Development and Utilization of Uniform Explanation and Coverage Documents and Standardized Definitions

Summary: Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage. The standards must be in a uniform format, using language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples to illustrate common benefits scenarios.

Status Update: On August 22, 2011, the Internal Revenue Service (IRS), Department of Labor (DoL) and the Department of Health and Human Services (HHS) issued two proposed rules implementing this section, with comments due October 21, 2011.

Next steps:
- March 23, 2011 – Secretary must develop standards.
- August 22, 2011 – IRS, DoL and HHS issue two proposed rules implementing this section.
- October 21, 2011 – Comments due to August 22, 2011 proposed rules.
- March 23, 2012 – Standards must be implemented.

Additional information:

Long summary:
Public Health Service Act (PHSA) sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions (as modified by sec. 10101).
Requires the Secretary, by March 23, 2011 and periodically update, to develop standards for use by a group health plan and an issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees and policyholders, a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan
or coverage. The Secretary must consult with the National Association of Insurance Commissioners (NAIC), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals. Such standards for the summary of benefits must meet specified requirements relating to appearance, language and contents.

**Requirement to provide.** By March 23, 2013, issuers (including a group health plan that is not self-insured) offering coverage within the U.S. or, in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan, must provide (prior to any enrollment restriction) a summary of benefits and coverage explanation pursuant to the above standards to applicants, enrollees and policyholders or certificate policyholders at the time of application; an enrollee prior to the time of enrollment or reenrollment, as applicable; and a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

**Notice of modifications.** Requires that if a group health plan or issuer makes any material modification in any terms of the plan or coverage (see §102 of ERISA) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days before the effective date of the modification.

**Preemption.** These Federal standards preempt any related state standards that require a summary of benefits and coverage that provides less information to consumers than that required under this section, as determined by the Secretary.

**Penalties.** If a covered entity (issuer, group health plan, etc.) willfully fails to provide the information required, such entity is subject to a fine of not more than $1,000 for each such failure and that failure with respect to each enrollee constitutes a separate offense.

**Development of standard definitions.** Requires the Secretary, by regulation, to provide for the development of standards for the definitions of terms used in health insurance coverage, including specified insurance-related terms and medical terms.

**Public Health Service Act (PHSA) sec. 2715A. Provision of additional information (as modified by sec. 10101).** Requires that plans not sold through the state Exchanges only be required to submit certain information required under the transparency in coverage provisions (e.g., claims payment, periodic financial disclosure and other disclosures as specified in §1311(e) to the Secretary and the state insurance commissioner, and make such information available to the public.

**Legislative text:**

SEC. 2715A. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

“(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

“(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection
(a) shall provide for the following:

“(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

“(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

“(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes—

“(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

“(B) a description of the coverage, including cost sharing for—

“(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

“(ii) other benefits, as identified by the Secretary;

“(C) the exceptions, reductions, and limitations on coverage;

“(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

“(E) the renewability and continuation of coverage provisions;

“(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

“(G) a statement of whether the plan or coverage—

“(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

“(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

“(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

“(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

“(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

“(d) REQUIREMENT TO PROVIDE.—

“(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

“(A) an applicant at the time of application;

“(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

“(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

“(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

“(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

“(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

“(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

“(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

“(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

“(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

“(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

“(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the
definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

“(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

“(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

“SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

“As added by section 10101(c) A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.