Summary of Benefits & Coverage (SBC) FAQ

FAQ ON THE IMPLEMENTATION OF SBC REQUIREMENT

The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) released a series of Frequently Asked Questions (FAQ's) regarding the implementation of the Summary of Benefits and Coverage (SBC) provisions contained in the Affordable Care Act. The FAQ contains answers to 24 questions received by the Departments regarding implementation of the SBC rules.

BACKGROUND

On February 9, 2012, the Departments released the final rules regarding the SBC. Included in these rules is the requirement that health plans provide participants with a uniform summary of benefits and coverage (SBC) beginning in 2012. The final regulations and the requirements to provide the new, standardized SBC are effective for group health plans on the following dates – both at open enrollment and for new:

- With respect to participants and beneficiaries who enroll or re-enroll during an open enrollment period, the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012.
- With respect to participants and beneficiaries who enroll in a plan at a time other than during an open enrollment period (e.g. new enrollees and HIPAA 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.

For example, an employer whose plan year begins October 1, 2012 but whose open enrollment period begins 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 for producing and providing a valid SBC to employers who sponsor group health plans. Employers who sponsor self-funded plans 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 of coverage (i.e. single vs. family).

- 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 to participants and beneficiaries in the following manner: 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 who is not yet participating in a plan, as long as the individuals is notified as to where and how to access the information. The Departments also provided sample language for this notification.
- Unless the plan or insurer knows of a separate address for a beneficiary, the SBC may be provided to the employee on behalf of other family members.

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 at the following times:

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, through a website or email, which 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 a change to the information required by 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 enrollment period, or provides them with the opportunity to change coverage options during this time, the plan or issuer must provide the SBC at the same time it distributes other open enrollment materials. If there is no requirement to re-elect or renew coverage(sometimes referred to as an "evergreen" election), and there is 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 is available.

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.

Versions of SBC language are available on the HHS Website for a number of languages. Written translations in Spanish, Chinese, Tagalog and Navajo will be available.

SUMMARY

Employers must determine how to incorporate the SBC into current employee communication processes and materials. Employers with fully-insured plans should expect to have access to SBCs from their carriers soon. Self-funded employers should work with their third party administrators to determine who will be responsible for SBC creation.

The full text of the Departments FAQ is available on the DOL Website.