



HEALTH CARE REFORM update



BlueCross BlueShield
of Kansas City

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Summary of Benefits and Coverage and Standardized Definitions

On March 23, 2010, President Obama signed into law the “Patient Protection and Affordable Care Act” (PPACA). A reconciliation bill making changes to the Act was signed by the President on March 30, 2010. The PPACA as amended by the reconciliation bill is collectively referred to as the Act in this summary. This summary provides an overview of the Summary of Benefits and Coverage (SBC) and Standardized Definitions provisions of the Act.

Summary

Every health insurer (in the individual and group markets) and every group health plan (insured or self-funded) must provide policy holders or certificate holders (Subscribers), applicants, and enrollees a summary of benefits and coverage (SBC) using a uniform format to be developed by the Secretary of Health & Human Services (Secretary) that accurately describes the benefits and coverage under the plan (PPACA §§1001 and 10101 (b) and (c) adding §2715 to Public Health Service Act (PHSA)). Proposed regulations regarding the disclosure of SBCs were published in the Federal Register on August 22, 2011.

Scope

Applicable to all individual and group (insured or self-funded) health coverage, which includes grandfathered plans.

Effective Date

Group health plans and health insurers must comply by March 23, 2012; however, the Secretary was to have issued regulations by March 23, 2011. As referenced above, these regulations were not published until August 22, 2011, and the regulators have requested comments on the feasibility of requiring these SBCs to be produced by the March 23, 2012 effective date. These provisions apply to grandfathered health plans. (PPACA §10103(d)(2)). (See Blue KC’s *Federal Healthcare Reform: Grandfathering* fact sheet for more information).

Requirements

The SBC cannot exceed 4 pages (the regulations stipulate that this is 4 pages front and back) and must use a minimum 12 point font. It must be understandable to the average enrollee and may be distributed in either electronic or paper format. The SBC must be provided to:

- Applicants at the time of application;

- Enrollees prior to the time of enrollment or reenrollment, as applicable; and
- Subscribers at the time of issuance of the policy or delivery of the certificate.

It must include:

- Uniform definitions of standard insurance terms and medical terms;
- A description of the coverage, including cost-sharing for each of the categories of the essential health benefits (See Blue KC's *Federal Healthcare Reform: Grandfathering* fact sheet for more information) and other benefits, as identified by the Secretary;
- Any exceptions, reductions, and limitations on coverage;
- Any cost-sharing provisions;
- Renewability and continuation of coverage provisions;
- A "coverage facts" label that includes examples to illustrate common benefit scenarios and related cost-sharing, including pregnancy benefits and chronic medical conditions;
- A statement of whether the plan or coverage provides minimum essential coverage (See Blue KC's *Federal Healthcare Reform: Product Design Mandates* fact sheet for more information) and whether the group health plan or insurer will provide coverage for at least 60 percent of such costs (effective for coverage beginning on and after January 1, 2014);
- A statement that the SBC is a summary of coverage and that the benefit documents (e.g., Subscriber Agreement) should be consulted to determine the governing contractual provisions; and
- A contact number for the insurer or group health plan and an Internet web address where a copy of the actual benefit document (e.g., Subscriber Agreement) can be reviewed and obtained.
- A Glossary of Terms must be available upon request.
- The location of information about network providers and prescription drug formularies, if applicable; and
- Premium information

Penalties

A health insurer or group health plan that willfully fails to provide the SBC may be fined up to \$1,000 per failure (per enrollee) (PPACA §1001 adding §2715(f) to the PHSA).

Notice Requirements

For any non-renewal/midyear changes that are material, the health insurer or group health plan must provide notice to enrollees at least 60 days prior to the effective date of any material modification in the terms of the plan or coverage.

Transparency and Disclosure Requirements

For plan years beginning on or after September 23, 2010, group health plans and health insurers must also comply with transparency and disclosure requirements (PPACA §10101(c) adding §2715A to the PHSA; PPACA §10104(f)). These include:

- Submit claims payment policies and practices, financial disclosures, enrollment data, data on claim denial and rating practices, cost-sharing and payments to non-network coverage, and enrollee rights information to HHS and the state Insurance Commissioner. This information must also be made public.

- Provide cost-sharing information with respect to specific items or services by a participating provider available to an individual upon request (at a minimum, through a website).

Preemption

The requirements for standard SBCs preempt state standards that provide less information to consumers; however, since the SBC is a summary of the applicable to insurance form (e.g., Subscriber Agreement) and not a contract itself, state law (e.g. filing, minimum information and readability requirements, etc.) that applies to such contracts are not preempted.

This summary is provided for informational purposes only and is not intended as legal advice. Please consult your legal advisor for additional information.

References

PPACA: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

Reconciliation: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdf

Proposed Regulation: <http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21192.pdf>