SBC Template, and Required Addendums for Covered Entities under ACA Section 1557

Updated March 2017

A Summary of Benefits and Coverage (SBC) is four page (double-sided) communication required by the federal government. It must contain specific information, in a specific order, and with a minimum size type, about a group health benefit's coverage and limitations. If an employer providing an SBC is a covered entity under the ACA's Section 1557, additional requirements apply.

On April 6, 2016, the Centers for Medicare and Medicaid Services (CMS), the Department of Labor (DOL), and the Department of the Treasury issued the final 2017 summary of benefits and coverage (SBC) template, group and individual market SBC instructions, uniform glossary of coverage and medical terms, a coverage example calculator, and calculator instructions.

The SBC is to be used by all health plans, including individual, small group, and large group; insured and self-insured; grandfathered, transitional, and ACA compliant. The new SBC must be used for plan years with open enrollment periods beginning after April 1, 2017. It will not be used for marketplace plans for the 2017 coverage year.

For fully insured plans, the insurer is responsible for providing the SBC to the plan administrator (usually this is the employer). The plan administrator and the insurer are both responsible for providing the SBC to participants, although only one of them actually has to do this.

For self-funded plans, the plan administrator is responsible for providing the SBC to participants. Assistance may be available from the plan administrator's TPA, advisor, etc., but the plan administrator is ultimately responsible. (The plan administrator is generally the employer, not the claims administrator.)

Changes

The template includes a new "important question" that asks "Are there services covered before you meet your deductible?" and requires family plans to disclose whether or not the plan has embedded deductibles or out-of-pocket limits. This is reported in the "Why This Matters" column in relation to the question "what is the overall deductible?" and plans must list "If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible has been met"

or alternatively, “If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.”

Tiered networks must be disclosed and the question “Will you pay less if you use a network provider?” is now included. The SBC also includes language that warns participants that they could receive out-of-network providers while they are in an in-network facility. The SBC also indicates that a consumer could receive a “balance bill” from an out-of-network provider.

The “explanatory coverage page” was dropped from the template.

The coverage examples provided clarify the “having a baby” example and the “managing type 2 diabetes” example, in addition to providing a third example of “dealing with a simple fracture.” The coverage example must be calculated assuming that a participant does not earn wellness credits or participate in an employer’s wellness program. If the employer has a wellness program that could reduce the employee’s costs, the employer must include the following language: “These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].”

The column for “Limitations, Exceptions, & Other Important Information” must contain core limitations, which include:

- When a service category or a substantial portion of a service category is excluded from coverage (that is, the column should indicate “brand name drugs excluded” in health benefit plans that only cover generic drugs);
- When cost sharing for covered in-network services does not count toward the out-of-pocket limit;
- Limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and
- When prior authorization is required for services.

The template and instructions indicate that qualified health plans (those certified and sold on the Marketplace) that cover excepted abortions (such as those in cases of rape or incest, or when a mother’s life is at stake) and plans that cover non-excepted abortion services must list “abortion” in the covered services box. Plans that exclude abortion must list it in the “excluded services” box, and plans that cover only excepted abortions must list in the “excluded services” box as “abortion (except in cases of rape, incest, or when the life of the mother is endangered).” Health plans that are not qualified health plans are not required to disclose abortion coverage, but they may do so if they wish.

Impact of Section 1557 of the ACA – Addendum Required for Covered Entities

On May 13, 2016, the Department of Health and Human Services (HHS) issued a final rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), which took effect on July 18, 2016. Under these regulations, covered entities must provide notices stating they do not discriminate on certain grounds in “significant public-facing publications.” HHS has gone on to confirm that an SBC is a significant public-facing publication.

ACA Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or be subjected to discrimination under any health program or activity which receives federal financial assistance from HHS on the basis of race, color, national origin, sex, age, or disability. The rule applies to any program administered by HHS or any health program or activity administered by an entity established

under Title I of the ACA. These applicable entities are “covered entities” and include a broad array of providers, employers, and facilities. State-based Marketplaces are also covered entities, as are Federally-Facilitated Marketplaces.

The final regulations are aimed primarily at preventing discrimination by health care providers and insurers, as well as employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and longer-term care coverage provided or administered by an employer, group health plan, third party administrator, or health insurer.

Practically speaking, employers with fully insured group health plans will be subject to the regulations (because the carrier is a covered entity and is prohibited from selling discriminatory plans), and many self-funded employers will be considered a covered entity based on their business model or financial details. Furthermore, most third party administrators (TPAs) will be considered a covered entity. The Office of Civil Rights (OCR) will investigate a TPA when there is alleged discrimination in the administration of the plan. However, if the alleged discrimination is in benefit plan design (that is, the choice of the employer), the OCR will process the complaint against the employer or plan sponsor. If the OCR lacks jurisdiction over the employer, it will refer the matter to the Equal Employment Opportunity Commission (EEOC). This means that employers who are not covered entities, but have a self-funded group health plan that utilizes a TPA that is a covered entity, could become the subject of an EEOC investigation for discriminatory business practices.

Employers with self-funded group health plans should seek legal counsel to determine if they are a covered entity, and to obtain legal advice on the applicability of these regulations to their individual situation.

Covered entities must take steps to notify beneficiaries, enrollees, applicants, or members of the public of their nondiscrimination obligations with respect to their health programs and activities. Covered entities are required to post notices stating that they do not discriminate on the grounds prohibited by Section 1557, and that they will provide free (and timely) aids and services to individuals with limited English proficiency and disabilities. These notices must be posted in conspicuous physical locations where the entity interacts with the public, in its significant public-facing publications, and on its website home page. In addition, covered entities that employ 15 or more persons must designate a responsible employee to coordinate the entity’s compliance with the rule and adopt a grievance procedure. Employers who are covered entities should seek advice of counsel on the ways these requirements apply to them and their group health plan, and employers who are not covered entities but have a fully insured group health plan should discuss how the insurance carrier will meet these requirements.

The OCR has provided a model notice and model statement of nondiscrimination, and taglines for employers to use. The OCR has also created an FAQ and table relating to the top 15 languages spoken in each state.

HHS has stated that an SBC is a publication that is "significant" under the Section 1557 regulations. As a result, CMS requires the use of an addendum to the SBC to accommodate applicable language access standards. Accordingly, covered entities required to provide an SBC must include the nondiscrimination notice and taglines in its addendum along with other applicable language access standards. This addendum must contain only the Section 1557 nondiscrimination notice and taglines and other applicable language access information.

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