

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART IX)



May 11, 2012

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the summary of benefits and coverage (SBC) provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://cciio.cms.gov/resources/factsheets/>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Q1: A previous FAQ outlined the circumstances in which an SBC may be provided electronically.¹ The FAQ discussed a safe harbor for providing the SBC to participants or beneficiaries covered under the plan who are able to effectively access documents provided in electronic form at the worksite. Are there any additional safe harbors for electronic delivery of SBCs?

Yes. The Departments have adopted the following additional safe harbor. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. (In addition, for individual market issuers that offer online enrollment or renewal, the SBC may be provided electronically, at all issuances, to consumers who enroll or renew online, consistent with the regulations.)

Q2: What are the circumstances that will trigger the requirement for an issuer to provide an SBC to an individual applying for coverage in the individual market, or to a group health plan or its sponsor applying for coverage? In particular, how do the terms “upon application” and “first day of coverage (if there are changes)” apply to an individual (or a plan or its sponsor) shopping for coverage?

The regulations state that a health insurance issuer must provide the SBC upon application for health coverage. For this purpose, a plan or issuer must provide the SBC as soon as practicable, but no later than seven business days after receiving a substantially complete application for a health insurance product.

If an individual, plan, or 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 (unless an updated SBC is requested) until the first day of coverage. The updated SBC

¹ See Q10 of FAQs Part VIII at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.

should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

Q3: If an individual (or a plan or its sponsor) receives an SBC prior to application for coverage, must an issuer automatically provide another SBC upon application, if the information required to be in the SBC has not changed?

No. A duplicate SBC is generally not required to be provided at the time of application unless requested by the applicant. However, if by the time the application is filed, there is a change in the information required to be in the SBC, the issuer or plan must update and provide a current SBC to the individual (or plan or its sponsor) as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. Similarly, if an SBC is provided upon application, there is no requirement to provide the SBC again on the first day of coverage, unless there is a change to the information that is required to be in SBC or an SBC is requested by the applicant.

Q4: Are issuers required to provide SBCs to group health plans (or their sponsors) who are “shopping” for coverage, but have not yet submitted an application for coverage?

Yes, but only in certain circumstances. The regulations generally provide that an SBC must be provided upon request for an SBC or “summary information about a health insurance product.” The latter phrase is intended to ensure that persons who do not ask exactly for a “summary of benefits and coverage” still receive one when they explicitly ask for a summary document with respect to a specific health product. Other, general questions about coverage options or discussions about health products do not trigger the requirement to provide an SBC. (See also, Q1 regarding electronic delivery options for providing SBCs.)

Q5: A previous FAQ stated that an SBC provided in connection with a group health plan may include a reference to the summary plan description (SPD).² For SBCs provided in connection with coverage in the individual market, can the SBC refer to other documents associated with the coverage?

Yes. While it is not permitted to substitute a reference to any other document for any content element of the SBC, an SBC may include a reference to another document in the SBC footer. In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of other documents in order to supplement or elaborate on that information.

Q6: Are certain electronic features (such as scrolling and expansion of columns) permitted when displaying the SBC electronically?

Yes. Minor adjustments are permitted to accommodate the plan’s or issuer’s information and electronic display method, such as expansion of columns. Additionally, it is permissible to display the SBC electronically on a single webpage, so the viewer can scroll through the information required to be in the SBC without having to advance through pages (as long as a printed version is available that

² See Q15 of FAQs Part VIII at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.

meets the formatting requirements of the SBC). However, the deletion of columns or rows is not permitted when displaying a complete SBC.

(For more on minor adjustments, see FAQs Part VIII at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html. Specifically, Q3 and Q4 state that “plans and issuers may combine information ...provided the appearance is understandable” and Q19 states that “minor adjustments are permitted...as long as the information is understandable.”)

Q7: Some plans or issuers provide web-based or print materials to illustrate the differences between benefit package options (including comparison charts and broker comparison websites). Is it permissible to “combine” SBCs or SBC elements to provide a side-by-side comparison?

Yes. Issuers and plans (and agents and brokers working with such plans) may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals and employers shopping for coverage. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or other cost sharing of several benefit package options. This could be achieved by providing the “deductible row” of the SBC for several benefit packages, but without having to repeat the first one or two columns, as appropriate, of the SBC for each of the benefit packages.

However, such a chart, website, or other comparison does not, itself, satisfy the requirements under PHS Act section 2715 and the final regulations to provide the SBC. The full SBC for all the benefit packages included in the comparison view/tool must be made available in accordance with the regulations and other guidance.

Q8: Under what circumstances can penalties be imposed for failure to provide the SBC or the uniform glossary?

PHS Act section 2715(f) states that an entity is subject to a fine if the entity “willfully fails to provide the information required under this section.”

As stated in previous FAQs,³ the Departments’ basic approach to ACA implementation 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.” Accordingly, 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 comply.

³ See FAQs Part I Q1 (available at <http://www.dol.gov/ebsa/faqs/faq-aca.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs.html) and FAQs Part VIII Q2 (available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html).

Q9: For the first year of applicability,⁴ can the Departments provide further assistance with regard to the coverage examples, such as a streamlined calculator?

Yes. The Departments are developing a calculator that plans and issuers can use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion; because this approach will be less accurate, it will be allowed as a transitional tool for the first year of applicability.⁵ The calculator will allow plans and issuers to input a discrete number of elements about the benefit package. Calculator inputs generally are expected to be taken from data fields used to populate the front portion of the SBC template. (See <http://cciio.cms.gov/resources/other/index.html#sbcug> for a list of calculator inputs.) The output will be a coverage example that can be added to the corresponding SBC. The Departments will also provide the algorithm that was used to create the calculator. The calculator and algorithm will be posted at <http://cciio.cms.gov/resources/other/index.html#sbcug> soon.

Q10: A previous FAQ discussed the utilization of “carve-out arrangements” under which a plan or issuer contracts with a service provider to help manage certain benefits under the plan or policy.⁶ In another type of “carve-out arrangement,” a plan sponsor may purchase an insurance product for certain coverage from a particular issuer and purchase a separate insurance product or self-insure with respect to other coverage (such as outpatient prescription drug coverage). In these circumstances, the first issuer may or may not even know of the existence of other coverage, or whether the plan sponsor has arranged the two benefit packages as a single plan or two separate plans.

What are an issuer’s obligations to provide an SBC with respect to benefits it does not insure?

Unless it contracts otherwise, an issuer has no obligation to provide coverage information for benefits that it does not insure. However, group health plan administrators are responsible for providing complete SBCs with respect to a plan. A plan administrator that uses two or more insurance products provided by separate issuers with respect to a single group health plan may synthesize the information into a single SBC, or may contract with one of its issuers (or other service providers) to perform that function.

Due to the administrative challenges of combining benefit package information from multiple issuers, during the first year of applicability, for enforcement purposes, with respect to a group health plan that uses two or more issuers, the Departments will consider the provision of multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple different insurers and that individuals who would like assistance understanding how these products work together may contact the plan administrator for more information (and provide the contact information).⁷

⁴ In the Federal Register notice dated February 14, 2012, FAQs Part VIII, and in these FAQs, the term “first year of applicability” refers to SBCs and uniform glossaries provided with respect to coverage beginning before January 1, 2014.

⁵ The SBC template makes clear that the coverage examples are not a cost estimator and should not be used to estimate a particular individual’s actual expenses under the plan.

⁶ See Q5 of FAQs Part VIII at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.

⁷ See the sample completed SBC template, as well as Q3, Q4, and Q6 of FAQs Part VIII at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and

Q11: A previous FAQ provided a link where written translations for the SBC template and the uniform glossary would be available in the future.⁸ Are these translations available?

Written translations in Spanish, Chinese, and Tagalog are now available. Navajo translations will be available shortly. For more information, see CCIIO website at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.

Q12: Are health insurance issuers required to provide SBCs for insurance products that are no longer being offered for purchase?

The Departments understand that most plans and issuers have to develop new databases and technology systems in order to extract information about coverage terms and provide SBCs. The Departments also understand that, with respect to insurance products that are no longer being offered for purchase (sometimes referred to as closed blocks of business), there is a significant volume of data that is not stored in electronic form or is not stored in an information system that is compatible with the new electronic systems being developed for the SBC. Accordingly, due to the additional administrative complexities with respect to providing SBCs with respect to closed blocks of business, the Departments will not take any enforcement action against a plan or issuer for failing to provide an SBC before September 23, 2013 with respect to an insured product that is no longer being actively marketed for business, provided the SBC is provided no later than September 23, 2013 (at which time, enrollees and small employers will have new opportunities to compare coverage options available through an Exchange).

Q13: Expatriate plans and policies face special circumstances and considerations in complying with the SBC requirements. Can the Departments provide any assistance or relief with respect to expatriate coverage?

Yes. The Departments recognize that expatriate coverage carries additional administrative costs and barriers in filling out SBCs, including benefit and claims systems that are distinct from those for domestic coverage, which makes compliance more difficult. Therefore, for purposes of enforcement, the Departments will not take any enforcement action against a group health plan or group health insurance issuer for failing to provide an SBC with respect to expatriate coverage during the first year of applicability.

Q14: Other than the FAQs, are there any updates to the SBC template and related documents on the Departments' websites that I need to know about?

Yes. In the diabetes treatment scenario, the version originally posted contained a typographical error, listing the allowed amount for insulin as \$11.92, rather than \$119.20 – a difference that impacts the total cost of care for diabetes in the coverage example calculations.

To correct this error, the Departments have posted updated versions of the SBC template, the sample completed SBC, and the guide for coverage examples calculations – diabetes scenario. The updated

http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html for more information on circumstances when it may be helpful to note assumptions or other information in connection with the SBC coverage examples.

⁸ See Q14 of FAQs Part VIII at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.

SBC template and sample completed SBC also include sample taglines for obtaining translated documents, to be included if appropriate consistent with paragraph (a)(5) of the regulations, as well as updated Sample Care Costs amounts for the diabetes coverage example, due to more accurate rounding in making these calculations. Finally, the updated versions include some appearance modifications (such as changes in bolding, underlining, shading, capitalization, margin justification, use of hyphens, and row and column sizing) to ensure the document is accessible to individuals with disabilities, consistent with section 508 of the Rehabilitation Act. Plans and issuers may use either version, or may make similar modifications to their own SBCs, without violating the appearance requirements for an SBC.

The updated versions of these documents are labeled “corrected on May 11, 2012” in the lower right corner of the first page and are available at <http://www.dol.gov/ebsa/healthreform> and <http://cciio.cms.gov>. These three documents replace the prior versions issued contemporaneously with the final regulations in February 2012.