FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Uniform Coverage Summaries for Consumers

A new proposed federal regulation aims to provide consumers with new, standardized summary information about what private health insurance covers and how it works.[1] This regulation implements a provision in the Affordable Care Act (ACA) that requires private individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. The intent is to help consumers compare health insurance coverage options before they enroll and understand their coverage once they enroll. The provision applies to all individual and group health plans, regardless of whether they are "grandfathered" or not,[2] and takes effect by March 23, 2012.

INFORMATION INCLUDED IN THE SBC

The SBC must be brief – no longer than 4 double-sided pages according to the regulation. It must use words understandable to the average consumer and be presented in a culturally and linguistically appropriate manner. It cannot contain "fine print." It must describe the plan's premium, coverage features (such as exclusions or benefit limits) and patient cost-sharing for each of the categories of the essential health benefits required under the ACA, and rules regarding use of network providers. (See Figure 1.) It must also indicate whether the plan meets standards for minimum essential coverage[3] and has an actuarial value of at least 60 percent.[4] And, it must include "coverage facts labels" that illustrate how the plan or policy would cover common benefit scenarios. (See Figure 2.)

The proposed rule hews closely to recommendations of the National Association of Insurance Commissioners (NAIC), which convened a working group of consumer advocates, insurers, health care providers, advocates for individuals with limited English proficiency, and other experts who studied and debated approaches to development of this information for about a year and submitted their recommendations to testing by consumers and health insurers.

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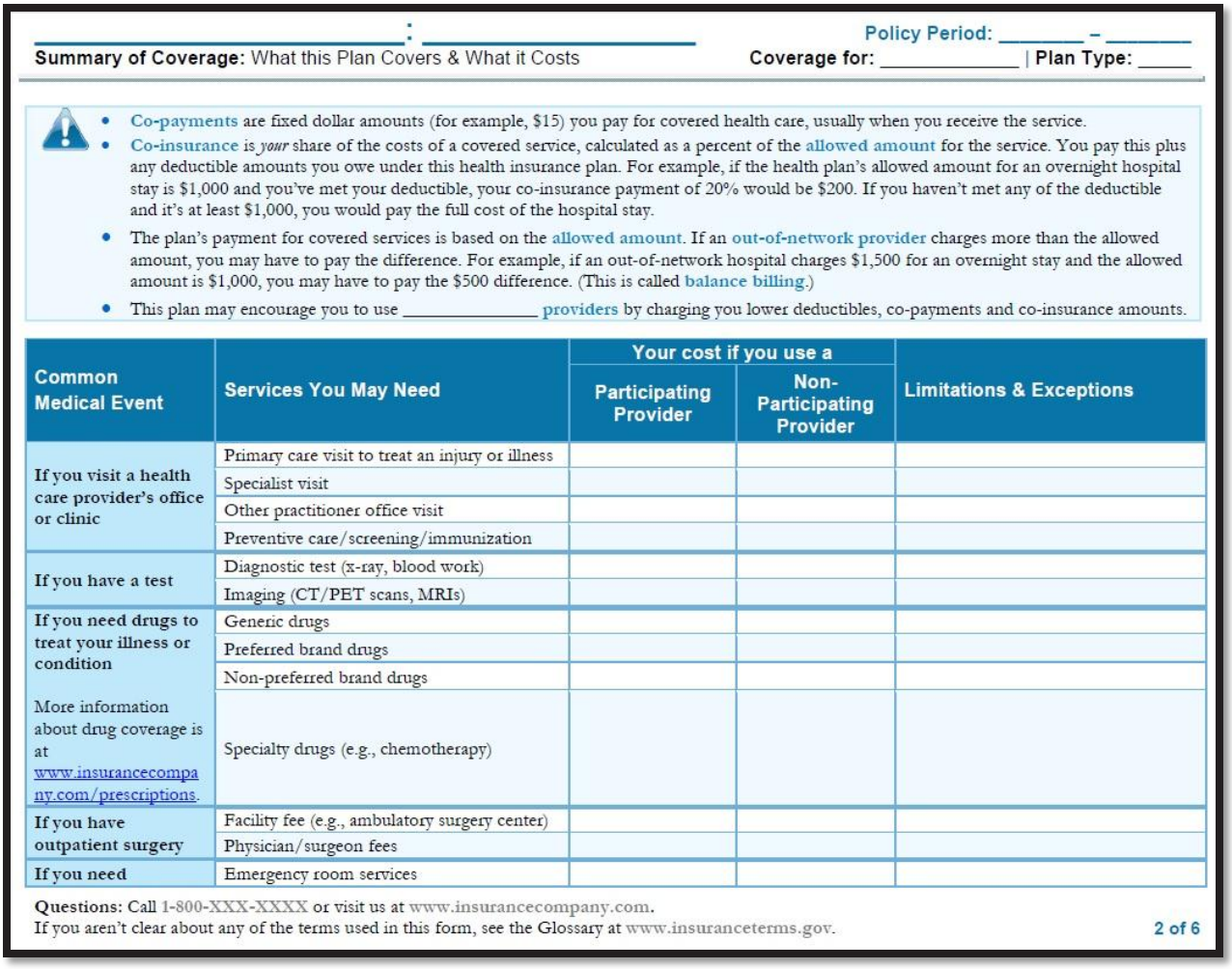
[1] See http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf

[2] A grandfathered health plan is one that was in effect on March 23, 2010, the day the Affordable Care Act was enacted. Grandfathered plans do not have to follow all of the new rules for private coverage established under the ACA. For example, grandfathered plans are not required to provide first dollar coverage for preventive services.

[3] By 2014, people must be enrolled in minimum essential coverage or pay a tax penalty. Minimum essential coverage includes qualified health plans that cover essential benefits specified in the ACA, including hospital care, emergency care, prescription drugs, etc. Other private health coverage offered by employers, as well as grandfathered health plans, also count as minimum essential coverage, as do public programs such as Medicare, Medicaid, CHIP, TriCare, and VA health care.

[4] Actuarial value is a measure of the level of coverage a health plan will provide for health care expenses. If a plan has an actuarial value of 80 percent, that means, on average, the plan will pay 80% of medical expenses and the patient will pay 20%. The higher the cost sharing is under a plan (deductibles, co-insurance, co-pays, etc.), the lower the actuarial value, on average. Under the ACA, qualified health plans must have an actuarial value of at least 60% (the so-called "bronze" plan level). In addition, people who are offered employer sponsored coverage that does not have an actuarial value of at least 60% may be eligible for subsidies in the exchange.



_____ : _____ Policy Period: _____ – _____

Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** _____ | **Plan Type:** _____

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions.	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs (e.g., chemotherapy)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need	Emergency room services			

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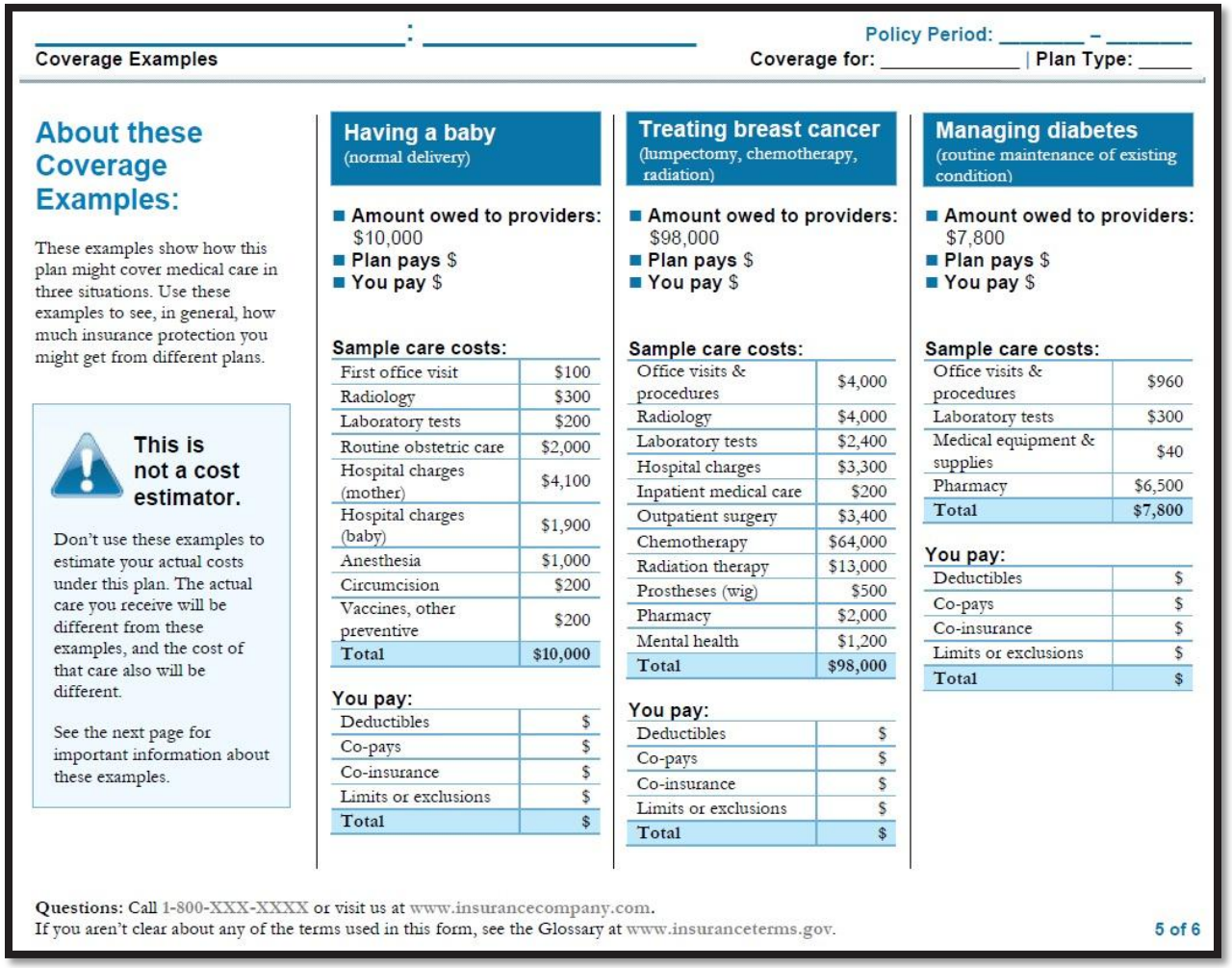
Figure 1. Sample page from proposed Summary of Benefits and Coverage

The ACA also requires development of "standards for definitions" of insurance-related and medical terms used in health coverage. The NAIC developed a glossary of insurance terms, which the proposed rule also requires health plans to make available to applicants and enrollees. The glossary provides generic definitions of common insurance terms. For example, "out-of-pocket limit" is defined as "the most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100%... Some health insurance or plans don't count all of your co-payments, deductibles … or other expenses toward this limit." The generic glossary definition helps consumers understand what is generally meant by the term "out-of-pocket limit" while the detailed instructions for completing the SBC provides consumers with specific information about how the out-of-pocket limit works in any given health plan or policy. This information will help consumers distinguish between plans that otherwise might appear similar – e.g., two plans with a $2,500 out-of-pocket limit, one of which constrains co-pays and one which does not.

In addition to describing key features of a health plan, the SBC includes coverage illustrations that show how the plan, in its entirety, would cover common medical events. Under the proposed rule, the SBC will include illustrations showing how the plan would cover an uncomplicated pregnancy, treatment for

breast cancer, and care to manage diabetes for a year. To produce these estimates, the Department of Health and Human Services (HHS) will develop illustrative claims and cost scenarios for different conditions. Health plans and insurers would then "run" these simulated claims against the policies they offer and estimate the amount of total costs that consumers would have to pay in deductibles and other cost sharing or because the plan limits or excludes coverage for services. In this way, consumers would be able to compare different health plans against static cost illustrations to get a tangible idea of the relative protection plans offer.



_____: _____ Policy Period: _____ – _____

Coverage Examples Coverage for: _____ | Plan Type: _____

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $10,000
- **Plan pays** $
- **You pay** $

Sample care costs:

First office visit	$100
Radiology	$300
Laboratory tests	$200
Routine obstetric care	$2,000
Hospital charges (mother)	$4,100
Hospital charges (baby)	$1,900
Anesthesia	$1,000
Circumcision	$200
Vaccines, other preventive	$200
Total	**$10,000**

You pay:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	$

Treating breast cancer
(lumpectomy, chemotherapy, radiation)

- **Amount owed to providers:** $98,000
- **Plan pays** $
- **You pay** $

Sample care costs:

Office visits & procedures	$4,000
Radiology	$4,000
Laboratory tests	$2,400
Hospital charges	$3,300
Inpatient medical care	$200
Outpatient surgery	$3,400
Chemotherapy	$64,000
Radiation therapy	$13,000
Prostheses (wig)	$500
Pharmacy	$2,000
Mental health	$1,200
Total	**$98,000**

You pay:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	$

Managing diabetes
(routine maintenance of existing condition)

- **Amount owed to providers:** $7,800
- **Plan pays** $
- **You pay** $

Sample care costs:

Office visits & procedures	$960
Laboratory tests	$300
Medical equipment & supplies	$40
Pharmacy	$6,500
Total	**$7,800**

You pay:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	$

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Figure 2. Proposed Coverage Examples in SBC

How will the SBC be used after 2014?

Beginning in 2014, new health insurance exchanges serving individuals and small businesses will offer new health plan options. These plans, too, will be required to present information to consumers and small businesses using the standardized SBC format established under the ACA. Over time, consumers

may move in and out of exchange coverage – for example, if they change jobs – and when they do, standardized SBCs will allow consumers to compare to compare their old and new coverage.

Health insurance is a complex product, and will remain so even after 2014, when market reforms requiring insurers to provide coverage to anyone regardless of pre-existing health conditions are implemented and essential health benefit standards will likely reduce the variation in market. Plans offered through exchanges will be labeled according to their actuarial value (bronze, silver, gold, and platinum), giving consumers a general indication of the relative protection different plans offer. However, as a previous Kaiser analysis[5] has noted, actuarial value is not an inherently intuitive idea for most people. In addition, it is a rough measure of the comprehensiveness of coverage. Two plans with the same actuarial value can leave a person paying significantly different amounts in cost sharing for covered care. For example, a 2009 study[6] that compared plans offered in Massachusetts' Commonwealth Connector found that a breast cancer patient might pay approximately $7,600 for her care under one bronze plan but more than $12,000 under a different bronze plan providing the same overall level of coverage.

The proposed coverage illustrations can provide consumers more specific information as they compare plans and try to understand how much protection they offer if a health condition arises and different types of services would be needed. In NAIC's consumer testing, for example, people found the concrete illustrations helpful in understanding and comparing coverage. The illustrations also reportedly opened some consumers' eyes to the cost of care in a way they had not previously understood. [7,8]

The proposed regulation discusses how the SBC will be coordinated with other disclosure requirements in the health reform law. The ACA requires HHS to establish an internet web site that displays information about private health insurance policies offered in the individual and small group markets in every state. This site, www.healthcare.gov, currently shows information about benefits, cost sharing, and premiums for thousands of health insurance products. Hundreds of insurers report this information to HHS and update it quarterly. The ACA requires information on healthcare.gov must be displayed in a standardized format that is consistent with standards adopted for the SBC. The proposed regulation provides that insurers can satisfy the requirement to make this information available to prospective enrollees in the individual market and small group market by posting SBCs for those products on healthcare.gov.

The ACA also requires employers to inform employees and the IRS about whether group health plans they offer meet the requirements for minimum essential coverage and affordable coverage; workers who can document that they are not offered such coverage at work may be eligible for premium and cost-sharing subsidies in an exchange. The proposed regulation requests public comment on whether the SBC could serve a dual purpose of providing this documentation to employees and regulators.

[5] See http://www.kff.org/healthreform/8177.cfm
[6] See http://www.naic.org/documents/committees_b_consumer_information_coverage_facts_paper.pdf
[7] See http://naic.org/documents/committees_b_consumer_information_110603_consumers_union_testing.pdf
[8] See http://naic.org/documents/committees_b_consumer_information_110603_ahip_bcbsa_consumer_testing.pdf

Where possible, aligning and coordinating the public and governmental disclosure requirements under the ACA could reduce costs and ensure greater efficiencies within the health care system.

Balancing benefits and costs

The draft regulation estimates it will cost insurers and third party administrators (TPAs) for self-funded employer health plans approximately $50 million per year over the next 3 years to develop, update, and provide the SBC and glossary to applicants and enrollees. This estimate includes $25 million in 2011 for start-up costs (e.g., programming to extract from existing computer systems information that will be included in the SBC) $73 million in 2012 for continued start-up costs and production and distribution, and $58 million in 2012.

In addition, the proposed rule requests comment on whether large employer plans should be exempt from the requirement to provide the SBC. Large employers are the primary providers of group health plan benefits and they typically already provide summary plan information to their employees and prospective enrollees, for example, during annual open enrollment periods. The Employee Retirement and Income Security Act (ERISA) already requires that all employers who sponsor group health plan benefits must provide a "summary plan description" (SPD) that explains coverage to plan participants and beneficiaries. The proposed rule requests comment on whether the SBC should be incorporated into the SPD instead of being provided as a stand-alone document.

Exempting large employers from the new information requirements would significantly reduce the cost burden, but it would also result in non-standardized information provided to consumers.

The proposed rule notes that SPDs have grown to 100 pages in length in many cases, and tend to be written at a college reading level with significant technical language and jargon. In addition, ERISA does not require uniform standards for SPDs, so these documents will not always include the same content or order of information required under the SBC.

The benefits to consumers of having more understandable, standardized information about health plan options are described in the proposed rule, though not quantified. Families and employers incur costs related to understanding and comparing health plan options. Low health insurance literacy rates are well-documented, as are difficulties consumers have understanding health insurance today. [9,10] Research also shows that when consumers are confused by the complexity of health plan options, they are more likely to mis-estimate the value of coverage compared to its cost and to select a plan that is not most closely aligned to their needs and preferences. [11]

A central premise of health reform is to improve the efficiency of market competition in health insurance. Through heightened competition, according to advocates of the law, insurers will have an incentive to negotiate lower provider prices and adopt more effective cost containment strategies. However, efficient market competition relies fundamentally on transparency of information, with

[9] See http://content.healthaffairs.org/content/12/3/204
[10] See http://www.ebri.org/pdf/notespdf/ebri_notes_10-20061.pdf
[11] See http://content.healthaffairs.org/content/early/2003/09/24/hlthaff.w3.449/suppl/DC1

consumers able to distinguish plans that are cheaper because they cover less from those that are cheaper because they are more efficient.

The balance of costs and benefits is a key issue in the implementation of these new requirements. In addition to direct tradeoffs, other strategies may be considered to limit industry costs while assuring consumers receive this information. For example, the proposed rule requests public comment on whether requirements for the SBC – and, in particular, for the new coverage illustrations component – should be phased in to allow more time for, and presumably moderate the cost of, implementation. Another consideration may be the extent to which the federal government can provide technical assistance to health insurers and TPAs during implementation. Training, help lines, the sharing of best practices, and other assistance could also help to reduce the cost of providing the new information to consumers.

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