

**FEDERAL HEALTHCARE REFORM:
PATIENT PROTECTION AND AFFORDABLE CARE ACT
UNIFORM COVERAGE DOCUMENTS AND
STANDARDIZED DEFINITIONS**



On Tuesday, March 23, 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. 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 uniform coverage document and standard definition requirements 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))

Scope: Applicable to all individual and group (insured or self funded) health coverage.

Effective Date: Group health plans and health insurers must comply by March 23, 2012; however, the Secretary must issue regulations by March 23, 2011. These provisions apply to grandfathered health plans. (PPACA §10103(d)(2)). (See BCBSRI’s *Federal Healthcare Reform: Grandfathering* fact sheet for more information)

Requirements: The SBC cannot exceed 4 pages 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 to be developed by the Secretary;
 - A description of the coverage, including cost-sharing for each of the categories of the essential health benefits (See BCBSRI’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 BCBSRI’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;
 - 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.
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Penalties:	A health insurer or group health plan that willingly fails to provide the SBC may be fined up to \$1000 per failure (per enrollee). (PPACA §1001 adding §2715(f) to the PHSA)
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Notice Requirements:	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 any of the terms of the plan or coverage.
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Transparency and Disclosure Requirements:	<p>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:</p> <ul style="list-style-type: none"> • 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).
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Preemption:	The requirements for standard SBC's 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.
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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
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