



October 21, 2011

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human
Services
200 Independence Avenue, SW
Washington, DC 20201
Attn: CMS-9982-P; CMS-9982-NC

Internal Revenue Service
U.S. Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224
Attn: REG-140038-10

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20201
Attn: RIN 1210-AB52

RE: Notice of proposed rulemaking regarding summary of benefits and coverage and the uniform glossary; and solicitation of comments on templates, instructions, and related materials under the Public Health Service Act

Dear Sir or Madam;

On behalf of the National Partnership for Women & Families, I applaud the Departments' ceaseless efforts to implement the Affordable Care Act (ACA) swiftly and effectively. Thanks to the Departments' diligent work, the law is already beginning to eliminate the punitive and predatory insurance practices that have penalized women and families for decades. Implementation of the summary of benefits and coverage (SBC) and uniform glossary requirements will move us even closer to a health insurance market that works for consumers.

In millions of American families, women are the primary health care decision makers – responsible for gathering the information, comparing plans, and making the decision about which plan is best. Today, this is no easy task. Information is diffuse, jargon-filled, and inconsistent. Simply accessing meaningful information about a single plan is hard enough; being able to make “apples to apples” comparisons of plan options is nearly impossible. Accordingly, many women and families choose one plan only to find out too late – when they get sick and make claims – what their health plan does and does not cover and what it really costs. For example, one major national survey found that 23 percent of privately insured cancer patients reported their health insurance provided less coverage for cancer treatment than they expected it would, and 13 percent reported their plan didn't pay at all for care they thought was covered.¹

¹ USA Today, Kaiser Family Foundation, Harvard School of Public Health, Publication No. 7591. (2006, November). *National Survey of Households Affected by Cancer*. Retrieved October 20, 2011, from <http://www.kff.org/kaiserpolls/upload/7591.pdf>.

Section 2715 of the ACA gives us tools to fix this problem, calling for the creation of a standard form describing health insurance coverage that is culturally and linguistically appropriate and understandable to the average consumer with a uniform glossary of medical and insurance terms. To ensure that the documents are broadly available and accessible, the ACA requires that all private health plans provide the documents to enrollees and those shopping for coverage.

The proposed rule implementing these requirements makes great strides in providing an understandable health insurance disclosure to women and families. We offer detailed comments in the appendix to ensure that the SBC and glossary are useful to as many people as possible, and that consumers' ability to use the form is monitored and improved over time. In particular, we recommend that the Departments should:

- Uphold the March 23, 2012 effective date for these requirements;
- Explore methods for helping health insurance issuers and employers minimize the costs associated with compliance rather than contradicting Congressional intent and limiting the application of Section 2715 to non-group plans;
- Ensure that consumers can receive the SBC in a timely fashion and on paper unless an electronic copy is requested;
- Adopt more robust plain writing and language access standards so that all consumers can benefit from the SBC;
- Require insurers to provide six coverage examples that are relevant to as wide and diverse a population as possible; and
- Amend the glossary to better meet consumer information needs.

If you have any questions regarding our comments, please contact please contact Kirsten Sloan, Vice President, at ksloan@nationalpartnership.org or Christine Monahan, Health Policy Advisor, at cmonahan@nationalpartnership.org or (202) 986-2600. We look forward to working with you to ensure that the ACA delivers on its promise of a health insurance market that meets the needs of women and families.

Sincerely,



Debra L. Ness
President

APPENDIX: DETAILED COMMENTS FROM THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES

Effective date for compliance with SBC requirements

The proposed rule seeks public comment on the feasibility of timely implementation of Section 2715 requirements. We strongly urge prompt publication of a final rule with the requirements of this section taking effect no later than two years after the date of enactment of the ACA, as the statute requires. We note that the National Association of Insurance Commissioners (NAIC) working group invested hundreds of hours of study and deliberation involving a broad range of subject matter experts to arrive at its recommendations for the SBC, including coverage illustrations. Drafts of the SBC and coverage illustrations were tested with plans and consumers to validate both costs and benefits of this new information resource. The Departments, in turn, took four to five months to consider the NAIC's March 2011 recommendations before publishing its proposed rule this summer. In light of the thorough work undertaken by so many to design the SBC, we urge timely implementation. We further urge the Departments to engage in ongoing efforts to monitor the costs and benefits of the SBC as it is implemented and to make future refinements and improvements based on such monitoring.

Timely implementation will help women and families better understand their coverage and health insurance options and reduce the costs and frustrations of trying to decipher the confusing coverage documents people must rely on today. One industry survey found most people would rather go to the gym or work on their income taxes than try to read their health insurance policy.² The required changes will provide better and more understandable health insurance information, one of the benefits of the ACA for many Americans.

All private health plans and health insurance issuers should provide SBC

The ACA requires that *all* private health plans provide the SBC and glossary to enrollees and those shopping for coverage – group and non-group, grandfathered and non-grandfathered, fully-insured and self-insured, inside or outside the exchange.

When consumers use the same form across these settings, as the ACA requires, it allows them to “learn” the form. Investing the time in understanding how to use the form pays off because they can apply their knowledge regardless of where they are purchasing private health insurance. This will be particularly important for families that have to choose between different options – for instance, between competing offers of employer-sponsored insurance if both spouses work – or have unstable incomes and switch back and forth between employer-sponsored plans and subsidized individual market plans.

Provision of the uniform SBC to enrollees in employer-sponsored group health plans is particularly important. Information disclosure for consumers in group health plans is currently inadequate. For decades, the Employee Retirement and Income Security Act (ERISA) has

² ehealth, Inc. (2008). New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology [Press Release]. Retrieved from http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712.

required private sector group health plan sponsors to provide a summary plan description (SPD) to enrollees, with information about covered benefits and enrollee rights and responsibilities. However, over the years the SPD has developed into a bulky, complex document that few consumers can understand. Indeed, one study found that the typical SPD was written at a college reading level whereas most consumers are more comfortable reading at the 6th to 8th grade reading level.³ Other summary information provided by employers (for example, at open season) is inconsistent.

The SBC provides consumers with illustrations of how coverage works for illustrative treatment scenarios – including one for breast cancer treatment described in the proposed rule. Consumer testing found these illustrations to be very helpful to consumers. No such illustrations are routinely provided today under SPDs. The millions of working women and their families covered by group health insurance should not be deprived of this information. Furthermore, applying the SBC and glossary requirements to all private health plans, as Congress intended, will close a gap in current ERISA health plan information disclosure requirements that leaves out tens of millions of public employees who are covered under state, county, and municipal governmental health plans.

While many health insurance issuers and employers have expressed concern about the costs of applying the SBC and glossary requirements to employer-sponsored group health plans, these costs are largely limited to the first years of implementation and are outweighed by the immense benefits for employees. Not only will the SBC and glossary requirements save time and reduce stress for workers, but the forms will enable workers to pick health plans that better meet their needs and thus face fewer unaffordable or unexpected medical bills.

Furthermore, the SBC will play a key role in documenting compliance with other requirements in the ACA. Provision of the SBC to all enrollees and prospective enrollees can and should satisfy the requirement under Section 1512 of the ACA (Section 18B (a)(2) of the Fair Labor Standards Act) that employers shall provide written notice to employees whether the group plan has an actuarial value of at least 60 percent. In addition, to minimize duplicative information reporting requirements on employers, the Departments should clarify that the SBC can constitute a portion of the documentation that employers must provide to the Internal Revenue Service (IRS) in order to avoid tax penalties for failure to offer minimum essential coverage, as required under Section 1513 of the ACA. And, as described in the proposed regulation and recommended by the National Association of Insurance Commissioners (NAIC), the SBC should indicate the share of premium that the employee must pay. All consumers, including those enrolled in employer-sponsored group health plans, will need such information to prove they are enrolled in minimum essential coverage. In addition, consumers will need information about their group health plan's actuarial value and its cost in order to determine whether they may be eligible for subsidies offered through the Exchange.

Given the important roles the SBC will fill, the Departments should explore methods for helping health insurance issuers and employers minimize the costs associated with compliance rather than contradicting Congressional intent and limiting the application of Section 2715.

³ Employee Benefit Research Institute. (2006, October). How Readable Are Summary Plan Descriptions for Health Care Plans?. *Notes*, 27(10), 1-10. Retrieved from http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf

However we do caution against one proposal to minimize costs considered in the proposed rule – incorporating the SBC into the SPD. Under the proposed rule, consumers have a right to receive the SBC for all health plan options for which they are eligible, but ERISA only requires distribution of the SPD for the plan in which an employee enrolls. Incorporating the SBC into the full SPD would add to employer cost burdens by requiring plan sponsors to distribute copies of the full SPD for all plan options to all prospective enrollees when they are first hired, during special enrollment opportunities, and, upon request, during annual open seasons. Furthermore, such a move would defeat the purpose of the disclosure requirements under Section 2715. The short, concise SBC will be significantly easier for consumers to keep handy, consult frequently, and understand than the SPD. While employers certainly should be able to deliver the SBC in the same envelope used to deliver the SPD, the SBC must remain freestanding and not buried within a larger, unwieldy document.

When to provide an SBC to consumers

There are a number of scenarios when an SBC should be made available to a consumer. We support requiring that the SBC be provided when the issuer renews or reissues the policy, any time an applicant or group plan requests it, with application materials at enrollment, and whenever there is a change in plan information or benefits.

More specifically:

- For plans in the group market, the SBC should be provided to the employer when the employer is shopping for coverage along with any plan marketing materials. It should be provided to current employees annually at the beginning of the open enrollment season (or at the beginning of the plan year if there is not an open enrollment season); 60 days prior to a change in benefits; and when the employee reports an event that triggers special enrollment rights. It should be provided to new employees as soon as possible after a hire but no later than seven days before the date coverage is effective. The instructions should also be clear that the SBC must be provided to each covered employee, rather than simply requiring issuers to provide the SBC to employers.
- For individual market plans, the SBC should be provided to prospective enrollees with any marketing materials upon request, and upon application. It should be provided to current enrollees in individual plans upon enrollment, at renewal, 60 days prior to a change in benefits, and, if the carrier has a restricted open enrollment season when individuals might change policies, at the start of that open enrollment season.

Consumers choosing health coverage need adequate time to review materials and fully understand their options in order to make an informed decision. Sufficient lead time is important. The proposed rule specifies that the SBC must be provided as part of any written enrollment application materials distributed by the plan or issuer, or if a plan or issuer does not distribute written materials, the SBC must be provided no later than seven days prior to the date a participant is eligible to enroll in coverage. This is consistent with the timeframe included in the rule for special enrollment. Similarly, we support the proposal to make the SBC available within seven days in the case of special enrollment or when an SBC is requested at a time other than enrollment periods. We also note that the requirement that issuers provide the SBC upon request

at any time should clearly permit consumers to request an additional copy of the SBC for their plan if they misplace, damage, or lose the document.

We understand the concern some insurers have about the potential administrative burdens if a significant number of consumers make requests for SBCs outside of the enrollment period. While we do not believe most consumers will want nor need an SBC at other times, we suggest that the Departments monitor the number of requests during the first year to determine whether changes in the policy are warranted.

If an applicant's final premium quote is different than the premium cost information provided in the SBC, the insurer should issue an amended SBC that provides the updated premium information for their plan. In 2014, when the prohibition on health status rating in the Affordable Care Act becomes effective, there will be less frequent changes in premium information. Once this provision is effective insurers should provide premium information for each plan based on family size, age, smoking status, and geographic location.

How to provide an SBC to consumers

General requirements

The SBC serves a unique function by “accurately [describing] the benefits and coverage under the applicable plan or coverage” (PHS section 2715) using plain language and a format that is more accessible to consumers than the documents insurers currently provide. The Departments also released a draft template for the SBC. This template creates a standard format that is uniform across plans, allowing consumers to more easily compare the benefits of each insurance product. We recommend that insurers be required to use the standard template for the SBC that is proposed.

Because consumers applying for health insurance coverage, as well as current enrollees, may receive a large number of documents relating to their coverage, we believe that it is important to make sure that the separate SBC is prominent and visible among other health plan disclosure documents. Specifically, we recommend that insurers provide the SBC on a different color or texture paper than the other documents. The SBC should also be clearly marked as an important document by including a note at the beginning or in a header stating “This document contains important plan information and should be kept for your records.”

Form of disclosure

We strongly recommend that the SBC be provided in paper form as a default option, unless the applicant or beneficiary explicitly elects to receive the form through electronic means. The consumer should have multiple mechanisms for requesting an SBC (e.g., via post, phone, fax, or email). Consumers submitting a request through any of these mechanisms, including online, should be able to specify the form in which they prefer to receive the SBC.

Though consumers frequently submit requests for assistance through program websites, they often have low computer literacy and do not provide email addresses for online communication.

According to 2010 U.S. Census Bureau Internet usage statistics, almost 40 percent of households with an annual income between \$25,000 and \$34,999 that report using the Internet do not have a computer with Internet access in their home. Of households with an annual income of less than \$15,000, more than 60 percent who reported that they use the Internet do not have computers with Internet access in their home.⁴ This indicates that though consumers may be able to submit requests for assistance and plan documents electronically, they may not have consistent access to a computer and the Internet. Accordingly, we recommend that applicants and enrollees be permitted to specify how they wish to receive the SBC, even if they make their SBC request online.

In addition, we agree that the SBC should also be made available by posting the document on the Web. Specifically, we recommend that the SBC for each benefit package offered by the issuer be posted on the insurer's website, as well as state and federal websites that aggregate health insurance information for consumers, such as Exchange websites and healthcare.gov. Posting the SBC on these websites will enable consumers to review benefits information before requesting plan documents. This may result in consumers requesting fewer paper copies of SBCs for plans or insurance products as they compare coverage options. SBCs posted on Exchange websites and on healthcare.gov should be posted in a uniform format that is compatible with the search functions of these websites, as well as a broad range of computer operating systems, platforms, and Internet broadband speeds. Users should not be required to leave the website or download additional software in order to view SBCs. Additionally, consumers should not have to set up a password-protected account with the site in order to view the SBC, although this could be provided as an option for consumers who would like to save information on the plans they are comparing. Requiring consumers to link to other websites, open separate windows, download software, or set up password-protected accounts would create unnecessary confusion and barriers to accessing this information, especially for consumers with low computer literacy.

New and modified information requirements

Inclusion of premium information

The proposed rule follows the NAIC recommendation that the SBC should display prominently – in the top right corner of the first page – the premium or cost of coverage for policyholders/group health plan enrollees. The proposed rule also notes, however, that premium information is not a specific statutory requirement under Section 2715 and requests public comment on whether such information should be included.

We strongly urge that premium information be included on SBCs for non-group health insurance policies (individuals and families) and that cost of coverage information be included for enrollees in group health plans. In the latter instance, the SBC should indicate the cost of coverage to employees and their dependents net of the employer contribution to the premium. A

⁴ U.S. Census Bureau. (2011). *Household Internet usage in and outside of the home by selected characteristics: 2010* from the Statistical Abstract of the United States: 2012, Table 1155. Accessed online on September 30, 2011 at <http://www.census.gov/compendia/statab/2012/tables/12s1155.pdf>.

primary purpose of the ACA is to get insurers to compete on the basis of ‘value’ not just price. Therefore, the SBC must contain information about both the cost and content of coverage so that consumers can evaluate this information together.

Premium (and other cost-sharing information) in the SBC also must be provided for coverage options other than for self-only coverage. For example, if a plan or policy offers family coverage, the premium and cost of coverage for families must be depicted, as must the annual deductible, out-of-pocket maximum, and other coverage features that may vary.

New disclosures in 2014

In 2014, consumers will face a new obligation to purchase coverage, as well as new opportunities to access subsidized plans. As contemplated by the proposed rule, the SBC should include the relevant disclosures that help consumers function in this new world.

To help consumers understand whether or not the coverage meets these requirements, the ACA requires inclusion in the SBC of 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.”

The 60 percent actuarial value threshold is a standard that is widely used by the ACA and one that consumers should become familiar with. Hence, we recommend that this disclosure be required for all plans (non-group, group, grandfathered, non-grandfathered), as envisioned by the ACA. However, consumer testing indicates that using the phrase “On average, this plan will pay at least 60% of the total allowed costs for the benefits listed in the policy” will not work.⁵ Testing found that consumers “skipped over” this information because it appeared to be a required, but unimportant disclaimer. Also, consumers questioned how it could be of use since it was the same on every plan (also likely to be true in 2014). Consumers also reported that they did not understand the phrase. The term “on average” made participants feel the percentage paid by plan was not stable and could vary a great deal. Additionally, consumers were unfamiliar with the term “allowed cost,” and guessed (incorrectly) that only certain types of treatments would be covered. Finally, many participants overlooked the term “at least.” So, instead of understanding “this plan pays at least 60% of total allowed costs,” participants would typically read it as “the plan pays 60%.”

These testing results illustrate the value of rigorously consumer testing included warnings and disclaimers. An alternative phrases for testing could include: “This plan offers coverage that is at or above federally recommended minimums” or, for use when the value is below 60 percent “This health plan is below federally recommended minimums. You may want to consider other coverage options.”

⁵ Kleimann Group and Consumers Union. (2011, September 28). *Early Consumer Testing of Actuarial Value Concepts*. Retrieved October 20, 2011 from http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf

In addition, early consumer testing of the proposed precious metal tiers (Bronze, Silver, Gold, Platinum) shows that these designations are very helpful to consumers, as they quickly convey the relative strength of the coverage of their health plan options. This small, but useful, consumer aid should be incorporated into the SBC in 2014 for non-group and small group plans.

Plain writing requirement

Plain writing is essential to help individuals better understand their health coverage, make meaningful comparisons when shopping for a new plan, and understand terms and concepts commonly used in health coverage.⁶

In designing the template for the SBC and the uniform glossary, the NAIC working group strived to meet the statutory “plain language” requirements but strongly advised that testing and assessments be done in consultation with representative consumer organizations.⁷ We support the NAIC’s recommendation. A review of the current SBC by ThoughtForm provides illuminating examples of how the SBC could be designed to be clearer.⁸

We strongly recommend that before the Departments authorize the SBC and uniform glossary, they should 1) contract with recognized literacy/plain writing experts to test the proposed SBC and uniform glossary templates for language, structure, and layout; 2) focus test the revised forms with the intended audience so they can examine and comment on the content and the presentation of the materials; and 3) make appropriate revisions to provide additional information to individuals or to improve the efficacy of the disclosures. This additional testing with experts and consumers should be prioritized so that it can be accomplished before the SBC requirements go into effect on March 23, 2012.

Culturally and linguistically appropriate requirement

The use of plain language increases the accessibility of the SBC and glossary, but only if it is a language known to the shopper or enrollee. Congress recognized this, and required that the SBC be presented in a “culturally and linguistically appropriate manner.”

The Departments have attempted to satisfy this statutory mandate by incorporating the rules for providing appeals notices pursuant to Section 2719 of the ACA (hereinafter “appeal rules”).⁹ The appeal rules provide that, in counties in which at least ten percent of the population residing in the county is literate in only the same non-English language, both translation and interpretation services must be provided upon request.¹⁰ However, this standard would severely

⁶ See, Cass Sunstein, Office of Management and Budget, Office of Information and Regulatory Affairs to Heads of Executive Departments and Agencies. (2011, April 13). Memorandum on the Final Guidance on Implementing the Plain Writing Act of 2010. Retrieved from <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2011/m11-15.pdf>.

⁷ National Association of Insurance Commissioners. (2010, December 17). Letter to Secretary Sebelius and Secretary Solis. Retrieved from http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.

⁸ http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf

⁹ 26 C.F.R. § 54.9815-2715(a)(5); 29 C.F.R. § 2590.715-2715(a)(5); 45 C.F.R. § 147.200(a)(5).

¹⁰ 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136(e).

curtail limited English proficient (LEP) persons' access to one of the most important documents regarding their health insurance to which they will have access and running afoul of civil rights laws, including Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA.

Unlike the appeals rules, the proposed SBC rules expressly state that the intention is to meet the requirements of Title VI, 42 U.S.C. § 2000d *et seq.*, which prohibits discrimination by any entity receiving Federal financial assistance and requires that they take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. In addition, Section 1557 provides that no health program or activity receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, administered by an Executive Agency or established under Title I of the ACA may discriminate on the ground prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973.

The proposed 10 percent threshold for translation and provision of oral language assistance is much higher than standards currently adopted by the Departments of Justice and Health and Human Services in their "LEP Guidances" (see www.lep.gov) and the Department of Labor in its regulations governing group plans for the provision of notices of appeals. In the LEP Guidance, HHS explicitly considered the cost of compliance to recipients of Federal financial assistance. Indeed, there was recognition that large documents such as enrollment handbooks might not have to be translated as long as the vital information contained in such documents – presumably like the information which is contained in the SBC – is translated.¹¹

Thus, we recommend that the Departments adopt a combined threshold based on LEP plan enrollees utilizing the existing DOL regulations and DOJ/HHS LEP Guidances. We suggest that the threshold should be 500 LEP individuals or five percent of a plan's enrollees, whichever is less. The five percent is utilized in both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans. As some plans may undertake specific marketing and outreach activities to particular ethnic/cultural/language groups, we also recommend that the Departments adopt a secondary requirement to provide language services to any language group to which the plan specifically markets. (This must be in addition to the basic thresholds.) This standard would recognize that a plan could not conduct marketing and outreach to enroll LEP members and then fail to provide assistance when those members need additional information.

The Departments should also require plans and insurers to provide taglines in at least 15 languages with the SBC to ensure that enrollees are informed about how to obtain assistance when questions or issues arise. Taglines are an effective and cost-efficient manner of informing LEP individuals and will help assist plans in determining in which languages additional materials should be provided. To reduce compliance costs to plans, the Departments should provide tagline language and translations for plan usage.

Finally, regardless of whether a plan is required to provide written translations of SBCs, the Department should ensure that oral assistance – through competent interpreters or bilingual staff – is provided to all LEP enrollees.

¹¹ 68 Fed. Reg. 47319.

Coverage examples

The proposed rule invites comment on a number of issues related to the coverage examples that are to be included in the SBC and possibly online. Consumer testing of the prototype coverage examples found the examples to be extremely valuable to consumers.¹² They provided a sense of how much the plan would pay for certain conditions – information that consumers cannot calculate on their own. They also helped crystallize the fundamental concept of insurance for many consumers, who otherwise approached their shopping task as an effort to acquire pre-paid health care. Indeed, this was one of the most valuable parts of the SBC form for many consumers.

Phase-in of coverage examples

As with the SBC overall, the requirement to make coverage examples available to all health care consumers must be implemented in a timely manner. Consumer testing conducted by Consumers Union and by the health insurance industry found that coverage illustrations added significantly to consumers' understanding of health insurance coverage. Further, NAIC relied on private insurers to test the methodology and feasibility of generating coverage illustrations as part of the SBC. We appreciate that it may take some additional time for insurers and third-party-administrators to upgrade computer systems in order to automate the computation of coverage illustrations.

Accordingly, we would support a phased in requirement for this component of the SBC. Specifically, we would agree that in the first year of implementation (2012), group health plans that offer multiple plan options would only be required to include coverage illustrations in the SBCs for the four most popular plans offered. Similarly, for health insurance issuers in 2012, the requirement to include coverage illustrations in the SBCs would only apply for up to four plans – the two most popular plans the issuer sells in each market and two other plans that the issuer has most recently introduced in each market. Such a phase in would make it practical for plan sponsors and issuers to manually generate coverage examples during the first year while they implement changes to produce automated coverage examples in subsequent years. It would also assure that people enrolled in the most popular plans – or who may be considering new products insurers are most interested in selling – would see coverage illustrations in the first year.

Number of coverage examples

The Departments requested comment on the development of multiple coverage examples and how such examples might promote or hinder the ability to understand and compare coverage. We recognize the competing interests that the Departments are trying to balance by limiting the coverage examples that health plans would have to provide to three initially and to a maximum of six. However, in light of their value to consumers and the phase-in we suggest above, we

¹² See, for example, Kleimann Group and Consumers Union. (2011, August). *Early Consumer Testing of Coverage Facts Labels: A New Way of Comparing Health Insurance*. Retrieved from http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf

recommend that the Departments require inclusion of six medical scenarios in the SBC beginning immediately in 2012.

Selection of coverage examples

When selecting the treatment scenarios to include, the Departments should choose examples that are relevant to as wide and diverse a population as possible. Specifically, we urge the Departments to take into account the following factors:

- Prevalence of conditions in the population overall.
- Prevalence of conditions in key subpopulations. There should be coverage examples that are relevant to both men and women. At least one example should be for a condition prevalent in children and young adults.
- Cost-sharing operates significantly differently under family coverage compared to self-only coverage. There should be at least one example relevant to family coverage.
- Typically health plans apply different coverage rules, limits, and cost-sharing for certain types of benefits (e.g. hospitalization, outpatient prescription drugs, mental health care, rehabilitative services, etc.). The collection of coverage examples should demonstrate to consumers how these coverage differences work under each plan.

Insurer vs. consumer generation of coverage examples

The proposed rule requests comment on whether plans and issuers might be required only to provide consumers raw information about coverage features that consumers would then use to generate their own coverage illustrations. We strongly oppose such a change. As noted throughout these comments, consumers already face tremendous barriers to understanding their health insurance coverage today. Consumer testing underscores that the public has difficulty understanding the meaning of basic coverage features, such as deductibles, co-pays, and coinsurance. Asking consumers to take on the burden of generating their own coverage illustrations would be unfair and would ensure that few if any consumers would ever be able to obtain this information.

The proposed rule also requests comment on whether plans and issuers should input plan- or policy-specific information into a central web site, such as healthcare.gov, that would then generate coverage examples for each plan or policy. We also strongly oppose this option. Given the ambitious agenda of implementation activities to be accomplished by 2014 and limited resources appropriated to the federal government, this transfer of responsibilities would be unwise. It would be far easier and more economical for plan sponsors and insurers to develop coverage illustrations for each of the few dozen plans they offer than for the federal government to generate them for tens of thousands of plans.

We do, however, favor a requirement that plans and issuers should display SBCs, including coverage examples, on healthcare.gov so that the public can readily find this information. Further, we support a requirement that the federal government should establish support resources and technical assistance to plans and issuers as they begin to generate SBCs. We would note in particular that technical support provided by HHS has been highly effective and made possible the reporting and display of extensive information about all individual and small group market

health insurance plans in a short period of time. We trust that the Departments will continue to provide this level of technical assistance to health insurance issuers and health plan sponsors so that they can comply with Section 2715 disclosure requirements timely and efficiently.

Additions and changes to the glossary of health insurance and medical terms

Consumer testing

Consumer testing found that a number of the definitions contained in the glossary were unclear, often because the definitions used additional terminology that they did not understand.¹³ For instance, the definition of coinsurance included the term “allowed amount” that, in turn, referenced the term “balanced billing,” all of which the respondents did not understand.

Some changes were made to the glossary since that research was conducted, but the glossary has not been retested. Accordingly, the Departments should conduct additional consumer testing of the glossary (including the new recommended additions below), modifying definitions until they are understandable to the average enrollee, to ensure that this document meets the goals of Section 2715 of the ACA. Incorporating more examples of the concepts may help.

Additional definitions

Several consumer testing studies have demonstrated that key terms are missing from the glossary.¹⁴ In addition, many consumers are not familiar with the terms *network*, *preferred*, or *participating providers*. Accordingly, the final version of the glossary should include consumer-tested definitions of the following terms:

- HMO/Health Maintenance Organization
- PPO/Preferred Provider Organization
- EPO/Exclusive Provider Organization
- Actuarial Value (or corresponding term used on materials)
- Out-of-network provider
- Catastrophic plan
- Cost sharing
- Prescriptions—generic, non-preferred brand, preferred brand
- Prescriptions – retail vs. mail-order
- Medical underwriting
- Prescription drug “tiers”
- Specialty drugs
- Formulary
- Network, preferred, or participating providers

¹³ People Talk Research and Consumers Union. (2010, December). *Early Consumer Testing of New Health Insurance Disclosure Forms*. Retrieved from http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU_Consumer_Testing_Report_Dec_2010.pdf

¹⁴ See, for example, Kleimann Group and Consumers Union. (2011, September 28). *Early Consumer Testing of Actuarial Value Concepts*. Retrieved from http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf

In addition, while very brief descriptions of particular services may suffice for purposes of a general glossary of terms, we also suggest adding a consumer-tested definition of “covered services,” something like “the care, services, treatment and other measures that your health insurance or plan will pay for or cover. Covered services are defined in the insurance policy.”

Definition of “medically necessary”

Today, insurers define and apply medical necessity differently, even internally across plans, to the detriment of consumers. This incoherence is amplified by consumers’ common misconception that anything their provider orders or prescribes is medically necessary. Consumers need to understand the basis behind coverage decisions so they can understand and challenge decisions that affect their access to a service or product.

To address these issues, we support robust standards for how medical necessity is defined and applied at the plan level, including requirements that medical necessity definitions be transparent and clear to the public. Defining medical necessity (or “medically necessary” as is used in the proposed rules) in the Glossary will also be important to educating consumers about the concept and how it can impact their access to benefits. However, we are concerned that it is premature to refine the Glossary definition at this stage, with the establishment of national standards for medical necessity under consideration as part of the Essential Health Benefit (EHB) rule-making process.

Accordingly, we encourage the Departments to align the Glossary definition with any medical necessity standards or definitions adopted in the EHB rulemaking process. In the interim, the Departments could consider a placeholder definition explaining that medical necessity is a policy used by health plans to determine whether or not an item or service is covered.