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Brief Notes

News for Brokers and Consultants

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**Applies to:** Most markets. (There are some exceptions.)

## New rules issued for the Summary of Benefits and Coverage

*Rules mandated under the Affordable Care Act*

**Overview:**
The Affordable Care Act (ACA) mandates health insurance issuers and group health plans to provide a Summary of Benefits and Coverage (SBC). An SBC needs to be provided:

- To all new groups at application.
- When a group is requesting information about its benefits (including pre-sale situations).
- To all groups when they change coverage.
- To groups for their Open Enrollment period.
- To groups on renewal.

The government recently issued final rules around SBCs. Horizon Blue Cross Blue Shield of New Jersey created the following questions and answers to help educate you on the final rules. The new rules apply to health insurance coverage issued during 2014 (or plan year 2014 for group health plans).

**Questions and answers about the new SBC rules**

**Q1. What are the changes required for SBCs?**

A1. The SBC template has changed to include statements about whether the coverage provides Minimum Essential Coverage and whether the plan does or does not meet the Minimum Value requirements.

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The federal government released a new SBC template for group health plans and health insurance coverage beginning after January 1, 2014, and before January 1, 2015.

- The template (authorized for second-year use) is *here*.
- The sample of a completed SBC (authorized for second-year use) is *here*.

**Q2. What is Minimum Essential Coverage?**
A2. The government defines Minimum Essential Coverage as any one of the following plans or programs:

- Government-sponsored programs (e.g., Medicare, Medicaid);
- Employer-sponsored plans inclusive of any employer-sponsored health coverage offered in the small or large group market;
- Health plans in the Individual market;
- Grandfathered health plans; and
- Certain health insurance or health benefits programs.

**Q3. What are the rules around the Minimum Value requirement**?
A3. Under the ACA, employers may be subject to a penalty for failure to provide Minimum Value as part of their employer-sponsored plan/Minimum Essential Coverage. A plan fails to provide Minimum Value, if the allowed cost of benefits under the plan is less than 60 percent of the covered benefits, as determined by the federal government's Minimum Value calculator or any other permitted methods.

**Q4. How does an employer know whether its coverage meets the Minimum Value requirement?**
A4. The federal government has a Minimum Value calculator available. The Minimum Value calculator is similar to the Actuarial Value calculator that the government is also making available.

You can use the calculator to determine Minimum Value *here*.

Employers can enter certain information about benefits into the calculator, including details on:

- Doctor and mid-level practitioner care.
- Hospital and Emergency Room services.
- Pharmacy benefits.
- Laboratory and imaging services.
- Deductibles and copayments.

The employer will be able to see whether the plan provides Minimum Value when it covers at least 60 percent of the total allowed cost of benefits under the plan. Minimum Value is based on the total population and not on a per-service calculation.

**Q5. What is the Safe-Harbor rule around administrative burdens for SBCs?**
A5. The federal government will not take action against a plan or issuer for using the first-year template, if there is significant administrative burden to change the template to the new requirements. In this case, the group health plan or health insurance issuer must provide a cover letter or other communication stating that it does or does not provide Minimum Essential Coverage and Minimum Value.

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**Q6. Which safe harbors does the federal government extend for SBCs?**
A6. The federal government is extending the following safe harbors to stay in place through the end of the second year (plan year 2014 in most markets, though some may be earlier):

- **Approach to implementing SBC requirements** – The federal government permits plans to make changes, with certain limits, to the SBC where it is needed to accurately describe the terms of the coverage (e.g., page numbers).
- **Circumstances in which the SBC may be sent electronically** – SBCs may be sent electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be sent electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to get a paper copy on request. (For Individual market issuers that offer online enrollment or renewal, the SBC may be sent electronically to consumers who enroll or renew online.)
- **Penalties for failure to provide the SBC or Uniform Glossary** – During the second year, as was the case in the first year of the SBC requirements, the government will not impose penalties on plans and issuers that work diligently and in good faith to comply.
- **Coverage Calculator** – Extending the use of the coverage calculator to be used as a safe harbor during the second year.
- **Multiple Issuers/Administrators/Carve-Outs** – Due to the administrative challenges of combining benefit information from two or more issuers, during the first and second years, the federal government will consider allowing multiple, partial SBCs that, together, provide all information to meet the SBC content requirements. The plan or issuer, if contracting to complete the multiple SBC must monitor the performance under the contract to avoid any penalty.
- **Exemption for certain coverage types** – Continued exemption from SBC rules for the Expatriate and Medicare Advantage coverage and closed books of business.
- **Anti-Duplication** – When there are multiple parties sharing the responsibility of providing an SBC, the completion by one party is sufficient. For example, where the issuer provides the SBC upon request, the group health plan has satisfied its requirement to provide the SBC upon request.

We hope that the information in this brief helps you navigate the complexities of the ACA. If you have questions, please contact your Horizon BCBSNJ sales executive or account manager.