Deadline To Send ACA Summary of Benefits & Coverage (SBC) Adds Pressure For Employers To Finalize 2014 Plan Designs As Agencies Add MEC & MV Disclosures To SBC

By Cynthia Marcotte Stamer[1]

Employer and union group health plan sponsors and insurers of group and individual health plans (Health Plans) agonizing over 2014 health plan design decisions need to keep in mind that impending deadlines to update and deliver required Summary of Benefits and Communications (SBC) disclosures mandated by the Patient Protection and Affordable Care Act (Affordable Care Act) shorten the time to finalize decisions including new requirements to disclose whether the Affordable Health Plan-covered Health Plans provide "minimum essential coverage" (MEC) and "minimum value" within the meaning of the Affordable Care Act.

The Affordable Care Act's requirement that Health Plans distribute updated SBCs before the beginning of the enrollment period for coverage to be provided in 2014 creates added urgency and pressure for Health Plans and their employer and other sponsors to finalize and implement their decisions on their Health Plans 2014 plan designs and coverages to allow adequate lead time to prepare and deliver the required SBCs for 2014.

The Departments of Health & Human Services (HHS), Labor (DOL) and Treasury (IRS)(collectively, the Agencies) announced April 23, 2013 that SBCs for periods of coverage after December 31, 2013 must disclose if the Health Plans provide MEC and minimum value. Health Plans, their sponsors, fiduciaries, and insurers generally will need to update their Health Plans' SBCS to include these disclosures as well as to incorporate other changes necessary to accurately disclose other plan design changes made to post-December 31, 2013 coverage before the enrollment period begins. Plan sponsors planning changes to their health plans must allow sufficient lead time to both finalize plan designs and contracts, amend plan documents, make MEC and minimum value determinations, and then timely update and distribute the SBC in accordance with the SBC rules. This means that most plan sponsors of Health Plans have much less time than historically used to finalize their decisions.

ACA SBC Mandate Overview

As amended by the Affordable Care Act amended the Public Health Services Act (PHS) § 2715, Employee Retirement Income Security Act (ERISA) § 715 and the Internal Revenue Code (Code) §§ 9815 require that Health Plans provide a SBC and a "Uniform Glossary" that "accurately describes the benefits and coverage under the applicable plan or coverage" in a way that meets the format, content and other detailed SBC standards set for the Affordable Care Act as implemented by the Departments regulatory guidance.

The **Summary of Benefits and Coverage and Uniform Glossary Final Regulation** (Final Regulation) implementing this requirement published February 14, 2012 generally requires Health Plans at specified times including before the first offer of coverage under the Plan as well as following certain material changes to the Plan. For Health Plans providing group health plan coverage, **FAQs About Affordable Care Act Implementation (Part VII)**[*] set the deadline for Health Plan to deliver a SBC as follows, while at the same time indicating that the Departments would not impose penalties on plans and issuers "working diligently and in good faith" to provide the required SBC content in an appearance consistent with the Final Regulations:

- To covered persons enrolling or re-enrolling in an open enrollment period (including late enrollees and re-enrollees) as the first day of the first open enrollment period that begins on or after September 23, 2012; and
- For individuals enrolling in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees) as the first day of the first plan year that begins on or after September 23, 2012. See **FAQs About Affordable Care Act Implementation (Part VIII).**

The Final Regulation and other existing guidance generally dictates that Health Plans follow a required template for providing the SBC and accompanying glossary. When publishing the Final Regulation, the Departments also published the required SBC template form (2013 SBC Template) and instructions for Health Plans to use to prepare and provide the required SBC for coverage beginning before January 1, 2014 and promised updated guidance and templates for use in providing SBCs for post-2013 coverage. While the Agencies clarified certain other details about the SBC rules, they did not materially change the required content or form of the 2013 SBC Template until their April 23, 2013 release of **FAQs About Affordable Care Act Implementation (Part XIV)**. See e.g. FAQs About Affordable Care Act Implementation **Part IX** and **Part X**.

FAQ Part XIV Requires MEC and Minimum Value Disclosures In SBC

FAQs About Affordable Care Act Implementation (Part XIV) published April 23, 2013 announces the updated required **2014 SBC Template** that the Agencies are requiring to SBCs for periods of health coverage from January 1, 2014 to December 31, 2014. Along with the 2014 SBC Template, the Agencies also published **2014 Sample Completed SBC**, which provides an example of a SBC completed for a hypothetical health plan prepared by the Agencies.

The 2014 SBC Template updates the 2013 SBC Template and Sample Completed Template to add information the Agencies believe individuals eligible for Health Plan coverage should know in light of the impending implementation of the individual shared responsibility requirements of Internal Revenue Code (Code) **§ 5000A** and the employer shared responsibility rules of Code **§ 4980H** commonly called the Affordable Care Act's "pay-or-play" rules. These were the "penalty" provisions that the Supreme Court ruled are taxes last Summer.

Rationale For SBC Changes

Beginning in 2014, Code § 4980H generally requires employers of 50 or more full-time employees to pay a penalty if the employer fails to offer a group health plan providing MEC and meeting the "minimum value" requirements of the Affordable Care Act. Code § 36B(c)(2)(C)(ii) provides that an employer-sponsored Health Plan provides MV if the ratio of the share of total costs paid by the Health Plan relative to the total costs of covered services is no less than 60% of the anticipated covered medical spending for covered benefits paid by a group health plan for a standard population, computed in accordance with the plan's cost-sharing, and divided by the total anticipated allowed charges for covered benefits provided to a standard population is no less than 60%. See **Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Regulation**. HHS has published a MV Calculator for use in calculating this percentage.

Meanwhile, Code § 5000A generally imposes a penalty tax on individuals that fail to maintain enrollment in "minimum essential coverage" (MEC) within the meaning of Code § 5000A(f) and not otherwise exempt under Code § 5000A(d).

SBC Changes Required By FAQs XIV In Response To Pay-Or-Play Rules

Since choosing to enroll in an employer-sponsored health plan providing MEC is one of the options that individuals can choose to avoid incurring the individual penalty under Code § 5000A, the Agencies feel that the SBC should disclose whether the offered Health Plan provides MEC and provides the requisite Minimum Value. Accordingly, the 2014 SBC Template requires that the SBC disclose if the Health Plan provides MEC and meets Minimum Value. The Agencies did not make any changes to the uniform glossary, Instructions for Completing the SBC, "Why This Matters" language, or to the coverage examples for the SBC.

In general, the SBC requires that Health Plans update their existing SBCs to make the following disclosures for post-December 31, 2013 periods of coverage:

> **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."**

Health Plans will need to finalize plan designs and conduct the necessary analysis to decide the correct way to complete this language, then update SBCs to be provided for post-December 31, 2013 periods of coverage to include the required language appropriately completed based on the findings. Where the design of the 2014 SBC is too advanced already to do this, the Guidance allows Health Plans to provide the required language by sending the language in a supplemental SBC communication. However, most Health Plans will want to avoid the added cost and expense of the printing and distribution of this notification.

Other SBC Requirement Clarifications in FAQs XIV

While the 2014 SBC Template remains unchanged other than for the additional required statements about the MEC and minimum essential coverage, FAQs XIV does provide various other helpful clarifications about how to complete the 2014 SBC Template about the applicability of lifetime and annual limits in light of the Affordable Care Act's restrictions on these limitations.

In addition, FAQs XIV also continues for another year the guidance in:

- 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) for another year;
- Affordable Care Act Implementation FAQs Part IX, Q1 regarding the circumstances in which an SBC may be provided electronically and associated enforcement relief;
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);

- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
- 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); and
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);
- Current enforcement relief about the Special Rule contained in the Instruction Guides for Group and Individual Coverage and about Medicare Advantage Plans contained in Affordable Care Act Implementation FAQs Part X, Q1
- Continues Affordable Care Act Implementation FAQs Part VIII, Q5 regarding use of carveout arrangements "until further guidance is issued."
- Extends to September 23, 2014 existing relief for plans and issuers with respect to an insured health insurance product is not being actively marketed where the health insurance issuer has not actively marketed the product at any time on or after September 23, 2012 provided the SBC is provided for that product no later than September 23, 2014; and
- The anti-duplication rule for student group health coverage in the Final SBC regulations.

SBC Delivery Deadline Means Time Short To Finalize 2014 Plan Designs

Employer and other health plan sponsors, insurers, administrators and others involved in 2014 Health Plan decisions and preparations must take into account the deadline for distributing the SBC before the enrollment period begins and allow adequate lead time to properly finalize their Health Plan design decisions and the analysis required to accurately prepare and deliver the SBC.

Since Health Plan design decisions must be finalized to properly prepare the newly added MEC and minimum value and other required SBC disclosures, the need to prepare and distribute the SBC by the beginning of enrollment periods for post-December 31, 2013 periods of coverage means time running short to finalize 2014 plan designs. Employer and other Health Plan sponsors and others involved in 2014 Health Plan decision-making must take into account the SBC requirements and deadlines to ensure that they allow adequate time to complete the analysis and other preparations necessary timely to prepare and distribute SBCs in respond to the design decisions ultimately elected. This includes the careful preparation of the SBC to accurately reflect Health Plan design and terms, the review and coordination of the language of existing Health Plan documents and summary plan descriptions to identify and address potential discrepencies between the government-mandated terms and language in the Glossary and SBC and those documents, proper structuring and formatting of all of these documents and timely distribution in accordance with applicable regulations to participants and beneficiaries entitled to receive these documents in a manner that positions the Health Plan to show compliance. In regard to distributions, Health Plans and others involved in the planning and execution of these processes also need to ensure that any electronic or other methods of distribution meet applicable requirements and that copies are distributed to all entitled parties – employees and dependents – in accordance with the applicable rules.

For Help or More Information

If you need help with the SBC or other 2014 health plan decision-making or preparation, or with reviewing and updating, administering or defending your group health or other employee benefit, human resources, insurance, health care matters or related documents or practices, please contact the author of this update, Cynthia Marcotte Stamer.

---

[1] A Fellow in the American College of Employee Benefit Council, immediate past Chair of the American Bar Association (ABA) RPTE Employee Benefits & Other Compensation Group and current Co-Chair of its Welfare Benefit Committee, Vice-Chair of the ABA TIPS Employee Benefits Committee, a council member of the ABA Joint Committee on Employee Benefits, and past Chair of the ABA Health Law Section Managed Care & Insurance Interest Group, Ms. Stamer is recognized, internationally, nationally and locally for her more than 25 years of work, advocacy, education and publications on cutting edge health and managed care, employee benefit, human resources and related workforce, insurance and financial services, and health care matters.

A board certified labor and employment attorney widely known for her extensive and creative knowledge and experienced with these and other employment, employee benefit and compensation matters, Ms. Stamer continuously advises and assists employers, employee benefit plans, their sponsoring employers, fiduciaries, insurers, administrators, service providers, insurers and others to monitor and respond to evolving legal and operational requirements and to design, administer, document and defend medical and other welfare benefit, qualified and non-qualified deferred compensation and retirement, severance and other employee benefit, compensation, and human resources, management and other programs and practices tailored to the client's human resources, employee benefits or other management goals. A primary drafter of the Bolivian Social Security pension privatization law, Ms. Stamer also works extensively with management, service provider and other clients to monitor legislative and regulatory developments and to deal with Congressional and state legislators, regulators, and enforcement officials concerning regulatory, investigatory or enforcement concerns.

Recognized in Who's Who In American Professionals and both an American Bar Association (ABA) and a State Bar of Texas Fellow, Ms. Stamer serves on the Editorial Advisory Board of Employee Benefits News, HR.com, Insurance Thought Leadership, Solutions Law Press, Inc. and other publications, and active in a multitude of other employee benefits, human resources and other professional and civic organizations. She also is a widely published author and highly regarded speaker on these matters. Her insights on these and other matters appear in the Bureau of National Affairs, Spencer Publications, the Wall Street Journal, the Dallas Business Journal, the Houston Business Journal, Modern and many other national and local publications. You can learn more about Ms. Stamer and her experience, review some of her other training, speaking, publications and other resources, and register to receive future updates about developments on these and other concerns from Ms. Stamer **here**.