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*Via: [www.regulations.gov](http://www.regulations.gov)*

**Comments of the Consumer Representatives to the  
National Association of Commissioners  
on  
Section 2715 NPRM on the  
Summary of Coverage and Benefits form  
and Uniform Glossary**

The NAIC Consumer Representatives listed at the end of this document are pleased to provide the following comments.

Section 2715 of the Patient Protection and Affordable Care Act (ACA) envisions a standard form describing health insurance coverage that is understandable to the average consumer, called the Summary of Benefits and Coverage (SBC). Section 2715 also calls for a Uniform Glossary of Medical and Insurance terms (Glossary). Together, these documents are designed to help consumers “compare health insurance coverage and understand the terms of coverage (or exception to such coverage).”

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. Further, the statute requires that the SBC information be presented in a “culturally and linguistically appropriate manner and be understandable by the average plan enrollee.”

The benefits of a uniform, standard disclosure are great. Consumer confusion regarding health plan terms—particularly cost-sharing terms—is well documented. If consumers can’t understand the coverage offered by a plan, they can’t make an informed selection. When consumers do not understand their choices, they find themselves in plans that don’t have the coverage they need. Indeed, several research studies have estimated a huge consumer welfare loss associated with difficulty in shopping for health insurance.<sup>1</sup>

The proposed rule put forth by HHS, DOL and Treasury (“the Departments”) makes great strides in providing an understandable health insurance disclosure to consumers. As Consumer Representatives to the NAIC, our comments are intended to ensure that the SBC is useful to as many consumers as possible, and that consumers’ ability to use the form is monitored and improved over time.

Our comments address the following issues:

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<sup>1</sup> Randall D. Cebul, James B. Rebitzer, Lowell J. Taylor and Mark E Votruba. *Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance*, American Economic Review, August 2011. Nicole Maestas, Mathis Schroeder, Dana Goldman. *Price Variation in Markets with Homogeneous Goods: The Case of Medigap*, NBER, January 2009.

## **All private health plans and health insurance issuers should provide the 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, inside or outside the exchange.<sup>2</sup>

When consumers use the same Health Insurance 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. It also allows them to compare their health insurance options across settings on an “apples to apples” basis. For example, a family may have a fully-insured plan offered to one spouse and a large, self-insured employer plan offered to the other spouse.

In 2014, the SBC will play additional roles for consumers. The SBC will give consumers critical information they need to know about whether they are in compliance with the new requirement to be enrolled in minimum essential coverage. The SBC must describe the extent of coverage and cost sharing for essential health benefits; it also must indicate whether coverage under the plan or policy has an actuarial value of at least 60 percent. And, as described in the proposed regulation and recommended by the National Association of Insurance Commissioners (NAIC), the SBC indicates the share of premium that the employee must pay. Consumers that have an offer of employer-sponsored coverage will need such information in order to determine whether they may be eligible for subsidies offered through the exchange.

### ***No Employer Plans Should be Excluded from the Requirement to Provide the SBC***

Provision of the SBC to enrollees in employer-sponsored group health plans is particularly important. The vast majority of privately insured people – 150 million non-elderly Americans in 2011 – are covered by employer-sponsored group health plans.<sup>3</sup> If the SBC is not provided to people in such plans, the protections Congress intended under Section 2715 of the Affordable Care Act would be denied to most privately insured Americans.

Information disclosure for consumers in group health plans today is inadequate. For decades, the Employee Retirement and Income Security Act (ERISA) has required private sector group health plan sponsors to provide a summary plan description (SPD) to enrollees describing covered benefits and enrollee rights and responsibilities. However, today’s SPD is a bulky, legalistic document that few consumers can understand.<sup>4</sup> Indeed, one study found that the typical SPD was written at a college reading level whereas most consumers are more comfortable reading at the 6<sup>th</sup> to 8<sup>th</sup> grade reading level.<sup>5</sup> This study concluded that “employers and plan administrators should explore the use of alternative methods of communication to plan participants beyond the written SPD.”

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<sup>2</sup> In addition, state, municipal and local government health coverage plans are to provide the form, but not the federal employee program (FEHBP).

<sup>3</sup> 2011 KFF Employer Health Benefits Survey, available at <http://ehbs.kff.org/>

<sup>4</sup> ERISA requires that the SPD document be written in a manner that is understandable to the average plan participant. The federal regulatory agency charged with overseeing enforcement of this requirement is the Department of Labor. Evidence suggests that this requirement has not been met. [http://www.ebri.org/pdf/notespdf/EBRI\\_Notes\\_10-20061.pdf](http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf)

<sup>5</sup> [http://www.ebri.org/pdf/notespdf/EBRI\\_Notes\\_10-20061.pdf](http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf)

Moreover, the SPD, as well as other summaries that employers and insurers provide today are not standardized and do not include the *Coverage Examples*. In contrast, the SBC standardizes the form, content, appearance of its information. Also, the SBC provides consumers with illustrations of how coverage works for illustrative treatment scenarios. Consumer testing found these illustrations to be very helpful to consumers.<sup>6</sup> A body of research documents that consumers do not understand how their health insurance works or what it covers. As a result, consumers learn too late – when they get sick and make claims – what their health plan does and doesn’t cover. 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.<sup>7</sup> Consumer testing demonstrated that the *Coverage Examples*, more than any other aspect of the SBC, helped consumers overcome this knowledge gap.<sup>8</sup> No such illustrations are routinely provided today under SPDs. Working Americans and their families should not be deprived of this information.

Additionally, current ERISA health plan information disclosure requirements do not apply to tens of millions of public employees who are covered under state, county, and municipal governmental health plans. As written, the proposed rule implementing Section 2715 closes that gap. We urge that the proposed rule be expanded to require Federal Employees Health Benefits (FEHB) plans to also provide this information for federal employees, retirees, and their dependents.

**Recommendation: Require the SBC for all private health plans, including employer-sponsored group health plans. Require that FEHB plans provide this information for federal employees, retirees, and their dependents, to ensure even greater uniformity across consumers with group and non-group coverage.**

#### ***Do Not Incorporate SBC into SPD***

The proposed rule requests comment on whether the SBC should be incorporated into the Summary Plan Description (SPD) that ERISA now requires. Such a move would defeat the purpose of the disclosure requirements under Section 2715. As noted above, the SPD has become so bulky and legalistic that few consumers rely on this document for understandable information about how health coverage works. The short, concise SBC will be easier for consumers to keep handy, consult frequently, and understand.

It is unlikely that employers would realize significant cost savings as a result of combining the two documents. Under the 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. It is more efficient and practical to maintaining the SBC as a separate document.

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<sup>6</sup>[http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A\\_New\\_Way\\_of\\_Comparing\\_Health\\_Insurance.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf)

<sup>7</sup> USA Today, Kaiser Family Foundation, Harvard School of Public Health, “National Survey of Households Affected by Cancer,” November 2006, at <http://www.kff.org/kaiserpolls/upload/7591.pdf>

<sup>8</sup> Ibid

**RECOMMENDATION: The SBC should not be incorporated into the SPD. but rather all private health plans should be required to provide the SBC as a separate, stand-alone document.**

***Other employer- reporting requirements can and should make use of SBC information***

The information that plan sponsors will need to compile in order to provide SBCs satisfies other employer reporting requirements under the ACA. The Administration should clarify that providing the SBC to all enrollees and prospective enrollees also satisfies 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 health plan has an actuarial value of at least 60 percent. In addition, the Administration should clarify that the SBC will 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. Such dual use will minimize duplicative information reporting requirements on employers.

**Recommendation: Clarify in the proposed rule that providing the SBC allows employers to meet additional reporting requirements under the ACA.**

***The Benefits Of Producing The SBC Outweigh The Costs***

There has been discussion as to whether it is too costly for health insurance issuers to produce the SBC form at all, particularly if they offer many plans. Some self-insured employers note that they already provide summaries of coverage to their employees and wonder if the cost of the new SBC is merited.

Producing the SBC requires insurance producers and employer plans (or their third party administrators) to evaluate their offerings and create information systems that will accurately describe benefits in the prescribed format. However, the Departments' own analysis shows that the annualized costs to industry of complying with these rules, as tabulated in the regulatory impact analysis, are an estimated \$50 million. These costs (estimated only for the first years of implementation) are clearly very modest relative to the number of covered lives (estimated by the agencies to be 176 million) -- at \$0.28 per covered life.

The benefits, on the other hand, as detailed throughout these comments, are substantial. Although the agencies do not attempt to quantify the aggregate benefits of the SBC, we are confident that a welfare analysis would show that the benefits of standardizing information about health insurance plans would substantially outweigh the costs. Researchers' estimates of the consumer welfare loss associated with high "search friction" — that is, difficulty shopping for coverage — vary but in all instances are far in excess of the \$50 million estimated annualized cost.<sup>9</sup> As demonstrated in consumer testing, a standardized form reduces these search frictions by making it easier to compare coverage. Even a tiny reduction in consumer search costs would more than compensate for the \$.28 cost per life to produce the form.

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<sup>9</sup> Randall D. Cebul, James B. Rebitzer, Lowell J. Taylor and Mark E Votruba. *Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance*, American Economic Review, August 2011. Nicole Maestas, Mathis Schroeder, Dana Goldman. *Price Variation in Markets with Homogeneous Goods: The Case of Medigap*, NBER, January 2009.

**RECOMMENDATION: All private health plans should provide the SBC, as the costs to produce the form appear to be greatly exceeded by the consumer welfare gains.**

### **Adhering to Plain Writing Requirements**

Plain writing is essential to the successful achievement of the legislative and administrative goal of helping individuals better understand their health coverage, the differences in coverage options for meaningful comparison when shopping for a new plan, and terms and concepts commonly used in health coverage.<sup>10</sup> Plain writing is consistent with the requirement in Section 2715(b)(2) that the SBC “utilizes terminology understandable by the average plan enrollee.”

As defined in the Plain Writing Act of 2010, plain writing is writing that is clear, concise, and well-organized.<sup>11</sup> By October 13, 2011, Federal agencies must write all new or substantially revised documents in plain writing.<sup>12</sup> The SBC template HHS releases should meet the requirements of this Act. Avoiding vagueness and unnecessary complexity will make it easier for individuals to understand and compare plan features.

The NAIC working group designed the recommended template for the SBC and uniform glossary, which the Departments propose for adoption. The work group strived to meet “plain language” requirements but strongly advised that additional testing and assessment be done in consultation with representative consumer organizations.<sup>13</sup> A review of the current SBC by ThoughtForm provides illuminating examples of how the SBC could be designed to be clearer.<sup>14</sup> We support the NAIC’s recommendation for additional review of the SBC and glossary in order to adhere to plain language standards.

**RECOMMENDATIONS: Before the Secretary authorizes the SBC and uniform glossary, HHS should 1) contract with recognized literacy/plain writing experts to test the proposed SBC and uniform glossary templates for language, structure, and layout; 2) consumer 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 accomplished before the SBC is released on March 23, 2012.**

### **Language Access**

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.

Section 2715(b)(2) of the Public Health Service Act requires the summary of benefits and coverage (SBC) should be presented in a “culturally and linguistically appropriate manner.” The NPRM proposes to satisfy this statutory mandate by incorporating the rules for providing appeals notices

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<sup>10</sup> See, Memorandum from Cass Sunstein, Office of Management and Budget, Office of Information and Regulatory Affairs to Heads of Executive Departments and Agencies, “Final Guidance on Implementing the Plain Writing Act of 2010” (April 13, 2011), available at <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2011/m11-15.pdf>.

<sup>11</sup> 5 U.S.C. § 301 (3)(3).

<sup>12</sup> 5 U.S.C. § 301 (4)(b).

<sup>13</sup> Letter from the National Association of Insurance Commissioners to Secretary Sebelius and Secretary Solis (Dec. 17, 2010), available at [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_ppaca\\_letter\\_to\\_sebelius.pdf](http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf).

<sup>14</sup> [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_110505\\_literacy\\_review.pdf](http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf)

pursuant to section 2719 of the ACA (hereinafter “appeal rules”).<sup>15</sup> 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.<sup>16</sup> This ten percent threshold is so high that appeal notices will only be translated into Spanish for a small segment of Spanish-speakers and virtually no other languages.<sup>17</sup>

We strongly oppose applying the standards from the appeal rules to the SBC rule. The Departments propose to severely restrict limited English proficient (LEP) persons’ access to arguably the most important document regarding their health insurance to which they will have access, the document that allows them to compare plans, shop for plans, and understand the terms and limitations of the plan in which they enroll. This is unwise, but also violates PHSA § 2715, Title VI and Section 1557 of the ACA.

Unlike the appeals rules, the proposed SBC rule 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.

In addition, Section 1557 of the ACA prohibits discrimination in any “health program or activity, any part of which is receiving Federal financial assistance, “including credits, subsidies, or contracts of insurance . . . .” Every health plan that participates in an Exchange will receive Federal financial assistance, at least in the form of premiums financed by advanced payment tax credits and cost-sharing subsidy payments. Further, the exchanges themselves receive federal assistance in the 2014. Thus, every one of those plans is obligated under both Title VI and Section 1557 not to discriminate, and that means that they must provide culturally and linguistically appropriate services, independent of the appeal or SBC rules.

Further, the language of § 2715 itself requires that the SBC be provided in a culturally and linguistically appropriate manner. We do not believe that a 10 percent threshold for translation and provision of oral language assistance would ensure the provision of culturally and linguistically appropriate services.

HHS’s LEP Guidance (see [www.lep.gov](http://www.lep.gov)) recognizes the need for a dual standard for translating documents including both numeric and percentage thresholds. This guidance provides two “safe harbors” or rules recipients of Federal funds could follow and be sure they were in compliance with Title VI: first, the HHS recipient provides written translation of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served; and second, if there are fewer than 50 people in a language group that reaches the five percent threshold, the recipient can provide written notice of the right to receive competent oral interpretation of the written materials, free of cost. Further, the LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed.

In the LEP Guidance, HHS took great pains to consider 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*

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<sup>15</sup> 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).

<sup>16</sup> 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136(e).

<sup>17</sup> *Ibid.*

*is translated.*<sup>18</sup> Surely, a double-sided four-page SBC that contains basic plan information is both vital and short.

We recommend that the Departments adopt the dual threshold approach, using a standard of 500 LEP individuals or 5% of a plan's service area (for non-group plans) or workforce (for group plans), whichever is less. The 5% 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.

Further, the Departments must ensure that the translation is competent and not done through machine translation which does not produce competent translations. "Machine translation" refers to the use of a computer program to automatically translate information from one language to another. At this point in time, neither free nor commercial machine translation programs provide sufficiently accurate translations to rely upon for use with LEP patients. Thus Exchanges, QHPs, and others should be prohibited from using machine translation to develop translated materials and instead utilize best practices as recognized by the American Translators Association (ATA) for translating documents. ATA offers a guide called "Getting it Right" that offers advice on what to look for when evaluating translation services. The Guide is available at [https://www.atanet.org/docs/Getting\\_it\\_right.pdf](https://www.atanet.org/docs/Getting_it_right.pdf).

Finally, we strongly believe that ***regardless of whether a plan is required to provide written translations*** of SBCs, the Department must ensure that oral assistance – through competent interpreters or bilingual staff – is provided to ***all*** LEP enrollees. The current appeal rules only require plans to provide language services when the thresholds are met. We do not believe this meets the letter or spirit of PHS A § 2715, Title VI or the nondiscrimination provision of the ACA since this would leave millions of LEP individuals without any assistance from their plans when trying to understand information about services that are and are not covered and to make an educated decision about which plan in which to enroll. It is hard to understand how the statutory requirement in PHS A § 2715 to provide the SBC in a culturally and linguistically appropriate manner is upheld if plans can ignore the most basic communication needs of LEP individuals. In addition, it has been a longstanding recognition under Title VI of the Civil Rights Act of 1964, reiterated with the enactment of the nondiscrimination provision in Section 1557 of the ACA, that oral communication with LEP enrollees must be provided to every individual, regardless of whether thresholds to provide written materials are met. Thus, no less should be required here.

In sum, the SBC is one of the most vital of all documents that will be issued by a plan. To provide anything less than the same language access that is required of other recipients of Federal financial assistance would be to undermine the intent of the ACA's requirement of linguistic and cultural appropriateness, as well as Title VI and Section 1557's promise of non-discrimination. The rule should be amended to bring it into compliance with the HHS Guidance, at the very least.

**RECOMMENDATIONS: The Departments should provide already translated templates for the SBC in major languages. Require plans to competently translate their portion of the SBC into any language which comprises 5 percent or 500 LEP plan's service area (for non-group plans) or workforce (for group plans), whichever is less. Require plans to provide oral language services – through competent bilingual staff or interpreters – for all LEP individuals with questions about the SBC.**

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<sup>18</sup> 68 Fed. Reg. 47319.

## **New/Modified Disclosures for SBC**

As a primary document that will be viewed by most consumers enrolling in health coverage, the SBC is well suited to provide key health insurance disclosures to consumers. Some of these disclosures are already included in the SBC but might be improved. Others are new suggestions. Some are relevant to 2012 and others are associated with the new consumer rights and responsibilities that occur in 2014.

### **Existing and Proposed Disclosures for 2012**

Beyond the specific plan features, the SBC will include information about using the health plan, such as information on grievances and appeals. SBC also will include statements that are akin to warnings, such as the lead statement reminding consumers that the summary is not their policy. For warnings to serve the purpose of protecting consumers, consumers must be able to comprehend the warnings, understand how they affect them and whether there are any actions they can take to reduce the potential dangers. The Departments need to be aware that too many warnings/disclosures, poorly worded or poorly placed, will detract from consumers' ability or willingness to use the SBC form.<sup>19</sup> The Departments should carefully test existing and proposed disclosures to assess the critical tradeoff between providing consumers with valuable information and protections vs. making the form unappealing or confusing.

The following proposed and modified disclosures for 2012 will provide key information that consumers need in one location – the SBC.

**Recommendation: For 2012, the following statements should be consumer tested and added to the SBC. Consumer testing should identify the best location and phrasing for the disclosure.**

- **KEEP THIS DOCUMENT WITH YOUR OTHER IMPORTANT PAPERS if you enroll in this health plan.**
- **This plan [is/is NOT] a grandfathered health plan. Grandfathered health plans may meet your coverage needs but also may contain fewer consumer protections than non-grandfathered plans. For a list of differences, see [web address].**
- **Need help comparing your health coverage options? Contact [state's] consumer assistance division at [phone number/website].**
- **Call [state Insurance Department] for information on the rates paid under this plan to out-of-network providers and to learn about your rights regarding how much you can be charged by out-of-network providers.**
- **[If true] This plan excludes some pre-existing medical conditions. See [web address] to see how this might affect you.**

### **Disclosures planned or recommended for 2014**

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

#### ***60% Actuarial Value Disclosure***

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<sup>19</sup> See <http://www.bis.gov.uk/files/file44367.pdf> or [http://findarticles.com/p/articles/mi\\_hb3250/is\\_2\\_35/ai\\_n28879116/](http://findarticles.com/p/articles/mi_hb3250/is_2_35/ai_n28879116/)

Coverage that fulfills the individual's requirement to have "minimum essential" health coverage includes coverage under a government-sponsored health care program (e.g., Medicaid, Part A of Medicare), an "eligible" employer-sponsored plan, coverage under a plan offered in the individual market, a grandfathered health plan, and other health coverage as recognized by the Secretary of Health and Human Services. The coverage offered by employers with at least 50 full-time-equivalent employees is required to meet certain conditions or employers may face penalties.<sup>20</sup> If large employers fail to offer a plan that has an actuarial value of at least 60 percent, and charge premiums that cost less than 9.5 percent of an employee's income, the employee may be eligible for tax credit subsidies in the exchange.

To help consumers understand whether or not the coverage meets these requirements, the ACA mandates 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% actuarial value threshold is a standard that is widely used by the ACA and one that consumers should become familiar with.

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.<sup>21</sup> 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 didn't understand the phrase. The term "on average" made participants feel the percentage paid by the plan was not stable and could vary a great deal. Additionally, they 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%."

In order to ensure this important concept is comprehensible in the SBC, alternative language should be consumer-tested.

Additionally, in the fully-insured non-group and small-group markets, the 60% actuarial value standard is tied to the essential health benefits package. It is unclear whether the large employer's 60% actuarial value requirement will be tied to the same standard, or calculated over a different or even varying set of covered medical services.

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<sup>20</sup> One area of concern is "self-insured" plans offered by small employers. Because these employers have *less* than 50 full-time-equivalent employees, they aren't subject to the penalties facing larger employers if their coverage falls below a 60% actuarial value threshold. In reality, however, employers of this size aren't really self-insured. They actually purchase large "stop gap" insurance policies with low attachment points. Unless HHS or individual states enact rules to prevent it, a small, self-insured firm could offer a plan that doesn't conform to the rules for qualified coverage.

<sup>21</sup> *Early Consumer Testing of Actuarial Value Concepts*, Kleimann Group and Consumers Union, September 2011. [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org\\_testing\\_actuarial\\_value\\_concepts.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf)

It is indisputable that consumers would be better off having a standard that is consistent across the non-group, small group and large group markets. This would be construed as a reporting requirement or method of measuring large employer actuarial value, not as a requirement that large employers cover the essential health benefits.

If actuarial value is not calculated using a consistent set of medical services in all markets, then the SBC for large employer plans must have additional language that explains the implications for consumers.

**RECOMMENDATIONS: To be displayed on SBCs for plans that are effective January 1, 2014 or later, consumer-test language and placement for the 60% disclosure. Disclosure language must reveal the purpose of the disclosure and use terminology understandable for most consumers. Alternate phrases for testing could include: “This plan offers coverage that is at or above federally recommended minimums.” Alternatively, include the following phrase ONLY when the value is below 60%: “This health plan is below federally recommended minimums. You may want to consider other coverage options.” The later option reflects the fact that there is no specific action for the consumer to take when the plan is above the 60% threshold. If future regulations do NOT require that the 60% actuarial value determination be made in a consistent fashion across large group, small group and non-group plans, consumer test additional language that draws out the implications for consumers of the large group variation.**

**Does the premium exceed 9.5% of income?**

If a consumer is offered coverage by an employer that does NOT meet the standard of “qualified coverage” (described above), they may have access to subsidized coverage in the Exchange. One condition that must be considered is whether the premium exceeds 9.5% of income. There is not an easy way for the SBC to indicate whether the specific premiums exceed 9.5% of income, but the SBC could usefully provide the benchmark income and explain the significance of the income threshold for consumers who are offered group health plans. This disclaimer should appear in the same row as the premium on page one.

**RECOMMENDATION: To be displayed on SBCs for Large Group plans that are effective January 1, 2014 or later, in the “Why this Matters” box, for the premium line, consumer test a phrase such as: If your household income is below [insert an amount that is the employee premium amount/.095], you may be able to get help purchasing coverage in your state’s exchange. See [website] for details.**

In 2014, consumers purchasing non-group coverage in the exchange may have tax credit subsidies and cost-sharing subsidies available to them. It seems unlikely that the insurer will know the net premium to the consumers after tax credit subsidies, but the premium box should indicate (for exchange plans) that a consumer’s costs may be lower than the indicated premium, if they are eligible for subsidies. HHS should test alternative language for this with consumers.

**RECOMMENDATION: To be displayed on SBCs for non-group plans that are effective January 1, 2014 or later, in the “Why this Matters” box, for the premium line, consumer test a phrase such as: If your income is below certain thresholds, you may be eligible for lower premiums. See [website] for details.**

**Add the plan’s “metal tier” designation, if non-group or small group**

Early consumer testing of the proposed “metal tiers” (Bronze, Silver, Gold, Platinum) shows that these designations are very helpful to consumers, as the tiers quickly convey the relative strength of the coverage of their health plan options.<sup>22</sup> This useful, consumer aid should be incorporated into the SBC in 2014.

**RECOMMENDATION: Consumer-test language and placement for a metal tier designation (Bronze, Silver, Gold, Platinum) for non-group and small group plans, to be displayed for plans that are effective January 1, 2014 or later.**

## **Additions and Changes to the Summary of Benefits and Coverage Template**

### **Inclusion of premium information**

The proposed rule follows the NAIC recommendation that the SBC should display the premium or cost of coverage for policyholders/group health plan enrollees prominently – in the top right corner of the first page. 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 emphatically recommend that premium information should be included on the SBC. In order to choose among health plan options, consumers need both premium *and* coverage information available to them. A primary purpose of the Affordable Care Act is to get insurers to compete on the basis of ‘value,’ not just price. Therefore, the SBC must contain information about both the cost of coverage and the content of coverage so that consumers can evaluate this information together.

In addition, consumers who are offered or enrolled in employer-sponsored group coverage must have premium/cost-of-coverage information in order to know whether their coverage meets the Affordable Care Act’s ‘affordability’ test. This test, along with the 60% actuarial value requirement, is key to determining eligibility for subsidies in the Exchange.

**RECOMMENDATIONS: The SBC must include information about the health plan premium/cost of coverage for consumers and display that information prominently on the top right corner of the first page.**

### ***When Family Options Are Offered***

Premium (and other cost-sharing information) must also 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 would be different under a family policy. It may be better for the consumer to have this information included in a new, separate SBC. HHS should test this with consumers.

**RECOMMENDATIONS: The Departments should consumer test alternative methods of conveying self vs family (and other coverage tiers that may be available).**

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<sup>22</sup> *Early Consumer Testing of Actuarial Value Concepts*, Kleimann Group and Consumers Union, September 2011. [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org\\_testing\\_actuarial\\_value\\_concepts.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf)

### **Non-network providers providing care in In-Network Facilities**

A leading complaint heard by consumer assistance plans is that patients are caught off guard when they receive large bills from out-of-network providers providing care in an in-network facility. The SBC provides an opportunity to address this common problem. While the Insurer Instructions include a requirement that health plans highlight the fact that some out-of-network specialists are used by In-network providers (instruction 7f), standard language is not provided.

Certain states, like Colorado, require that all care provided in an in-network facility is considered in-network. Insurer instructions should clarify that insurer responses in the SBC must be consistent with state law and provide an alternative phrase. The Coverage Example recommended below should likewise be amended, if state law conflicts.

**RECOMMENDATIONS: Except where prohibited by State or local law, include on the SBC consumer-tested language to convey the warning that out-of-network specialists may be used by in-network facilities. Provide a new *Coverage Example* that includes a mix of in-network and out-of-network providers to illustrate balance billing and the fact that in-network facilities do not work exclusively with in-network doctors. We recommend a scenario involving an in-network ER visit, combined with an out-of-network ER physician, unless consumer testing shows another example would better meet this need.**

### **Coverage Examples**

The NPRM 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.<sup>23</sup> They provided a sense of how much the plan would pay for certain conditions – information that consumers couldn’t 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.

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<sup>23</sup> See, for example, *Early Consumer Testing of Coverage Facts Labels: A New Way of Comparing Health Insurance*, Kleimann Group and Consumers Union, August 2011. [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A\\_New\\_Way\\_of\\_Comparing\\_Health\\_Insurance.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf)

### **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 (three initially up to a maximum of six). In light of their value to consumers, however, we recommend that the Departments require inclusion of six medical scenarios as *Coverage Examples* on the SBC beginning immediately in 2012, and consider additional scenarios in the future.

### **Selection of Coverage Examples**

When selecting the additional treatment scenarios, 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. There should also be at least one example relevant to family coverage since cost sharing operates significantly differently under family coverage compared to self-only coverage.
- Scenarios that illustrate differences in how health insurance coverage varies for different types of care. Typically health plans apply different coverage rules, limits, and cost sharing for certain types of benefits – hospitalization, outpatient prescription drugs, mental health care, rehab services, etc. Selection of coverage illustrations should show 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 would 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. It is not reasonable to expect consumers to successfully estimate out-of-pocket costs that could result from such features. 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 [www.healthcare.gov](http://www.healthcare.gov), that would then generate coverage examples for each plan or policy. We would also strongly oppose this change. 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 favor 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 HHS and the Department of Labor 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.

**RECOMMENDATIONS: Require inclusion of six medical scenarios in the SBC beginning immediately in 2012. The six examples should be chosen for their relevancy to as wide and diverse a population as possible. We further recommend that the Departments closely monitor consumer satisfaction with the *Coverage Examples* feature of the SBC and, if warranted, consider requiring insurers to generate additional *Coverage Examples* that would be made available on the Internet for enrollees or prospective enrollees seeking an example for additional conditions. However, plans and issuers, not consumers or the Federal government, must be responsible for generating coverage illustrations.**

### **Additions and Changes to the Glossary of Health Insurance and Medical Terms**

Consumer testing<sup>24</sup> 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. For example, the definition of “coinsurance” relied on the term “allowed amount” that, in turn, referenced “balanced billing,” all terms the respondents did not understand. Some changes were made to the glossary since that research was conducted, but the glossary has not been retested to ensure the terminology is understandable and clear to consumers.

**RECOMMENDATION: 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. It may be that incorporating more examples of the concepts may help.**

Several consumer testing studies<sup>25</sup> have demonstrated that key terms are missing from the glossary. In addition, many consumers are not familiar with the phrases “network”, “preferred” or “participating providers.” 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.”

**RECOMMENDATION: Add consumer tested definitions for “network,” “preferred,” or “participating providers” (and explain that they are similar in terms of their import for consumers), “covered services,” and the following additional terms:**

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<sup>24</sup> *Early Consumer Testing of New Health Insurance Disclosure Forms*, People Talk Research and Consumers Union, December 2010,

[http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU\\_Consumer\\_Testing\\_Report\\_Dec\\_2010.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU_Consumer_Testing_Report_Dec_2010.pdf)

<sup>25</sup> See, for example, *Early Consumer Testing of Actuarial Value Concepts*, Kleimann Group and Consumers Union, September 2011, [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org\\_testing\\_actuarial\\_value\\_concepts.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf)

- 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

**Definition of “medical necessity”**

The definition of “medical necessity” must be amended. As written, the definition excludes a broad range of individuals who will need health care: those whose needs are the result of conditions such as developmental disabilities and congenital problems. Under the currently proposed definition, individuals will be informed that their insurance policy will cover an individual who needs a prescription or medical equipment due to an injury but it will not cover an individual whose needs result from a physical disability. The exclusion of populations with physical and mental disabilities from the definition of “medical necessity” ignores the purposes of the Americans with Disabilities Act and the Affordable Care Act. And as pointed out by Professor Sara Rosenbaum, the proposed “medical necessity” definition is “the absolute embodiment of the very types of discriminatory practices the Affordable Care Act is intended to stop.”<sup>26</sup> Also, some states have statutory definitions of “medical necessity” that should be substituted in those states.

**RECOMMENDATION: To accommodate these concerns, we propose that the definition of medical necessity be amended to add the word “condition” in listing, as follows “... illness, injury, disease, condition, or its symptoms...” Also include language that allows states to have more broad definition of “medical necessity” to confirm with state law.**

**Improving the SBC and Glossary Over Time**

Even with additional consumer testing, consumers’ ability to use the SBC and the glossary will not be fully revealed until the form is in widespread circulation. The Departments should anticipate that additional problems will be identified.

We note that state consumer assistance programs supported by the ACA can be very helpful in tracking the efficacy of the SBCs. As a condition of ACA grants, all consumer assistance programs are required to collect extensive data on individual consumer cases. We recommend that the Center for Consumer Information and Insurance Oversight develop data fields for CAHPS to consistently collect and

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<sup>26</sup> Sara Rosenbaum, ‘Medical Necessity’ Definition Threatens Coverage for People with Disabilities, Health Affairs Blog (Sept. 16, 2011 @ 9:13am), at <http://healthaffairs.org/blog>.

report on the timeliness, language and accuracy of the SBCs. This will provide a robust set of data which can be shared with HHS and DOL on a periodic basis to determine the success the proposed regulations in achieving the goal of ensuring comprehensive, accurate information for consumers to make informed decisions in selecting healthcare coverage.

**RECOMMENDATIONS:** Establish a mechanism whereby problems and proposed improvements can be funneled to a central clearing house operated by HHS. Establish a process for annual review and improvement of the form, allowing input from consumer, provider and insurer stakeholders. Conduct periodic consumer testing, including non-English speaking and hard-to-reach populations, to monitor consumers' ability to use the form.

Thank you for your attention to these comments.

Sincerely,

Lynn Quincy

Tim Jost

Brenda Cude

Stacey Pogue

Barb Rae

Barbara Yondorf

Elizabeth Abbott

Kim Calder

Karrol Kitt

Peter Kochenburger

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