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Summary of Benefits and Coverage and the Uniform Glossary

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Summary of Benefits and Coverage and Uniform Glossary

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General Comment

The current Glossary is inadequate and does not meet the stated objective of mandating a Uniform Glossary.

The NAIC and Secretaries should consider hiring outside consultants who are involved in the day to day operations of the plan (hands on experitise) since most senior management types don't get involved with the details. This type of input would provide the common sense, practical side of things from an employer, employee and adminsitrative perspective that is missing from most of these proposed rules under ACA.

This type of input would greatly improve the end product.

Attachments

SBC Glossary Comments 9-20-11

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Date: September 16, 2011

From: Gloria L. Gillespie, Compliance Officer and Exec. V. P.

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Subject: **COMMENTS ON SUMMARY OF BENEFITS AND COVERAGE AND THE UNIFORM GLOSSARY – PHS §2715**

While the glossary is probably a good idea, it looks like more effort was put into making it look pretty versus being sufficiently accurate to provide full disclosure. It is very difficult to have a single glossary that will cover all types of plans, including High Deductible HSA plans, indemnity plans, HMO Plans and PPO Plans. **Requiring a Uniform Glossary only makes sense if it does not require plans to provide an additional Glossary or Definition of Terms in order to provide complete disclosure. The NHAI model, including proposed definitions to be added will still result in an inadequate Glossary!**

Much more work on the definitions is needed to have a meaningful document that can accomplish its purported purpose. Plans absolutely should have an opportunity to add additional definitions or language it feels is relevant. The current effort to micromanage virtually all communications, excessive disclosure and notice requirements on a combined basis are extremely confusing, burdensome, costly and detrimental overall to Plans and businesses. **Too much information is almost as bad as or worse than too little information.** Not even the government is keeping up. Most of the publications dealing with health care are totally out of date and incomplete.

The NAIC format is designed where plans can access the format and add changes, e.g. Plan name, contact and web information. This is essential. The definitions that need further clarification or that need to be included, in this author's view, include the following. I am sure there are probably additional ones that have been overlooked, but this is goes along way towards having some sort of standardized glossary that is appropriate for all plans.

The Glossary should include an appropriate introduction.

GLOSSARY OF HEALTH INSURANCE AND MEDICAL TERMS

The Uniform Glossary includes basic definitions of standard medical and health insurance terms, but it is not an full list. Often there are several terms that share the same meaning. The terms provided here are not contract terms. In all situations, your actual Plan document terms shall apply. See the examples at the end of the glossary showing how deductibles, coinsurance and out of pocket limits work together. Blue sections should be added to the Glossary.

Plan/Employer Name: ____
Bold text indicates a term defined in the Glossary.
You may get a copy of your policy or Summary Plan Description (SPD) and a copy of the SBC (Summary of Benefits and Coverage) at www.______________________ or you may call ______________ to request a copy.

Allowed Amount	Reference after Balance Billing, add: UCR
Deductible	Last sentence should read. "The deductible does not apply to preventive services and may not apply to some services. If your plan has both in and out of networks, a separate deductible may apply to out of network benefits."
Appeal	Add: "Appeals include both pre and post service claims and precertification appeals. An emergency appeal, including an External Appeal through an Independent Review Organization, may be requested for services involving continuation of care or approval of urgently needed care." Additional information on your Appeal Rights can be found at ……………… Or call ________________. (Also see Grievance)"
Coordination of Benefits (COB)	Rules that govern which plan pay first and which plan pays second. Most plans base their COB rules on the NAIC Coordination of Benefit rules. Generally, coverage as an employee or retiree is always primary to coverage as a dependent. Special rules apply to dependents of divorced parents and when a member is *eligible* for Medicare (See Medicare Secondary Payor rules under the Plan.) There are also special rules governing governmental plans that generally will make those plans pay last. This includes Medicaid, VA and Tri-Care. See your plan or check with your Plan Administrator for additional information.
COBRA	Continuation of Benefits rights for certain events involving the loss of coverage; for example: due to age, termination of employment, retirement, divorce. Plans with fewer than 20 employers are subject to state continuation rules, whereas employers with more than 20 employees are subject to the more favorable rule under state law for fully insured plans only or under federal law. Please refer to your Plan for additional information.

Custodial Care	Care that is provided in an assisted living, nursing home or in patient's home that is considered custodial or maintenance care where the patient has reached maximum medical improvement. Custodial or long term care is not covered under health plans or by Medicare. Long Term Care (LTC) coverage may be purchased to cover this type of expense, subject to insurability and underwriting.
Emergency Medical Condition	Should include a statement to the effect that: "All Plans are required to cover Emergency Care whether in or out of network."
Habilitation Services	Add: Habilitation services do not include long term or custodial care once a person has reached maximum medical improvement.
HIPAA	Health Insurance Portability and Accountability Act provides various protections including privacy rules, rules governing pre-existing condition exclusions (also see Pre-existing Conditions), COBRA, and the right to change your elections mid-year under the Special Enrollment rules for certain events. See your plan for information on your HIPAA rights.
HMO Definition Needed	Is a Plan that generally only covers network providers. Out of network providers are not covered at all, unless the plan specifically provides for out of network coverage, other than for emergencies.
Grievance	Add: "(See Appeal.)
Group Health Plan (Need to distinguish GHP from Health Insurance.)	A group health plan includes self funded group health Plans, including non-federal governmental and church plans, as well as any group health plan issued by a Health Insurance Carrier.
Health Insurance	Need further clarification: "Health insurance includes both individual and group health plans issued by a Health Insurance Issuer. All health insurance plans are subject to State laws governing insurance. A self funded plan is not considered to be health insurance. (See Group Health Plan)."
Health Reimbursement Account	Some plans offer a Health Reimbursement Account (HRA) to be used to offset some of the initial out of pocket costs under the Plan. Refer to the specific details on this plan if it is offered by your employer, as this plan works differently than traditional health plans.
High Deductible Health Plan (HDHP) that is HSA Qualified (This definition is necessary as some employers off these plans as an option.)	This is a unique type of plan that has different rules than traditional health plans. Contributions can be contributed to your individual Health Savings Account (HSA) either on a pre-tax basis through a Cafeteria Plan, if offered, or on a deductible basis claimed on your annual tax return (Form 8889 must be filed). These plans are subject to Federal rules. IRS Publication 969 is recommended for additional information on this type of Plan. Contributions to HSA's are not permitted once you attain age 65 or are Medicare eligible. See your Summary Plan Description or Summary of Benefits and Coverage for details.

Independent Review Organization	When a claim is denied in whole or in part or when services are not approved that you believe are medically necessary and should be covered, you have the right to request the appeal be review by an IRO or Independent Review Organization. See your Plan for your Appeal Rights and where to file an appeal.

Non-Preferred Provider	For clarification, recommend: Delete the balance of the sentence after "tiered" network. Add: "Non-Preferred Providers are also referred to as Out of Network or NPPO providers." Move the second sentence to the end of the paragraph.
Open Access Plan	A plan where you do not need a referral to see a or any other provider that is in network. You may go to any provider in the network. (See also Primary Care Physician.)
Out of Pocket Limit (most plans have dropped the hypens.)	Needs further clarification: Prescription drug copays are usually separate and do not count towards your deductible or out of pocket limits, unless the Plan specifically credits drug copays towards your Out of Pocket Limit. The exception to this rule is that Rx copays under a High Deductible/HSA Qualified Plan must count towards your deductible and out of pocket limits. Rx and medical costs combined are subject to the HDHP Deductible by law.
Plan	Add: at the end of the sentence: "that may include a self-funded plan that is managed by the union, employer, or both."
Point of Service (POS)	POS Plans are typically PPO Plans that may or may not provide out of network coverage. POS typically refers to the copay you must pay a PPO or participating provider at the time of service.
Preauthorization	Add: Failure to obtain the necessary plan authorization for listed services may result in that benefit not being covered or being paid at a reduced level. See your plan for precertification or preauthorization requirements.
Preferred Provider	After the first sentence, add: A preferred provider may also be referred to as a PPO or Participating provider; an In Network or Network Provider; or in HMO Plans as a HMO provider. From the second sentence on, the wording is confusing and unclear. "Tiered" network is not defined. Perhaps this would be clearer? "Some plans may have different groups or levels of providers, sometimes referred to as "tiers" with different copays or coinsurance amounts depending on which tier your provider falls within. Always check your Plan to determine what providers or networks are covered, whether or not your plan required referrals from a Primary Care Physician and whether and how Out of Network providers are covered."
Premium	Recommend you clarify by adding: "May also be referred to as cost of insurance. Most employers permit the employee portion of their Group Health cost to be deducted on a pre-tax basis under a Cafeteria Plan, also referred to as a Flexible Benefits or Section 125 Plan. Check with your Employer or your Plan."

Preventive Treatment	Certain preventive care is mandated by law under the Affordable Care Act. The effective date of coverage may vary depending on the plan. Grandfathered plans are exempted from these rules. Plans may always elect to voluntarily adopt preventive benefits, including those mandated for non-grandfathered plans. Mandated Preventive Benefits must be paid at 100% with no deductible, copay or coinsurance regardless of the type of plan. You may go to https://www.cms.gov/prevntiongeninfo/ for more information.
Pre-Existing Condition	All group health plans, excluding grandfathered plans, may not impose any pre-existing conditions limits or exclusions. Grandfathered plans (individual and group) are subject to the HIPAA Pre-existing Condition rules.
Primary Care Physician (PCP)	Clarify by adding: "Often referred to "PCP's" or "Gatekeeper". Plans may require you first get a referral from your PCP to see a specialist unless your plan is an Open Access Plan."
Provider	Recommend you add: "Plans may not discriminate against health care providers acting within the scope of their license as authorized by the state in which they practice. Grandfathered plans are not exempt from this rule."
SPD	A Summary Plan Description or SPD as it is referred to is required for all plans to be given to employees when they are first eligible to elect coverage. An SPD may be requested at any time by an employee.
SBC	Summary of Benefits and Coverage
UCR	The UCR is also referred to as the Allowed Amount or Eligible Expense that is the amount on which benefits are calculated or based. The UCR for Preferred Providers is based on the negotiated rate with the Insurer or Network. Preferred Providers may not balance bill you for any charges in excess of the Allowed Amount. Allowed charges for Out of Network providers, if covered under your plan, are determined by the UCR charges as defined by the plan and benefits are then paid based on the Out of Network fee schedule. Out of Network providers may balance bill you for difference between their actual charges or billed amount and what was paid by the Plan, unless a separate fee is negotiated with the provider by the Plan. In an emergency situation where some services are provided by out of network providers, you may be responsible for excess. (See Balance Billing.)