

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XIV)

April 23, 2013

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various 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 (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cciio.cms.gov/resources/factsheets/index.html>), these FAQs answers questions from stakeholders to help people understand the new law and benefit from it, as intended.

Summary of Benefits and Coverage

Public Health Service (PHS) Act section 2715, as added by the Affordable Care Act, directs the Departments to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing a summary of benefits and coverage (SBC) that “accurately describes the benefits and coverage under the applicable plan or coverage.” On February 14, 2012, the Departments published final regulations regarding the SBC.ⁱ At the same time, the Departments published a notice announcing the availability of templates, instructions, and related materials authorized for implementing the disclosure provisions under PHS Act section 2715 for the first year of applicability (that is, for SBCs and the uniform glossary provided with respect to coverage beginning before January 1, 2014).ⁱⁱ

The documents authorized for the first year of applicability do not include language for the statement in the SBC (required to be included by PHS Act section 2715(b)(3)(G) and paragraph (a)(2)(i)(G) of the final regulations) regarding whether a plan or coverage provides minimum essential coverage (MEC) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable minimum value (MV) requirements. When the documents authorized for the first year of applicability were first released, the Departments stated that updated materials would be issued for later years.ⁱⁱⁱ

Q1: What templates should plans and issuers use for the SBCs and the uniform glossary required to be provided after the first year of applicability?

An updated SBC template (and sample completed SBC) are now available at <http://cciio.cms.gov> and <http://www.dol.gov/ebsa/healthreform>. These documents are authorized for use with respect to group health plans and group and individual health insurance coverage for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to in this guidance document as “the second year of applicability”).

The only change to the SBC template and sample completed SBC is the addition of

statements of whether the plan or coverage provides MEC (as defined under section 5000A(f) of the Internal Revenue Code 1986) and whether the plan or coverage meets the MV requirements (that is, the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs). On page 4 of the SBC template (and illustrated on page 6 of the sample completed SBC), a plan or issuer should indicate in the designated entry on the SBC template that the plan or coverage "does" or "does not" provide MEC and whether the plan or coverage "does" or "does not" meet applicable MV requirements.

There are no changes to the uniform glossary. There are also no changes to the Instructions for Completing the SBC (for either group or individual health coverage), "Why This Matters" language for the SBC, or to the coverage examples.

Q2: Our plan is already working on the process of preparing SBCs for issuance in the second year of applicability and it would be an administrative burden to add the new data element to the template at this point in the process. Is any relief available to provide information about MEC and MV without changing the SBC template?

Yes. To the extent a plan or issuer is unable to modify the SBC template for disclosures required to be provided with respect to the second year of applicability, the Departments will not take any enforcement action against a plan or issuer for using the template authorized for the first year of applicability, provided that the SBC is furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV requirement under the Affordable Care Act. The language for these statements is as follows:

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does/does not provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does/does not meet the minimum value standard for the benefits it provides.**

Q3: A previous FAQ stated that the Departments intended to make changes to the SBC template for 2014 to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits.^{iv} Have the Departments made any changes related to this requirement?

No. As stated earlier, the only change to the SBC template and sample completed SBC is the addition of information to indicate whether the plan or coverage provides MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable MV requirements under the Affordable Care Act.

Plans and issuers should continue to complete the SBC template consistent with the Instructions for Completing the SBC (for either group or individual health coverage, as applicable) for the *Important Questions* chart that appears on page 1 of the SBC:

- In the *Answers* column, the plan or issuer should respond “No,” where the template asks, “Is there an overall annual limit on what the plan pays?”, as plans and issuers are generally prohibited from imposing annual limits on the dollar value of essential health benefits for plan years (in the individual market, policy years) beginning on or after January 1, 2014.^v
- In the *Why This Matters* column, the plan or issuer must show the following language: “The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.”^{vi}

Additionally, as applicable, plans and issuers should continue to include information regarding annual or lifetime dollar limits on specific covered benefits as required in the chart starting on page 2 of the SBC (in the *Limitations & Exceptions* column), as described in the Instructions for Completing the SBC (for either group or individual health coverage, as applicable).

To the extent a plan or issuer wishes to modify the SBC template for disclosures required to be provided for the second year of applicability to remove this information, the Departments will not take any enforcement action against a plan or issuer for removing the entire row in the *Important Questions* chart on page 1 of the SBC (with the question: “Is there an overall annual limit on what the plan pays?”).

Q4: A previous FAQ stated that the Departments intended to add additional coverage examples for 2014.^{vii} Have the Departments made any changes related to this requirement?

To help transition to new market changes in 2014, the Departments believe it is prudent to maintain the current coverage examples. Additional coverage examples are not required as part of the SBC at this time. As with the SBC authorized for the first year of applicability, the documents authorized for the second year of applicability continue to require the same two coverage examples authorized for the first year of applicability – having a baby (normal delivery) and managing type 2 diabetes (routine maintenance of a well-controlled condition).

Q5: Safe harbors and other enforcement relief were provided by the Departments related to the requirement to provide an SBC and a uniform glossary for the first year of applicability. Will this relief be extended?

Yes. As stated in previous FAQs,^{viii} 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.” In recognition of and to ensure a smooth transition to new market changes in 2014, the Departments believe it is prudent to extend the following enforcement relief to apply through the end the second year of applicability:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the Departments’ basic approach to implementation of the SBC requirements during the first year of applicability);^{ix}
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);^x
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);^{xi}
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator);^{xii} and related information related to use of the coverage examples calculator;^{xiii}
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer’s obligation to provide an SBC with respect to benefits it does not insure);^{xiv} and
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);^{xv}

In addition, the following enforcement relief continues to apply through the second year of applicability, consistent with existing guidance:

- The Special Rule contained in the Instruction Guides for Group and Individual Coverage;^{xvi}
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);^{xvii} and
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage).^{xviii}

Additionally, Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements) applies “until further guidance is issued.” The relief provided in this Affordable Care Act Implementation FAQs Part VIII, Q5 continues to apply, and plans and issuers may rely on this relief at least through the end of 2014.

This guidance supersedes any previous subregulatory guidance (including FAQs) stating that enforcement relief for the SBC and uniform glossary requirements is limited to the first year of applicability.

Q6: A previous FAQ provided an enforcement safe harbor until September 23, 2013 for plans and issuers with respect to insurance products that are no longer being offered for purchase (“closed blocks of business”).^{xix} Will this relief be extended?

Yes. The relief provided in this FAQ extends this date to September 23, 2014 for plans and issuers with respect to an insured product that meets three conditions:

- The insured product is no longer being actively marketed;
- The health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and
- The health insurance issuer has never provided an SBC with respect to the insured product.

That is, if a health insurance product is not being actively marketed and the health insurance issuer has not actively marketed the product at any time on or after September 23, 2012, the Departments will not take any enforcement action against the plan or issuer for failing to provide an SBC before September 23, 2014 with respect to a product, provided the SBC is provided for that product no later than September 23, 2014.

However, if an insured product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the insured product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and the final regulations.

Q7: The final regulations regarding the SBC included an anti-duplication provision for group health coverage clarifying that an entity required to provide an SBC would be considered to have satisfied that requirement with respect to an individual if another party provides a timely and complete SBC.^{xx} Is a similar anti-duplication rule applicable for student health insurance coverage?

Yes. On March 21, 2012, HHS issued a final rule establishing requirements for student health insurance coverage.^{xxi} The final rule defines student health insurance coverage as a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer.^{xxii} HHS is extending the anti-duplication rule for group health coverage set forth in the final SBC regulations to student health insurance coverage, as defined in 45 CFR 147.145(a). Therefore, the requirement to provide an SBC with respect to an individual 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.

- ⁱ See 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200, published at 77 FR 8668 (February 14, 2012).
- ⁱⁱ See 77 FR 8706 (February 14, 2012).
- ⁱⁱⁱ See *id.* at 8707. See also ACA Implementation FAQs, Part VIII, Q24, available at www.dol.gov/ebsa/faqs/faq-aca8.html and cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.
- ^{iv} See ACA Implementation FAQs Part VIII, Q24, available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.
- ^v See 26 CFR 54.9815-2711(a)(2) and (f); 29 CFR 2590.715-2711(a)(2) and (f); and 45 CFR 147.126(a)(2), (d) and (f).
- ^{vi} The rules of PHS Act section 2711 and its implementing regulations do not prevent a plan or issuer from placing annual or lifetime dollar limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law. See 26 CFR 54.9815-2711(b); 29 CFR 2590.715-2711(b); and 45 CFR 147.126(b); see also section 1302(b) of the Affordable Care Act and its implementing regulations at 45 CFR 156.100 et seq.
- ^{vii} See ACA Implementation FAQs Part VIII, Q24, available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.
- ^{viii} See FAQs Part I Q1 (available at www.dol.gov/ebsa/faqs/faq-aca.html and cciio.cms.gov/resources/factsheets/aca_implementation_faqs.html); FAQs Part VIII Q2 (available at www.dol.gov/ebsa/faqs/faq-aca8.html and cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html); and FAQs Part IX Q8 (available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html).
- ^{ix} Available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html.
- ^x Available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html.
- ^{xi} Available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html.
- ^{xii} Available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html.
- ^{xiii} See <http://cciio.cms.gov/resources/other/index.html#sbcug>.
- ^{xiv} Available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html.
- ^{xv} Available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html. See also FAQs Part XIII, available at <http://www.dol.gov/ebsa/faqs/faq-aca13.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs13.html, which provides broader relief to expatriate coverage that is group health insurance, as described therein. For self-insured expatriate coverage, this guidance extends the enforcement relief for the SBC to the second year of applicability.
- ^{xvi} See What This Plan Covers and What it Costs: Instruction Guide for Group Coverage, February 2012 edition (available at <http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf> and <http://cciio.cms.gov/resources/files/Files2/02102012/instructions-group-final.pdf>) and What This Plan Covers and What it Costs: Instruction Guide for Individual Health Insurance Coverage, February 2012 edition (available at <http://www.dol.gov/ebsa/pdf/SBCInstructionsIndividual.pdf> and <http://cciio.cms.gov/resources/files/Files2/02102012/instructions-individual-final.pdf>).
- ^{xvii} Available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html.
- ^{xviii} Available at <http://www.dol.gov/ebsa/faqs/faq-aca10.html> and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs10.html.
- ^{xix} See ACA Implementation FAQs Part IX, Q12, available at www.dol.gov/ebsa/faqs/faq-aca9.html and http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs9.html.
- ^{xx} For example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual. See 26 CFR 54.9815-2715(a)(1)(iii)(A); 29 CFR 2590.715-2715(a)(1)(iii)(A); and 45 CFR 147.200(a)(1)(iii)(A).
- ^{xxi} See 45 CFR 147.145, published at 77 FR 16453 (March 21, 2012).
- ^{xxii} See 45 CFR 147.145(a).