



Subject:

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- **Final Rules And Format For Uniform Summary Of Benefits And Coverage**
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Date:

February 10, 2012

Final Rules: Summary of Benefits and Coverage

The governing Agencies (HHS, IRS and DOL) responsible for interpreting and regulating the Affordable Care Act (ACA), have been busy these last days issuing guidance to employers. Of particular note, we now have guidance on ACA's requirement for a uniform summary of benefits and coverage (SBC).

As background, ACA requires individual and group health plans to provide a written 4-page (can be double-sided but cannot be smaller than 12-point font) uniform summary of benefits and coverage. Plans must begin using this SBC for the first open enrollment period occurring on or after September 23, 2012. For calendar year plans, this would be the open enrollment period occurring in late 2012 for 2013 calendar year. If a plan does not have an open enrollment period, the SBC would be required for special enrollment events occurring on or after the first day of the first plan year after September 23, 2012.

What's in the SBC?

SBCs must include the following information:

1. Uniform definitions of standard insurance and medical terms for purposes of comparing and understanding health coverage;
2. A description of the coverage, including cost sharing, for each category of benefits;
3. The exceptions, reductions, and limitations of the coverage;
4. The cost-sharing requirements of the coverage, including deductible, coinsurance, and copayment obligations;
5. The renewability and continuation of coverage provisions;
6. Coverage examples that illustrate benefits provided under the plan for common benefit scenarios, such as pregnancy or a chronic medical condition;
7. A statement that the plan provides minimum essential coverage (only applicable to coverage beginning on or after January 1, 2014);
8. A statement that the SBC is a summary only, and that the plan document or insurance policy, certificate, or contract must be consulted to determine the governing contractual terms of the coverage;
9. Contact information, including phone numbers and internet address for consumers to ask questions, and to request a copy of the plan document or insurance policy, certificate, or contract. In addition, the relevant contact information must be provided for obtaining the plan's list of network providers, and information about a plan's prescription drug formulary, if applicable.

10. An internet address and contact phone number for obtaining the uniform glossary, as well as a statement about the availability of paper copies of the glossary.

SBC Templates

The governing agencies provide templates for the SBCs and uniform glossary that can be used:

- [Summary of Benefits and Coverage Template](#)
- [Uniform Glossary of Coverage and Medical Terms](#)

Additional instructions for completing the SBC, sample completed SBCs and coverage examples are available from both HHS and DOL websites.

Who Provides the SBC?

Generally, for insured plans, the SBCs will be provided by the insurer. For self-funded plans, the plan sponsor will be responsible for issuing SBCs.

It is important for plans subject to ERISA to remember that they are still obligated to comply with all of the reporting and disclosure requirements of ERISA, including the summary plan descriptions and summary of material modifications. This guidance affirms that an SBC can be incorporated with another document, such as an SPD (summary plan description), as long as it is clearly identified as the SBC and is placed at the beginning of the document into which it is incorporated. This should come as welcome news to those responsible for ERISA plans.

What's the Timeframe for Providing the SBCs?

The SBCs must be provided in the following timeframes:

From Insurer to Plan Sponsor

1. Upon application for coverage. The SBC must be provided upon application for coverage as soon as practicable but no later than 7 days following receipt of the application.
2. By the first day of coverage if there are any changes made to the information contained in the SBC.
3. Upon contract renewal, the insurer must provide a new SBC if written application is required for the renewal no later than the date the application materials are distributed. If the contract automatically renews, the SBC must be provided within 30 days prior to the beginning of the first day of the new plan year.
4. Upon request. The SBC must be provided upon the plan sponsor's request as soon as practicable but no later than 7 days following receipt of the request.

From Plan Sponsor to Plan Participants

Plan sponsors must provide the SBC to all participants and beneficiaries for each benefit package to which the participants and beneficiaries are eligible in the following timeframes:

1. Upon application. The SBC must be provided together with any written enrollment materials distributed to participants. If written enrollment materials are not distributed, then the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage.
2. By the first day of coverage if there are any changes made to the information contained in the SBC.
3. SBCs must be provided to special enrollees within 90 days of enrollment.
4. Upon contract renewal, the insurer must provide a new SBC if written application is required for the renewal no later than the date the application materials are distributed. If the contract

automatically renews, the SBC must be provided within 30 days prior to the beginning of the first day of the new plan year.

5. Upon request. The SBC must be provided upon the participant's request as soon as practicable but no later than 7 days following receipt of the request.

Notice of Material Modification. If a group health plan makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan must provide notice of the modification to enrollees no later than 60 days prior to the date on which the modification will become effective.

Multiple Benefit Packages. If a group health plan offers multiple benefit packages, SBCs need only be provided for the particular plan for which the individual is covered. However, participants can request an SBC to another benefit package; in this event, the SBC must be provided as soon as practicable but no later than 7 days following receipt of the request.

How are SBCs Distributed?

SBCs can be provided to participants in paper form, as well as electronically, such as by e-mail or internet posting. If delivered electronically to individuals in the workplace, the DOL's electronic distribution rules must be satisfied:

1. The individual has ready access to a system (a computer).
2. A plan administrator must ensure receipt of the document. Suggestions include use of return-receipt or notice of undelivered mail features, or conducting periodic reviews or surveys to confirm receipt of transmitted information.

For electronic disclosure to individuals outside the workplace, certain conditions must be met. The individual must:

1. Consent, in writing, to the electronic disclosure. The consent must identify the type(s) of document to which it applies. The consent must occur after the individual has been given information about the electronic disclosure. Individuals have the right to withdraw a consent at any time, without charge.
2. Provide his/her e-mail address to receive the electronic disclosure, if applicable.
3. Be given applicable hardware and software requirements necessary to access the electronic disclosure. If any of these parameters change, an updated notice must be provided to the affected individual, and a new consent must be obtained.

All electronic disclosures must provide a clear statement that a paper copy of the document can be requested.

If a document includes any personal information, appropriate safeguards must be in place to ensure the confidentiality of the information. Use of a password or an individual identifier, as well as encrypting personal information, would be reasonable methods that could be used to ensure confidentiality.

FAQs: 90-day Waiting Period Limitation, Shared Responsibility Requirement and Automatic Enrollment Provision

The ACA governing agencies issued a set of Frequently Asked Questions ([IRS Notice 2012-17](#) and [EBSA Technical Release 2012-1](#), “Notice and Release”) relating to several ACA provisions, specifically, the 90-day waiting period limitation, the employer’s obligation under the shared responsibility requirement, and the automatic enrollment provision.

As background, in 2014, individual and group health plans cannot impose waiting periods under a plan exceeding 90 days. In addition, large employers, those employing 50 or more full-time equivalent employees, could be subject to a shared responsibility penalty if the employer fails to offer minimum essential coverage, or if the coverage offered is unaffordable ([link to bulletin](#)). Very large employers, those with 200 or more employees, will be required to automatically enroll their employees in health coverage with the individuals having the right to opt out of the coverage. It is very important to note that information contained in both the Notice and Release simply an iteration of how the governing agencies are thinking about developing implementing regulations. These documents are not regulation and are not binding in any way. Nevertheless, it gives some indication about how the governing agencies plan to interpret the law.

90-day Waiting Period Limitation

For plan years beginning on or after January 1, 2014, the maximum waiting period that can be imposed by grandfathered (those plans in existence on March 23, 2010) and non-grandfathered health plans or plans that have undergone significant change ([link to bulletin](#)) is 90 days. The Notice and Release confirms that the 90 day waiting period limitation applies to individuals eligible for coverage under the plan. It does not require that a plan offer coverage to any particular group of employees (though, see the Shared Responsibility discussion below).

Generally, the 90-day period is a strict 90-day period though the Notice and Release suggest that the government is looking at allowing the 90-day period to begin after certain eligibility conditions occur, such as attaining full-time status, a bona fide job category, or receipt of a required license. Once an individual has achieved the eligibility standard, then the 90-day period would be a strict 90-day period.

Shared Responsibility Requirement

For purposes of determining coverage affordability, the law provides that the cost of coverage cannot exceed 9.5% of household income. The Notice and Release restates the position that the government is looking at allowing employers to use W-2 earnings for purposes of this calculation.

Generally, the shared responsibility penalty applies if the employer offers inadequate coverage, or if the coverage is unaffordable for the employee. This penalty is triggered if any employee working 30 or more hours per week goes to the exchange and qualifies for premium assistance. The governing agencies address how to determine whether an individual will trigger a penalty in several ways.

First, the Notice and Release suggests that during the 90-day waiting period, a penalty would not be triggered, even if the individual qualifies for premium assistance through the exchange. The Notice and Release goes on to suggest that the agencies might contemplate an “intent” type provision whereby if an individual is hired on a part-time basis, but works full-time during an employer’s busy season, such as the holidays, but then drops down to part-time during the second 90 days of employment, then the penalty would not be triggered during that second 90-day period, as long as the fluctuation in hours is not a way to avoid the intent of the law.

The Notice and Release also suggest that the agencies are considering using a stability period (a look-back period), not to exceed one year. What this would mean is that if an individual would qualify during the look-back (stability) period, then the individual would be deemed to work 30 or more hours per week for the “measurement period.”

Automatic Enrollment in Health Plans

Employers subject to the Fair Labor Standards Act and who employ 200 or more employees are required to automatically enroll new full-time employees in one of their health benefit plans. Although this provision became effective on ACA’s enactment date (March 23, 2010), the governing agencies have indicated in prior guidance, as well as reiterated in the Notice and Release, that employers will not be required to comply with the provision until implementing regulations are issued, which may be after 2014.

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