TASC

COMPLIANCE CORNER

Q3 2012

ERISA Compliance: It's not an option, it's the law.

In this issue:

1) **How Employers should prepare for Medical Loss Ratio (MLR) and;**
2) **Summary of Benefits and Coverage (SBC) requirements effective September 23, 2012….*Are you prepared?***

Affordable Care ACT (ACA) MLR Requirements

Section 2718 of the Public Health Service Act (PHSA), 42 U.S.C. 300gg-18, as added by the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub.L. 111-148, 124 Stat. 119), enacted on March 23, 2010, requires that health insurance issuers publicly report on major categories of spending of policyholder premium dollars, such as clinical services provided to enrollees and activities that will improve health care quality. The law establishes medical loss ratio (MLR) standards for issuers. Issuers are required to provide rebates to enrollees when their spending for the benefit of policyholders on reimbursement for clinical services and health care quality improving activities, in relation to the premiums charged (as adjusted for taxes), is less than the MLR standards established pursuant to the statute. Rebates are based upon aggregated market data in each State and not upon a particular group health plan's experience.

The Employee Retirement Income Security Act (ERISA) of 1974 establishes minimum standards for retirement, health, and other welfare benefits plans, including life insurance, disability insurance, and apprenticeship plans.

How These New Rules Will Work – Ensuring Value for Consumers

Providing Rebates to Consumers:

Insurance companies that are not meeting the medical loss ratio standard will be required to provide rebates to their consumers. Insurers will be required to make the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year. The final regulations, issued in December of 2011, directly addressed that rebates were to be paid to the policyholder, which for group health plans usually means the employer/plan sponsor. The final regulations then went on to establish requirements about how the group policyholder must administer the rebate distribution. For ERISA plans, the Department of Labor (DOL) also issued Technical Release 2011-04 that explained how these rebates were to be administered for ERISA plans. Each enrollee must receive a rebate that is proportional to the premium amount paid by that enrollee.

Insurer Reporting Requirements:

Beginning in 2011, insurance companies that issue policies to individuals, small employers, and large employers have to report the following information in each State it does business:

- Total earned premiums
- Total reimbursement for clinical services
- Total spending on activities to improve quality; and
- Total spending on all other non-claims costs excluding federal and State taxes and fees.

ERISAEdge™

These reports will be posted publicly by HHS so residents of every State will have information on the value of health plans offered by different insurance companies in their State.

An insurer will report aggregate premium and expenditure data for each market, except for so-called "expatriate" and "mini-med" plans. For these plans, insurers will be allowed to report their experience separately. The regulation accelerates data collection and creates a special methodology that follows this recommendation to the extent permitted by the Affordable Care Act. HHS is allowing the same treatment for mini-med plans — insurance products with very low annual dollar limits and low premiums – to allow this type of coverage to continue until 2014 when better, more affordable options will be available to consumers.

The ERISAEdge Solution

ERISAEdge provides a solution to employers by performing all key areas of ERISA administration requirements and ensuring complete compliance with the law.

ERISAEdge Administration means TASC does the following:

- Provides Hold Harmless for all ERISA services provided.
- Ensures ERISA Plan is current with all regulations.
- Monitors the associated employee benefits to ensure timely disclosure of plan change to employees.
- Provides resolution assistance in the event that your employee benefit plans are reviewed by the DOL.
- Provides technical and customer service assistance.
- Provides access to experienced employee benefits professionals.
- Provides instruction regarding required on-site record keeping.
- Maintains all required records for the mandated amount of time.
- Provides online storage of Plan document(s)/SPD.
- Completes the required forms accurately and in a timely manner.
- Prepares the Wrap Plan Document/Summary Plan Description.
- Prepares the Summary Material Modification (if necessary).
- Prepares IRS Form 5500 and associated Schedule A or C (if required).
- Prepares the SAR (if required).
- Creates and distributes a bi-annual Client newsletter.

Don't fail a DOL audit! Don't owe monetary penalties to an Employee! Don't fail to provide the required legal documentation!

Insurers Notice of Rebates Requirement:

Insurers must provide notices of rebates, if any, to current group health plan participants, and group policyholders. The notice must include

(i) a description of the MLR concept generally,

(ii) the purpose of setting an MLR standard,

(iii) the applicable MLR standard,

(iv) the insurer's MLR for the calendar year being reported,

(v) the insurer's aggregate premium revenue as adjusted for the relevant tax and risk factors,

(vi) the rebate percentage for the involved group,

(vi) a statement that the aggregate group rebate is being provided to the group policyholder, and

(vii) a statement about the policyholder's obligations with respect to administering the rebate distribution, the content of which will depend on whether the policyholder is a sponsor of an ERISA plan, a non- federal government plan or a non-ERISA plan.

Enforcement:

The Affordable Care Act gives the Secretary direct enforcement authority for the medical loss ratio requirements. However, HHS recognizes States' capacity to assist in enforcement and will accept the findings of a State audit of MLR compliance if they are based on the medical loss ratio requirements set forth in federal law and regulations.

The regulation also requires insurers to retain documentation that relates to the data they reported and to provide access to those data and their facilities to HHS, so compliance with reporting and rebate requirements can be verified.

Finally, the regulation imposes civil monetary penalties if an insurer fails to comply with the reporting and rebate requirements set forth in the regulation, and it details the criteria and process for determining whether and in what amount such penalties should be imposed. Although the law allows HHS to develop

Failure to comply with ERISA's requirements can be quite costly, with possible DOL enforcement actions and penalty assessments and/or employee lawsuits resulting.

separate monetary penalties for medical loss ratio non-compliance, HHS has adopted the HIPAA penalties in this regulation. The regulation's penalty for each violation is $100 per entity, per day, per individual affected by the violation. These penalties do not include penalties that can be assessed by the DOL and IRS for failure to comply with the MLR rebates.

Employer/Plan Sponsor MLR Responsibility:

The Department of Labor (DOL) has determined the MLR rebates are plan assets. If the Plan Document/SPD is silent, 100% of the rebate falls under plan assets. By adding the terms via the Plan Document Amendment/ Summary of Material Modification (SMM), the employer can retain a prorated portion of the rebate equal to the percent of premium paid by the employer. Only the percent of the rebate equal to the percent of premium the participant paid will be considered plan assets and must be used exclusively for the benefit of the plan. This document allows the plan to retain its fair share of any premium rebate that may become due under the terms of Health Care Reform.

ERISA Plans -- *Are the Rebates Plan Assets?*

For group health plans, a distribution such as the rebate will be a plan asset if a plan has a beneficial interest in the distribution under ordinary notions of property rights. **Under ERISA section 401(b)(2), if the plan or its trust is the policyholder, the policy would be an asset of the plan, and in the absence of specific plan or policy language to the contrary, the employer would have no interest in the distribution. On the other hand, if the employer is the policyholder and the insurance policy or contract, together with other documents governing the plan, can fairly be read to provide that some part or all of a distribution belongs to the employer, then that language will generally govern, and the employer may retain distributions.**

- The portion paid by the employees must be treated as plan assets.
- If the employer pays the entire premium, no part of the rebate is a plan asset and the employer can keep the entire rebate.
- If the employees pay a percentage of the premium, that percentage is to be treated as a plan asset.
- If the employees pay a fixed amount and the employer pays the rest, the amount paid by the employees is a plan asset and the excess is not; whereas if the employer pays a fixed amount and the employees pay the rest, it is the excess of the employer payment that is the plan asset.
- The DOL has emphasized that employer/ plan sponsors are prohibited under ERISA from receiving a rebate amount greater than the total amount of premiums and other plan expenses paid by the employer.

ERISA Plans -- *Should the Rebates That Are Plan Assets Be Kept In Trust?*

To the extent the rebates are plan assets, ERISA would generally require they be held in trust.

Technical Release 2011-04, however, provides a safe harbor -- if the rebate is used to "pay premiums or refunds" within three months, then no trust is required.

ERISA Plans -- Distributing the Rebates

To avoid negative tax consequences to plan participants by making a cash payment to them of the rebates owed, the plan fiduciary could apply the rebate towards future premiums (i.e., a premium discount) or by putting it toward enhancing plan benefits.

The DOL allows for cash refunds to participants, though the decision to distribute the rebates in that manner is subject to fiduciary considerations.

The DOL has stated that the distributions need only be made to those who are plan participants in the year the rebates are received. Employers need not track down those who were participants in the year to which the rebates relate (the year for which the MLR was calculated), but are no longer in the plan.

The DOL has outlined three permissible distribution methods:

1. Reduce premiums for the subsequent year for all participants in the plan, even if they were not covered under the option that generated the rebate.
2. Reduce premiums only for those in the plan's option that generated the rebate.
3. Pay a taxable cash refund to those enrolled in the plan option that generated the rebate.

If distributing payments to any participants is not cost-effective (e.g., payments to participants are of "*de minimis*" amounts, or would give rise to tax consequences to participants or the plan), the fiduciary may utilize the rebate for other permissible plan purposes including applying the rebate toward future participant premium payments or toward benefit enhancements.

Non-ERISA Plan -- Distributing the Rebates

The Department of Health and Human Services (DHHS) regulations require that Non-Federal plans for which ERISA duties do not apply the rebates must be treated in a manner similar to an ERISA plan.

For plans that are neither government or ERISA plans (church plans), insurers are allowed to pay any rebates to the group policyholder only if the policyholder agrees, in writing, that they will pay the rebate to participants in the same manner for non-government plans. If there is no written agreement the insurer must pay the FULL amount of the rebate, including the amount paid by the employer policyholder, to the participants in equal amounts.

The Next Step:

Employers who sponsor insured group health plans should familiarize themselves with these MLR should there be rebates issued by their insurer.

They should begin planning for how they might want to administer the distributions of a possible rebate, consistent with their fiduciary obligations. Even f there are no rebates to be paid in 2012, there should be a written policy in place should rebate distributions be paid in 2013 or in any subsequent years.

PLEASE NOTE: Effect of lack of policy for refund of premiums on small employers:

Failure to provide refund policy could result in a small employers' 5500 filing requirement. As part of the small group exception (under 100) employer's that receive refunds from an insurance company for distribution to participants must have an allocation policy and let the participant know of such allocation policy or they must file a 5500 return for the plan.

In the past few carriers refunded premiums. Employers should review carrier certificates for broad language of Employer refund policy intent or must have the policy written in the ERISA wrap SPD or SMM.

Large employer Fully-insured Plans (100+ participants) would be required to file a Schedule H with their annual 5500 report.

MLR rebates do not apply to self-insured plans.

With the ACA requirement of the SBC quickly approaching, we have chosen to include all available Q&A's issued by the Departments responsible for the enforcement pf the SBC.

Should you have questions please contact your local TASC Regional Sales Director.

Summary of Benefits and Coverage (SBC):

On February 14, 2012, the Departments published the final rules regarding the SBC[1] These FAQs aim to answer some of the questions that have been raised to date.

Q1: When must plans and issuers begin providing the SBC?

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries 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 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 special enrollees), the SBC must

What are the consquences of IRS Form 5500 noncompliance?

Under ERISA, penalties can be imposed by the DOL for any refusal or failure to file a required IRS Form 5500. Penalties may be assessed for late or un-filed Form 5500s as well as for incomplete or otherwise deficient Form 5500s.

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.

Q2: What is the Departments' basic approach to implementation of the SBC requirement during the first year of applicability?

The Departments' basic approach to ACA implementation, as stated in a previous FAQ (see http://www.dol.gov/ebsa/faqs/faq-aca.html), 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. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.

In addition to the general approach to implementation, in the instructions for completing the SBC, we stated:

> "To the extent a plan's terms do not reasonably correspond to these 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."

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 provide the required SBC content in an appearance that is consistent with the final regulations. The Departments intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community.

Q3: Are plans and issuers 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?

No, plans and issuers may combine information 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.

Q4: If the participant is able to select the levels of deductible, co-payments, and co-insurance for a particular benefit package, are plans and issuers required to provide a separate SBC for every possible combination that a participant may select under that benefit package?

No, as with the response to Q3, 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. An example of how to note assumptions used in creating coverage examples is provided in the Departments' sample completed SBC[(2)].

Q5: If a group health plan is insured and utilizes "carve-out arrangements" (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, who is responsible for providing the SBC with respect to the plan?

The Departments recognize that different combinations of plans, issuers, and their

service providers may have different information necessary to provide an SBC, including the coverage examples.

The Departments have determined that, until further guidance is issued, where a group health plan or group health insurance issuer has entered into a binding contractual arrangement under which another party has assumed responsibility to (1) complete the SBC[2], (2) provide required information to complete a portion of the SBC, or (3) deliver an SBC with respect to certain individuals in accordance with the final regulations, the plan or issuer generally will not be subject to any enforcement action by the Departments for failing to provide a timely or complete SBC, provided the following conditions are satisfied:

- The plan or issuer monitors performance under the contract,
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practicable, and
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.

Q6: If a plan offers participants add-ons to major medical coverage that could affect their cost sharing and other information in the SBC (such as a health flexible spending arrangement (Health FSA), health reimbursement arrangement (HRA), health savings account (HSA), or wellness program), is the plan permitted to combine information for all of these add-ons and reflect them in a single SBC?

Yes. As stated in the preamble to the final regulations and the instructions for completing the SBC template[3], plans and issuers are permitted to combine such information in one SBC, provided the appearance is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them (the Departments' sample completed SBC[2] provides an example of how to denote the effects of a diabetes wellness program).

Q7: The final regulations require the SBC to be provided in certain circumstances within 7 business days. Does that mean the plan or issuer has 7 business days to send the SBC, or that the SBC must be received within 7 business days?

In the context of the final regulations, the term "provided" means sent. Accordingly, the SBC is timely if sent out within 7 business days, even if it is not received until after that period.

Q8: Are plans and issuers required to provide SBCs to individuals who are COBRA qualified beneficiaries?

Yes. While a qualifying event does not, itself, trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. See 26 CFR 54.4980B-5, Q&A-4(c) (requirement to provide election) and 54.4980B-3, Q&A-3 (definition of similarly situated non-COBRA beneficiary). In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary. There are also limited situations in which a COBRA qualified beneficiary may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event and this may trigger the right to an SBC. See 26 CFR 54.4980B-5, Q&A-4(b).

Q9: What circumstances will trigger the requirement to provide an SBC to a participant or beneficiary in a group health plan? In particular, how do the terms "application" and "renewal" apply to a self-insured plan?

The final regulations require that the SBC be provided in several instances:

- *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 (paper form or through a website or email) that 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 any change in the information required to be in 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 season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and 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[(4)].
- *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.

Q10: What are the circumstances in which an SBC may be provided electronically?

With respect to group health plan coverage, an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries who are eligible but not enrolled for coverage, if:

- The format is readily accessible (such as html, MS Word, or PDF format);
- The SBC is provided in paper form free of charge upon request; and
- If the SBC is provided via an Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by e-mail.

An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary who is covered under a plan in accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.

With respect to individual market coverage, a health insurance issuer must provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless:

- The format is readily accessible;
- If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible;
- The SBC is provided in an electronic form which can be retained and printed; and,
- The issuer notifies the individual that the SBC is available free of charge in paper form upon request.

In addition, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application.

However, issuers must provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations.

As stated in the regulations, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

Q11: Are issuers who have provided individual market plan information to HealthCare.gov in compliance with PHS Act section 2715 and its implementing regulations already?

The deemed compliance provision in the regulation requires issuers in the individual market to provide all of the data elements that are needed to complete the SBC template to HealthCare.gov. If the issuer fails to provide all of the data elements, it would not be deemed to be in compliance with the regulation. Today, HealthCare.gov does not collect all of the elements of an SBC, such as information necessary to complete the coverage examples. However, HHS will collect this information and display it in the format of the SBC template by September 23, 2012, so that providing information to HealthCare.gov fulfills the deemed compliance provision.

Q12: Can the Departments provide model language to meet the requirement to provide an e-card or postcard in connection with evergreen website postings?

Yes. Plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways. One example is:

> ***Availability of Summary Health Information***
>
> As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
>
> Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
>
> The SBC is available on the web at: www.website.com/SBC.

Q13: The regulations state that in order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Does this mean that the SBC must include a sentence on the availability of language assistance services?

Yes, if the notice 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 final SBC regulations provide that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of the claims and appeals regulations are met[6].

The claims and appeals regulations outline three requirements that must be satisfied for notices sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. In such cases, the plan or issuer is generally required to provide oral language services in the non-English language, provide notices upon request in the non-English language, and 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 or issuer.

Accordingly, plans and issuers must include, in the English versions of SBCs sent to an address in a county in which ten percent or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer. In this circumstance, the plan or issuer should include this statement on the page of the SBC with the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections.

Sample language for this statement is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc.

Current county-by-county data can be accessed at http://www.cciio.cms.gov/resources/factsheets/clas-data.html.

Even in counties where no non-English language meets the ten percent threshold, a plan or issuer can voluntarily include such a statement in the SBC in any non-English language. Moreover, nothing in the SBC regulations limits an individual's rights to meaningful access protections under other applicable Federal or State law, including Title VI of the Civil Rights Act of 1964.

Q14: Where can plans and issuers find the written translations of the SBC template and the uniform glossary in the non-English languages?

Written translations in Spanish, Chinese, Tagalog and Navajo will be available at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

Q15: Is an SBC permitted to simply substitute a cross-reference to the summary plan description (SPD) or other documents for a content element of the SBC?

No, an SBC is not permitted to substitute a reference to the SPD or other document for any content element of the SBC. However, an SBC may include a reference to the SPD in the SBC footer. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.")

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 the SPD in order to supplement or elaborate on that information.

Q16: Can a plan or issuer add premium information to the SBC form voluntarily?

Yes. If a plan or issuer chooses to add premium information to the SBC, the information should be added at the end of the SBC form.

Q17: Must the header and footer be repeated on every page of the SBC?

No. If a plan or issuer chooses, it may include the header only on the first page of the SBC. In addition, a plan or issuer may include the footer only on the first and last page of the SBC, instead of on every page.

The OMB control numbers (which were displayed on the SBC template and the Departments' sample completed SBC to inform plans and issuers that the Departments had complied with the Paperwork Reduction Act) should not be displayed on SBCs provided by plans or issuers.

Q18: For group health plan coverage, may the coverage period in the SBC header reflect the coverage period for the group plan as a whole, or must the coverage period be the period applicable to each particular individual enrolled in the plan?

The SBC may reflect the coverage period for the group health plan as a whole. Therefore, if a plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.

Q19: Can issuers and plans make minor adjustments to the SBC format, such as changing row and column sizes? What about changes such as rolling over information from one page to another, which was not permitted by the instructions?

Minor adjustments are permitted to the row or column size in order to accommodate the plan's information, as long as the information is understandable. The deletion of columns or rows is not permitted.

Rolling over information from one page to another is permitted.

Q20: Can plan names be generic, such as "Standard Option" or "High Option"?

Yes, generic terms may be used.

Q21: Can the issuer's name and the plan name be interchangeable in order?

Yes.

Q22: Can barcodes or control numbers be added to the SBC for quality control purposes?

Yes, they can be added.

Q23. Is the SBC required to include a statement about whether the plan is a grandfathered health plan?

No, although plans may voluntarily choose to add a statement to the end of the SBC about whether the plan is a grandfathered health plan.

Q24. My plan is moving forward to implement the SBC template for the first year of applicability. Are significant changes anticipated for 2014?

No. The Departments identified in the preamble to the final regulations certain discrete changes that would be necessary for plan years (or, in the individual market, policy years) beginning after the first year of applicability.

These changes include the addition of a minimum value statement and a minimum essential coverage statement, changes to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits, and the Departments' intent to add additional coverage examples.

The Departments are also considering making some refinements consistent with these FAQs and other requests from plans and issuers for clarification and to promote operational efficiencies. No other changes are planned at this time.

Below are additional FAQ's issued by the Departments:

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 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 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 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 www.dol.gov/ebsa/faqs/faq-aca8.html and 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.

Q9: For the first year of applicability[2], 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[4]. 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 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 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[5].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).

Q11: A previous FAQ provided a link where written translations for the SBC template and the uniform glossary would be available in the future. 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 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 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 SBC template and sample completed SBC also include sample taglines for obtaining translated documents, to be included if appropriate consistent with paragraph (a)[4] 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 www.dol.gov/ebsa/healthreform and cciio.cms.gov. These three documents replace the prior versions issued contemporaneously with the final regulations in February 2012.

Footnotes

(1) See 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200, published February 14, 2012 at 77 FR 8668.

(2) The Departments' sample completed SBC is available at: www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf

(3) See 77 FR 8668, 8670-71 (February 14, 2012) and page 1 of Instruction Guide for Group Coverage at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf.

(4) The final regulations provide an accommodation for insured coverage if the policy, certificate, or contract of insurance has not been renewed or reissued prior to the date that is 30 days prior to the first day of the new plan or policy year. In such cases, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(5) See 26 CFR 54.9815-2719T(e), 29 CFR 2590.715-2719(e), and 45 CFR 147.136(e), originally published on July 23, 2010, at 75 FR 43330 and amended on June 24, 2011, at 76 FR 37208.

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