the following clarifications:

- Plans and issuers are not 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.
- Where a participant is able to select the levels of deductible, copayments, and co-insurance for a particular benefit package, plans and issuers are not required to provide a separate SBC for each possible combination that a participant may select under that benefit package. Instead, this information can be presented in the form of options, such as deductible options and out-of-pocket maximum options.
- In the case of group health plan coverage, an SBC may be provided electronically by an issuer to a plan. In addition, electronic delivery is allowed by a plan or issuer to participants and beneficiaries *who are eligible but not enrolled for coverage*, if (1) the format is readily accessible (e.g., html, MS Word, or pdf format), (2) the SBC is provided in paper form free of charge upon request, (3) where the SBC is provided via an Internet posting, the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure by e-mail.
- An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary *who is covered under a plan* in accordance with the Department of Labor's disclosure regulations.[2] (Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.)
- In instances where SBCs must be issued within 7 days, the FAQs provide that the SBC will be considered timely if *sent* within 7 *business* days.
- COBRA-qualified beneficiaries generally have the same rights as actives to elect different coverage. SBCs must, therefore, be provided to COBRA-qualified beneficiaries. There are instances, moreover, in which a COBRA qualified beneficiary "may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event," thereby giving rise to a right to an SBC.
- Special rules apply where a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season. In these instances, the plan or issuer must provide the SBC at the same time it distributes open enrollment materials. If there is no requirement to renew (i.e., 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 year.

NOTE: The Departments offered the following model language in connection with evergreen elections:

> 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).

## Content and Format

The FAQs clarify a handful of content and format issues, including:

- An SBC may not substitute a reference to the SPD or other document for any content element of the SBC. The SBC may, however, include a reference to the SPD in the SBC footer.

  Example: "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description."

- If an SBC provides information that fully satisfies a particular content element, it may also make reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.
- The SBC may reflect the coverage period for the group health plan as a whole. In the case of a calendar year plan, for example, if an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.
- While minor adjustments are permitted to the row or column size in order to accommodate the plan's information, as long as the information is understandable, the deletion of columns or rows is not permitted.
- Plan names may be described generically, e.g., "Standard Option" or "High Option."
- There is no requirement to include a statement about whether the plan is a grandfathered health plan.

## Third-Party Vendors

The FAQs provide rules that apply in instances where a group health plan or group health insurance issuer has contracted with a third party to take on responsibility for all or some portion of the plan's SBC compliance. In these instances, the group health plan or issuer generally will not be penalized if the plan or issuer (1) monitors performance under the contract, (2) corrects any violations of which it has knowledge as soon as practicable, and (3) in instances where it lacks the information required for correction, promptly advises participants of the lapse and takes steps to avoid future violations.

## Conclusion

While the clarifications to the FAQ final rules are welcome, the Departments' failure to delay implementation is a major disappointment to many. The Departments may well view the grant of a good faith compliance period as a major concession, and perhaps it is. But "good faith compliance" is a notoriously imprecise standard. And where—as here—the penalties for non-compliance can be steep, the lack of certainty is worrisome.

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## Endnotes

1 The Act's SBC rules also apply to health insurance issuers that issue policies in the individual market. The rules governing individual market SBCs are not addressed in this advisory, which is targeted to the impact of the SBC rules on group health plans and issuers of group health insurance policies.

2 29 CFR 2520.104b-1.





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