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[www.GroupHealth.org](http://www.GroupHealth.org)

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Submitted electronically via eRulemaking Portal to [www.regulations.gov](http://www.regulations.gov)

RE: Summary of Benefits and Coverage and the Uniform Glossary Notice of Proposed Rulemaking  
File Code: CMS-9982-P

Dear Sir or Madam:

Group Health Cooperative (Group Health) appreciates the opportunity to provide comments in response to the Summary of Benefits and Coverage and the Uniform Glossary Notice of Proposed Rulemaking (Proposed Rule), as published in the Federal Register on August 22, 2011.

Group Health Cooperative is a nonprofit, tax-exempt health system that provides both coverage and care within a consumer governed structure. Our mission is to design, finance and deliver affordable, high-quality health care. Directly, and through our subsidiaries, we cover more than 650,000 residents of Washington State and Northern Idaho, about two-thirds of whom receive care in one of 26 Group Health owned-and-operated medical centers. About 1,000 physicians are part of the Group Health group practice, and we contract with more than 6,000 physicians and 44 hospitals. Extending Group Health's reach into the community, we also include a Foundation, making donations to increase childhood immunization rates and improve community health, and the world-renowned Group Health Research Institute, which conducts research in the public domain on health care system design, treatment options, and comparative effectiveness.

Our “members” are our consumers, who are also our patients. Joining Group Health is very similar to joining any other entity that offers health plan coverage. We offer health coverage through public programs and in the commercial market– in Medicare, Medicaid, the state Basic Health Plan, on the individual market, and to small, medium and large employer groups. Additionally, Group Health is one of the largest employers in Washington, ever-conscious about the cost and quality of health care for our own staff as well as our patients, with 9,500 employees from actuaries to nurses.

Group Health is fairly unique in the health care market for several reasons. First, we provide healthcare directly to the majority of our members. Second, we are a regional plan, serving Washington State and northern Idaho, subject to Washington state insurance regulation (and for our large employer coverage in northern Idaho, to Idaho regulation), and responsive to the needs of our local communities. Third, we are a consumer-governed not-for-profit corporation.

We support the over arching goals of the Proposed Rule to produce easy to understand health plan coverage documents to allow consumers to compare and contrast available health coverage in an easier manner. However, based upon our diverse and long-term experience within the Washington state health care market, we would like to provide the Department of Health and Human Services (HHS) with comments regarding the distribution requirements and the composition requirements of the benefit summary as currently outlined in the Proposed Rule.

We appreciate the opportunity to provide these comments for your consideration, and your willingness to consider these comments as you finalize the final rule for the summary of benefits and coverage.

Sincerely,

A handwritten signature in cursive script that reads "Megan Grover Howell".

Megan Grover Howell  
Director, Regulatory Affairs  
Group Health Cooperative

## **Attachment A**

### Compliance Deadline of March 23, 2012

The Proposed Rule gives the deadline March 23, 2012, which is overly burdensome and health plans may be incapable of building the required systems in such a quick timeframe. The Proposed Rule was issued five months after the deadline for such issuance outlined in the Patient Protection and Affordable Care Act (ACA), resulting in less implementation time available to health plans to meet the March 23<sup>rd</sup> deadline. Furthermore, the Proposed Rule does not contain the final specifications of the required documents and distribution requirements; current implementation will be based off of an estimated guess of how the final rule will be drafted. Although it is true that many health plan issuers currently distribute a form of benefit summary documents to enrollees, the changes required to comply with the Proposed Rule will likely cause reprogramming of many intricate systems in place, or complete construction of new systems to meet the new demands. Additionally, the Proposed Rule contains distribution requirements that will necessitate health plan issuers to strategically construct and staff new departments, or severely alter current departments in order to comply with the regulation. It is not feasible for health plans to make such considerable developments in less than 7 months without the final specifications set out in a final rule.

Group Health respectfully requests that the final rule include adequate implementation time frames once the final rule is developed. An adequate timeframe for the work that will be necessary to implement requirements of this magnitude is 18 months. In the alternative, we suggest that HHS adopt an enforcement grace period for compliance with the final rule, similar to the Department of Labor's Technical Release 2010-02, which set forth an enforcement grace period for compliance with certain provisions of the internal claims and appeals interim final rule.

### Group Plan Requirements for Distribution

#### ***Small Groups***

The Proposed Rule requires that a health plan issuer offering group health plan coverage provide the Summary of Benefits and Coverage (SBC) to a group health plan upon an application or when the employer or health insurance producer inquires for information about the health coverage. The Proposed Rule does not specifically outline what constitutes "inquires for information by the plan about the health coverage." In the small group market, employer groups and/or producers often ask for information regarding the coverage offered by a specific health plan issuer. The employer/producer will often then ask for quotes for the various health plans offered by the issuer. Many combinations of health coverage are available, differing on coinsurance, deductibles, pharmacy benefits, and optical coverage. It is also commonplace for employers/producers to sift through the mass amount of quotes obtained from various issuers, only presenting employer groups with the top three to five plans that the producer feels are of particular interest to the employer. All other quotes are simply tossed aside. Group Health receives quote requests for approximately 1,200-2,400 groups per month in the small group

market alone, with a corresponding 100 unique SBCs to be issued to each employer if a quote for all products is desired (which happens quite often). If issuers are required to supply SBCs for each plan combination for which a quote is requested, an undue burden will be placed on the issuer to produce such documents, adding administrative costs that may outweigh the consumer benefit. Therefore, it is most beneficial to employers to receive an SBC only once a plan is among the top choices or once the employer is likely to purchase such plan.

### ***Large Groups***

Furthermore, large employer groups have even more choice in the health plan market, making the combinations of potential health plan offerings to increase exponentially. Large groups generally have more choice, and engage in longer negotiations with issuers prior to purchasing coverage. Additionally, many large groups employ human resource specialists who are extremely knowledgeable about health plan offerings in the state, and utilize their internal health plan comparison tools to help aid in the purchasing decision. Requiring health plan issuers to distribute SBCs for every combination of health plan for which a large group inquires would result in an even more increased administrative burden and cost, with little increase in consumer benefit.

### **Premium Information**

#### ***Individual Plans***

In the preamble, the Proposed Rule states that although the National Association of Insurance Commissioners included health plan premiums as an element of the SBCs, its inclusion is not specifically required under ACA. Group Health believes that including health plan premiums in individual plan SBCs will likely cause increased consumer confusion, and lead to premium miscalculation prior to health plan enrollment. Although premium information is helpful for consumers to determine which coverage is best suited to their needs, including a premium in the SBC at the initial inquiry is problematic, as an applicant must fill out specific demographic information in order for premium quotes to be accurate. Supplying premium quotes for specific health plans prior to individual plan enrollment may lead to unanticipated premium changes once an applicant has submitted all required information and is enrolled in a plan.

Moreover, SBCs can be more readily available for all applicants if premium information is not required to be included. For example, a health plan issuer can provide all SBCs for all individual health plans offered on its website, allowing easy access for shoppers to use in comparison shopping. However, if premium information is required to be included in SBCs, a shopper will have to wait for SBCs to be specifically tailored to his/her information that was provided, and then sent back by the issuer. In the current “on demand” shopping atmosphere, quick, easily accessible information is more useful to shoppers at the initial stage to make determinations of which health plan generally suits the shopper’s needs. Therefore, Group Health strongly suggests that plan premium information not be required in the SBCs.

### ***Group Plans***

When shopping for group health plan coverage, employers and producers often want to see premium information of many plans in a side-by-side comparison, rather than sifting through packets of quote information. For example, employers and producers often develop their own multi-plan comparison worksheet containing only the top few health plans to be considered. Within this worksheet, premium information is included, along with basic health plan coverage information (i.e. deductibles, coinsurance, copay amounts). This allows the employer to make an informed decision, based upon one document that houses all decision making information. Benefit summaries usually serve as back up information, which employers read when they have specific coverage questions about a specific health plan. For these reasons, adding premium information to group plan SBCs is cumbersome for the health plan issuer, and provides little value to the employers and producers who are shopping for coverage.

### **60 Day Notice for Material Modification**

The Proposed Rule requires an SBC to be distributed 60 days prior to any material modification of the plan. This requirement is problematic in cases where regulators require changes to health plans immediately or in a time frame less than the 60 days. The immediate change may be due to a recent court decision or the implementation of an emergency regulation. The final rule should make an exception to the mandatory 60 day notice period for situations where state or federal law or regulation requires such change in less than the 60 day time period. In these situations, health plan issuers should be able to distribute an updated SBC as soon as practicable, but no later than 30 days after the effective date of the modification.