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FAQs Issued on SBC Rules

The agencies have issued a set of frequently asked questions (FAQs) focusing on the Summary of Benefits and Coverage (or "SBC") requirements under healthcare reform. This recently issued guidance addresses a number of technical and formatting matters not fully addressed by recently issued final regulations on the SBC requirements. See our earlier Update on the general SBC requirements.

The SBC rules require that participants have access to two key documents intended to help them understand and evaluate their health insurance choices:

- A Summary of Benefits and Coverage; and
- A Uniform Glossary of terms commonly used in health insurance coverage, such as "deductible" and "co-payment." Language on the uniform glossary provides that individual plan terms may differ from the general definitions provided in the uniform glossary.

Effective Date: Many employers were hoping for a delay in the effective date to give them more time to prepare and deliver the SBCs. But importantly, the first FAQ reaffirms that for disclosures to participants 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. For calendar-year plans, this means that SBCs will first be required during open enrollment in 2012 for the 2013 plan year. 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 new hires), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012. For disclosures from issuers to group health plans, and with respect to individual market coverage, the SBC must be provided beginning September 23, 2012.

Implementation Approach: According to the second FAQ in the new guidance, the implementation approach of the agencies is 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. Additionally, during the first year of applicability, the agencies will not impose penalties if the employer works diligently and in good faith to provide the SBC content consistent with the rules. So, for example, to the extent a plan's terms do not reasonably correspond to the instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms. This may occur, for example, if a plan provides a different structure for provider

network tiers or drug tiers than is represented in the SBC template and these instructions; if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement; or if a plan provides different cost-sharing based on participation in a wellness program.

Separate SBCs Not Required for Certain Arrangements: 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. Information may be combined for different coverage tiers in one SBC, provided the appearance is understandable. In such circumstances, the coverage examples should be completed using the cost sharing (e.g., deductible and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption. If the 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 every possible combination that a participant may select under that benefit package. Plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them.

Other Issues Addressed: A number of other issues are discussed in the FAQ document, including:

- “Carve-out” arrangements such as pharmacy benefit managers and managed behavioral health organizations;
- COBRA qualified beneficiaries;
- How the terms “application” and “renewal” apply to a self-insured plan;
- Add-ons to medical coverage (such as a flexible spending arrangements, health reimbursement arrangements or health savings accounts);
- Electronic distribution of SBCs; and
- Flexibility in formatting and wording of the SBC.

While no major changes to the model SBCs are anticipated, the agencies do intend to release additional FAQs. See the DOL healthcare reform website for a link to all SBC reference materials.

For a fully insured plan, insurers will prepare the SBC, although the employer is also responsible for providing the SBC. Employers with self-insured plans will need to work with their vendors to develop the SBC (only the employer is responsible for providing it to eligible individuals). Conner Strong & Buckelew is well positioned to assist clients with this requirement.

Employers are advised to continue to monitor healthcare reform developments. Should you have questions about this or any aspect of federal health insurance reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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