ACA OVERVIEW

Provided by Mosaic Employee Benefits

Summary of Benefits and Coverage

The Affordable Care Act (ACA) added a new disclosure requirement for group health plans and health insurance issuers—the summary of benefits and coverage (SBC).

The SBC is a short document providing simple and consistent information about a health plan's benefits and coverage. It must be provided free of charge at certain times, such as at open enrollment.

The SBC must follow strict formatting requirements. The Departments of Labor, Health and Human Services and the Treasury (Departments) have provided templates and related materials, including instructions and a uniform glossary of coverage terms, for use by plans and issuers.

On April 6, 2016, the Departments released a revised template and related materials for use beginning on or after April 1, 2017. The specific effective date for each plan will depend on whether it has an open enrollment period.

LINKS AND RESOURCES

- Current SBC template, instructions and Uniform Glossary
- Revised SBC template, instructions and Uniform Glossary (for use on or after April 1, 2017)
- DOL website regarding the SBC and implementation FAQs
- CCIIO website for SBC template translations and county language data

HIGHLIGHTS

SBC REQUIREMENTS

- The ACA requires health plans and issuers to provide an SBC.
- The SBC must be prepared in accordance with the required template.
- Penalties apply for violations, but will not be imposed on plans and issuers that are making good faith efforts to comply with the rules.

REVISED SBC TEMPLATE

- **Plans with annual open enrollment periods** must use the new template for open enrollment periods beginning on or after April 1, 2017.
- **Plans without an annual open enrollment period** must use the new template for plan or policy years beginning on or after April 1, 2017.

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Mosaic Employee Benefits

SBC REQUIREMENT

The ACA requires both grandfathered and non-grandfathered health plans and health insurance issuers to provide an SBC to applicants and enrollees, free of charge. The SBC does not replace any required disclosure documents for group health plan coverage, such as the summary plan description (SPD). Rather, it is a new document intended to help health plan consumers understand the coverage they have and compare different options when shopping for new coverage. The SBC requirement also includes the provision of a uniform glossary of coverage and medical terms (Uniform Glossary).

The SBC is limited to four double-sided pages in length and must be prepared in accordance with the required template. To the extent that a plan's terms do not reasonably correspond to the template and instructions, the template should be completed in a manner that is as consistent with the instructions as reasonably as possible, while still accurately reflecting the plan's terms.

The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner when 10 percent or more of the population residing in the individual's county are literate only in the same non-English language. Translated versions of the template and glossary, and a list of the counties where this requirement would apply, are available through the Centers for Consumer Information and Insurance Oversight (CCIIO) website.

The DOL has stated that ACA implementation will focus on assisting plans and issuers that are making good faith efforts to comply with the SBC requirements, rather than imposing penalties on them.

PLANS REQUIRED TO PROVIDE THE SBC

The SBC requirement applies to **group health plans and health insurance issuers**. It applies to both grandfathered and non-grandfathered plans, regardless of whether it is fully insured or self-funded.

An SBC is not required for plans, policies or benefit packages that qualify as **"excepted benefits"** under HIPAA. For example, the SBC requirement does not apply to standalone dental or vision plans or health flexible spending accounts (FSAs) that qualify as excepted benefits.

The Departments have provided guidance on how the SBC requirement applies to health FSAs, health reimbursement arrangements (HRAs) and health savings accounts (HSAs):

- **Integrated health FSA or HRA (not excepted benefits).** The SBC should be prepared for the major medical coverage and the effects of the health FSA or HRA can be included in the appropriate spaces on the SBC. A separate SBC may be required if the carrier of the major medical coverage will not incorporate terms of the health FSA or HRA.
- **HSAs.** HSAs are not group health plans and are not subject to the SBC requirement. The SBC for a high deductible health plan (HDHP) associated with the HSA can mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC form.

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SBC DEADLINES

The SBC must be provided in certain situations, and specific deadlines apply, depending on the situation. There are two scenarios where an SBC must be provided:

- By a group health insurance issuer to a group health plan; and
- By the insurance issuer or plan administrator to participants and beneficiaries.

Providing the SBC to the Group Health Plan

A **health insurance issuer** must provide an SBC to a **group health plan** (or the plan's sponsor):

- Upon application for health coverage (as soon as practicable, and no later than seven days after receipt of the application)
- By the first day of coverage, if there was any change in the information required to be in the SBC that was provided upon application and before the first day of coverage
- When the issuer renews or reissues the policy (see information below)
- Upon request (as soon as practicable, and no later than seven days after receipt of the request)

A **health insurance issuer or health plan administrator** must provide an SBC to **participants and beneficiaries** with respect to each benefit package for which the participant or beneficiary is eligible. The SBC must be provided:

- As part of any written application materials that are distributed by the plan or issuer for enrollment
- If the plan or issuer does not distribute written application materials for enrollment, no later than the first date that the participant is eligible to enroll in coverage
- By the first day of coverage, if there was any change to the information required to be in the SBC that was provided upon application and before the first day of coverage
- To special enrollees, no later than the deadline for providing the summary plan description (SPD) (within 90 days of enrollment)
- Upon renewal, if participants and beneficiaries must renew in order to maintain coverage (see information below)
- Upon request (as soon as practicable, and no later than seven days after receipt of the request)

Providing the SBC to Participants and Beneficiaries

The regulations do not specify whether the issuer or health plan administrator (usually the employer) must provide the SBC to participants and beneficiaries. There is a non-duplication rule providing that, if

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the issuer of a fully insured plan provides the SBC to participants and beneficiaries, the employer does not have to do so. This and other non-duplication rules are discussed in the next section.

The deadline for providing the SBC **at renewal time** depends on whether a written application is required for renewal.

- **If a written application is required:** the SBC must be provided no later than when the application materials are distributed.
- **If renewal is automatic:** the SBC must be provided no later than 30 days before the beginning of the new plan year, unless an insured plan's policy, certificate or contract of insurance has not been issued or renewed before this 30-day period. In this case, the SBC must be provided as soon as practicable, but no later than seven days after the issuance of the new policy, certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

If the issuer provides the SBC upon request before application for coverage, another SBC does not have be provided upon application, as long as there is no change to the information required to be in the SBC. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided to the plan or its sponsor (unless an updated SBC is requested) until the first day of coverage. The updated SBC is required to reflect the final coverage terms under the policy, certificate, or contract of insurance that was purchased.

NON-DUPLICATION RULES

Non-duplication rules apply in some situations to streamline the process for providing the SBC:

Fully insured plans	• If either the plan or issuer provides the SBC to a participant or beneficiary (and meets the timing and content requirements), both will have satisfied their SBC obligations. • **An employer with a fully insured plan satisfies the requirement to provide an SBC to an individual if the issuer provides a timely and complete SBC to the individual.**
Families	• A single SBC may be provided to a **family**, unless any beneficiaries are known to live at a different address. • Due to this rule, plans and issuers must provide separate SBCs to beneficiaries only in limited circumstances.

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Plans with multiple benefit packages	• For group health plans with **multiple benefit packages**, the plan or issuer must automatically provide a new SBC at renewal only for the benefit package in which a participant or beneficiary is enrolled. • SBCs for other benefit package options do not have to be provided automatically at renewal, but must be provided upon request.
Contractual responsibility	• A plan or issuer may enter into a **binding contractual arrangement** requiring another party to complete the SBC, provide required information to complete a portion of the SBC or deliver SBCs. • The plan or issuer **must monitor performance** under the contract and address any violations.
Multiple issuers	• A group health plan that uses **multiple insurance products** provided by separate issuers may provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. • The plan administrator should indicate that the plan provides coverage using multiple different insurers and provide contact information for assistance in understanding how the products work together.
Student health insurance coverage	• The SBC requirement 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.

FORMAT AND CONTENT OF THE SBC

The SBC must be provided in a standardized format to help provide clear, consistent and comparable information about health plan coverage and benefits. A **template** and a **uniform glossary** are available for this purpose. The template includes content required for the SBC, such as cost-sharing provisions, limitations on coverage and coverage examples that illustrate how much an individual would have to pay for certain medical services.

> **Group health plans and issuers are required to use the full template to satisfy the SBC requirement**. To the extent that a plan's terms cannot reasonably be described in a manner consistent with the template and its instructions, the plan or issuer must make its best effort to accurately describe the relevant plan terms in a way that is as consistent with the instructions and template format as is reasonably possible.

The SBC must be presented in a uniform format and must use terminology understandable by the average plan enrollee. The SBC cannot exceed **four double-sided pages** in length. The SBC template may be provided in color or black and white, but may not include print smaller than **12-point font**.

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The SBC is not required to include premium or cost of coverage information. However, the SBC must include a statement of whether the plan provides minimum essential coverage or meets applicable requirements to be considered to provide minimum value.

The SBC's coverage examples must be revised to reflect each plan's coverage of benefits. The Departments have provided an online calculator that plans and issuers can use to complete the coverage examples.

PROVIDING THE SBC

The SBC can be provided as either a standalone document or with other summary materials (for example, the SPD). To be provided with other summary materials, the SBC information must be intact and prominently displayed at the beginning of the materials (for example, immediately after the SPD's table of contents) and provided according to the SBC timing requirements.

The SBC may be provided in either paper or electronic form (such as by email or an internet posting), although restrictions apply to electronic delivery.

For SBCs **provided by an issuer to a health plan**, the SBC may be provided electronically if:

- The format is readily accessible by the plan or its sponsor;
- The SBC is provided in paper form free of charge upon request; and
- If the electronic form is an internet posting, the issuer timely advises the plan in paper form or email that the documents are available on the internet and provides the internet address.

For SBCs **provided to participants and beneficiaries**, the SBC may be delivered electronically to individuals who are already covered under the group health plan if the DOL's electronic disclosure regulations are met. For participants and beneficiaries who are eligible for but not enrolled in coverage, the SBC may be provided electronically if:

- The format is readily accessible;
- The SBC is provided in paper form free of charge upon request; and
- If the electronic form is an internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email that the documents are available on the internet, provides the internet address and notifies the individual that the documents are available in paper form upon request.

There is a safe harbor for electronic delivery of the SBC in connection with online enrollment. Under this safe harbor, the SBC may be provided electronically to participants and beneficiaries in connection with their **online enrollment or online renewal of coverage** under the plan. The SBC may also be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual

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must have the option to receive a paper copy upon request. This enforcement relief will continue to apply until further guidance is issued.

60-DAY ADVANCE NOTICE OF MATERIAL MODIFICATIONS

Plans and issuers are required to give at least **60 days advance notice of any material modification** in plan terms or coverage that are not reflected in the most recent SBC. This notice requirement is limited to material modifications that do not occur in connection with a renewal or reissuance of coverage.

A "material modification" includes:

1. An enhancement of covered benefits or services, such as coverage of previously excluded benefits or reduced cost-sharing;
2. A material reduction in covered services or benefits, such as through increased premiums or cost-sharing; or
3. More stringent requirements for receipt of benefits, such as a new referral requirement.

The material modification notice can be provided in a separate document describing the material modification or through an updated SBC.

PENALTIES

The ACA establishes a penalty of up to **$1,000** for each willful failure to provide the SBC. However, on July 1, 2016, the Department of Labor (DOL) issued an interim final rule that increases this civil penalty to **$1,087** per violation. The increased penalty amount took effect Aug. 1, 2016, and may apply for any violations occurring after Nov. 2, 2015.

In addition, failing to provide the SBC may also trigger an excise tax of **$100 per day** per individual for each day of noncompliance. However, the Departments have stated that their approach to implementation emphasizes assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to comply with the SBC requirements**.**

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