

OCT 24 2011
LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS
BRANCH
PUBLIC SUBMISSION

As of: October 24, 2011
Received: October 21, 2011
Status: Posted
Posted: October 24, 2011
Tracking No. 80f58262
Comments Due: October 21, 2011
Submission Type: Web

Docket: IRS-2011-0026
Summary of Benefits and Coverage and Uniform Glossary

Comment On: IRS-2011-0026-0001
Summary of Benefits and Coverage and Uniform Glossary

Document: IRS-2011-0026-0014
Comment on FR Doc # 2011-21193

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General Comment

See attached file(s)

Attachments

CU SBC comments V3



POLICY & ACTION FROM
CONSUMER REPORTS

October 21, 2011

Centers for Medicare & Medicaid Services Department of Health and Human Services 200 Independence Avenue, SW Washington, DC 20201 File code: CMS-9982-P	Office of Health Plan Standards and Compliance Assistance Employee Benefits Security Administration U.S. Department of Labor 200 Constitution Avenue, NW Washington, DC 20210 Attention: RIN 1210-AB52	Internal Revenue Service P.O. Box 7604 Ben Franklin Station Washington, DC 20044 Attention: REG-140038-10
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Via: www.regulations.gov

Section 2715 NPRM on the Summary of Coverage and Benefits Form and Uniform Glossary

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. This form is 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.

The proposed rule put forth by HHS, DOL and Treasury (“the Departments”) makes great strides in providing an understandable health insurance disclosure to consumers. Our comments below 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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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.¹

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. 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.² 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.³ 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.⁴ This study concluded that “employers and plan administrators should explore the use of alternative methods of communication to plan participants beyond the written SPD.”

¹ In addition, state, municipal and local government health coverage plans are to provide the form, but not the federal employee program (FEHBP).

² 2011 KFF Employer Health Benefits Survey, available at <http://ehbs.kff.org/>

³ 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

⁴ 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.⁵ 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.⁶ Consumer testing demonstrated that the *Coverage Examples*, more than any other aspect of the SBC, helped consumers overcome this knowledge gap.⁷ 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.

⁵http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf

⁶ 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>

⁷ 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. The Departments' analysis, for example, cites research by Maestas et al. on search costs in Medigap (i.e., the cost to consumers of finding the lowest cost plan among equivalent plans, e.g., the lowest cost Medigap "C" or "F" plan) – research that finds those consumer costs to be quite high per covered life.⁸ This study found that Medigap consumers were paying \$72 more per year (in higher premiums) due to these search frictions (or difficulty comparing options). A separate study found even higher costs for employers, particularly small employers, trying to choose among health coverage options.⁹ If better information reduces these shopping difficulties even modestly,

⁸ Nicole Maestas, Mathis Schroeder, Dana Goldman. *Price Variation in Markets with Homogeneous Goods: The Case of Medigap*, NBER, January 2009.

⁹ 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.

the consumer/employer gains will far outweigh the annual costs as estimated by the Departments.

RECOMMENDATION: All private health plans should provide the SBC, as the costs to produce the form appear to be greatly outweighed by the consumer benefit.

When should the SBC be made available to consumers?

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 Affordable Care Act, as the statute requires. We note that the 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. Consumers Union tested drafts of the SBC and the *Coverage Examples* to better understand the benefits of this new information resource. In light of the significant work to date, we urge timely implementation.

Timely implementation will help consumers better understand their coverage and health insurance options and reduce the costs and frustrations of trying to decipher the confusing 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.¹⁰

In addition, other key reform initiatives rely on the availability of information contained in the SBCs. As noted elsewhere in these comments, employers will need to compile the same information in order to satisfy other ACA reporting requirements. State Exchanges will need to collect the same information in order to evaluate eligibility for tax credit subsidies. Individuals and families will need this information in order to document compliance with the individual mandate. Experience working with the SBC in 2012 will inform the closely related work associated with these other aspects of the ACA.

In that vein, we urge the Administration to engage in ongoing efforts to monitor consumer and health plan experience with the SBC, and to make future refinements and improvements based on such monitoring (see additional discussion below).

RECOMMENDATION: Implement SBC on time, no later than March 23, 2012, as the ACA requires.

Providing the SBC to consumers

We strongly support the requirements outlined in the proposed regulation specifying that the SBC must be provided free of charge “with respect to each benefit package offered by the plan or issuer for which the participant is eligible” when an employer or individual is comparing health coverage options (§ 147(a)(ii)(A)). The proposed rule recognizes that there are different scenarios for when an SBC should be made available to a consumer. We agree that the SBC should be provided:

- to enrollees when the issuer renews or reissues the policy,
- any time an applicant, shopper or group plan requests it,

¹⁰ ehealth, Inc., “New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology,” January 3, 2008, available at http://www.insurancenewsnet.com/article.asp?a-top_news&id-89712.

- whenever application materials that are distributed by the plan or issuer for enrollment, and
- whenever there is a change in plan information or benefits.

We agree that a printed SBC must be provided within 7 days of a request.

Group Plan Considerations

The proposed instructions for group plans appear to allow the plan to provide the SBC to the employer rather than the employees. We believe it is essential that the SBC reach each covered employee and the instructions should be modified accordingly. Unless this document is provided to employees, they cannot use the document to compare their employer's coverage to other options that might be available to them.

For group plans, 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, along with other materials used to make a health plan selection.

Non-Group Plan Considerations

For individual 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.

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 containing the updated premium information. In 2014, when the prohibition on health status rating in the Affordable Care Act becomes effective, there will be fewer factors affecting premium information. Once this provision is effective, insurers should provide premium information for each plan based on age, tobacco use and geographic location or which ever factors are allowed under state law.

In general

The proposed regulation 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 the first date a participant is eligible to enroll in coverage. We urge the Departments to require the SBC to be made available at least seven days prior to when a participant is eligible to enroll. This is consistent with the timeframe included in the rule for special enrollment. Sufficient lead time is important. Consumers choosing health coverage need adequate time to review materials and fully understand their options in order to make an informed decision.

RECOMMENDATIONS: As called for in the NPRM, require the SBC to be made available within seven days of a request. Further, insurers should provide the SBC along with marketing materials provided to prospective employers and individual applicants/shoppers. For group plans, the SBC should be provided to employees at the beginning of the open enrollment season and to new employees as soon as possible after a hire, at the same time as other materials are provided for their health benefit selections. The proposed instructions for group plans should require that the SBC always be provided directly to employees. If any information included in the SBC changes, including premium information, insurers should be required to issue an amended SBC to enrollees and applicants within the timeframes specified in the regulation. The requirement that issuers provide the SBC upon request should permit consumers to request an additional copy of the SBC for their plan if they misplace, damage, or lose the document.

How should the SBC be made available to consumers/employees?

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.

Providing the SBC as a separate document is crucial to the intended purpose of the SBC. This enables consumers to identify the SBC among other plan documents easily. The SBC should not be incorporated into other plan documents, such as the Summary Plan Description (SPD); this would make it more difficult for consumers to locate the SBC and to understand their plan.

Because consumers applying for health insurance coverage, as well as current beneficiaries, 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. The SBC should 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.”

RECOMMENDATIONS: The SBC should be provided as a stand-alone document and should be made visible among other plan documents. The SBC should 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.”

Method 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. Even when consumers submit a request for information or assistance online, this does not guarantee that they have continuous access to a computer or the level of computer literacy required to access or use information provided through electronic means. Therefore, 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.

We agree that the SBC should also be made available through posting the document on the Web. Specifically, we recommend that the SBC for each benefit package offered by the non-group issuer be posted on the insurer's website, as well as state and federal websites that aggregate health insurance information for consumers, such as state Exchange websites (in 2014) 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 SBCs for fewer plans or insurance products as they compare coverage options. SBCs posted on state Exchange websites and on healthcare.gov should be posted in a uniform format, across issuers, 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.

Online access to the SBC should be tested with consumers, to ensure that online display (which may differ from the paper form) does not lessen consumer's ability to understand and navigate the information. Similarly, the SBC information that may be displayed as part of multi-plan "side by side" or comparison, should be tested with consumers. Regulations governing online display of SBC information (other than a downloadable PDF that mimics the paper form) should reflect the best practices learned from consumer testing.

RECOMMENDATIONS: The SBC should be provided in paper form as a default option, unless the applicant or enrollee explicitly elects to receive the form through electronic means. Consumers should be able to specify the form in which they prefer to receive the SBC (eg, via post, phone, fax, or email) even if they make a request for information and plan documents via the Internet. SBCs should be available on the Internet on the insurer's or plan's website, Healthcare.gov, and the Exchanges, in addition to being provided in hard copy or electronically if a consumer explicitly elects to receive an electronic copy of the SBC. Consumers should not have to set up a password-protected account with the site in order to view the SBC. Online access to the SBC should be tested with consumers, to ensure that online display (which may differ from the paper form) does not lessen consumer's ability to understand and navigate the information.

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.¹¹ Plain writing is consistent with the requirement in Section 2715(b)(2) that the SBC "utilizes terminology understandable by the average plan enrollee."

¹¹ 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>.

As defined in the Plain Writing Act of 2010, plain writing is writing that is clear, concise, and well-organized.¹² By October 13, 2011, Federal agencies must write all new or substantially revised documents in plain writing.¹³ 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 testing and assessment be done in consultation with representative consumer organizations.¹⁴ A review of the current SBC by ThoughtForm provides illuminating examples of how the SBC could be designed to be clearer.¹⁵ 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 pursuant to section 2719 of the ACA (hereinafter “appeal rules”).¹⁶ 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.¹⁷ 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.¹⁸

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

¹² 5 U.S.C. § 301 (3)(3).

¹³ 5 U.S.C. § 301 (4)(b).

¹⁴ 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.

¹⁵ http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf

¹⁶ 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).

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

¹⁸ Ibid.

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) 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 is translated.*¹⁹ 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

¹⁹ 68 Fed. Reg. 47319.

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.

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 § 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 § 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.

Ensuring Accuracy

Although the SPD or certificate of coverage is the full insurance contract and contains detailed legal requirements of the policy, it is clear from the provisions of the Affordable Care Act and the proposed regulations that the Departments understand that the language of those documents is often too complex for consumers to understand. As the SBC becomes a vital tool for consumers to use to compare plans and select coverage, consumers should be able to rely on the accuracy of the SBC in selecting coverage and making coverage decisions based on the SBC. State insurance departments, HHS and DOL will need to monitor the accuracy of the SBCs.

Anticipating that consumers will rely on the SBC to make critical health insurance decisions, the health insurance issuers and self-funded governmental and non-governmental plans must be accountable to consumers for misrepresentations that conflict with the underlying SPD or certificate of

coverage. It is imperative that a consumer who relies on a representation in an SBC concerning coverage be held harmless or permitted to obtain coverage in a situation in which the consumer either obtains services in reliance on the SBC or seeks services the coverage for which is misstated in the SBC.

Recommendations: First, we recommend that the Departments set up a Consumer feedback line for complaints on the SBC itself. Information on how to assess to this feedback line should be printed on the form itself. State and exchange consumer assistance programs should be tasked with collecting and reporting such complaints to the Departments. Second, state insurance departments should have the statutory discretion to approve SBCs at the same time they approve certificates of coverage for individual and group plans. They should also require that revised SBCs be submitted for approval. Third, as part of the evaluation of the accuracy of the SBC, including *Coverage Examples*, we recommend that state insurance departments, HHS and DOL conduct coordinated and random audits on a periodic basis to test the SBC.

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 (like information on grievances and appeals). 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.²⁰ 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. Indeed, initial consumer testing showed that the number of warnings and explanations associated with the Coverage Examples was excessive.²¹ Consumers disregarded the warnings and reported they reduced the appeal of the SBC.

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

Recommendation: For 2012, conduct additional consumer testing of the warnings and other disclosures included in the SBC, particularly the final page, to ensure that the warnings are, in fact, effective.

²⁰ See <http://www.bis.gov.uk/files/file44367.pdf> or http://findarticles.com/p/articles/mi_hb3250/is_2_35/ai_n28879116/

²¹ *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

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

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.²² If large employers do not offer a plan that has an actuarial value of at least 60 percent, and charges premiums that cost less than 9.5 percent of an employee's income or wage, 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;

²² 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.

The 60% actuarial value threshold is a standard that is widely used by the ACA and one that consumers must 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.²³ 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 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.

Another consumer concern is that in the fully-insured non-group and small-group markets, the 60% actuarial value standard is linked 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.

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. Requiring all health plans and issuers to complete the 60% actuarial value reporting requirement using the same methodology – by calculating the actuarial value for the services in the essential benefits package – would greatly enhance the utility of the disclosure for consumers. Note that this is just a reporting requirement (a 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, and small, self-insured 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 requirement. 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 conveys to consumers the implications of this inconsistent treatment.

²³ *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

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 no easy way for the SBC to indicate whether a premium amount exceed 9.5% of a specific person’s 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 under [insert an amount that is the employee annual premium amount/.095], you may be able to get help purchasing coverage in your state’s exchange. See [website/Human Resources department] 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.²⁴ 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.

²⁴ *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

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).

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.²⁵ 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.

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. The substantive material in the SBC currently takes up just five pages (counting front and back), leaving room for another page containing three coverage examples.

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.

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'

²⁵ 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

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 could support a short phased-in requirement for this component of the SBC. Specifically, 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 4 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. And it would 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.

All health plans offering coverage effective January 1, 2013 or later should include the coverage examples.

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, 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. If a phase-in is adopted, the phase-in should be complete by January 1, 2013.

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

Consumer testing²⁶ found that a number of the definitions contained in the glossary were unclear, often because the definitions used 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 studies²⁷ 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.”

RECOMMENDATION: Add consumer tested definitions for “network,” “preferred,” or “participating providers” (and explain that they are of similar importance to consumers) and the following additional 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

²⁶ *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

²⁷ 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

- Prescriptions – retail vs. mail-order
- Medical underwriting
- Prescription drug “tiers”
- Specialty drugs
- Formulary

RECOMMENDATIONS: Use clear, consumer-tested language to explain why the phrase “These are not contract terms” is important, what it means to the consumer, and what, if any, action the consumer is expected to take.

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.”²⁸ 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.

Additions and Changes to the Insurer Instructions

During the two rounds of consumer testing, insurers populated the SBC templates with real plan designs. This provided valuable testing documents, but also illustrated the profound importance of having complete, unambiguous instructions for populating the SBC. If insurers do *not* adhere to plain language guidelines or don’t provide unambiguous responses in the empty boxes of the SBC, the document will not serve its intended purpose, no matter how carefully crafted the template is. As such, the insurer instructions have an enormous impact on consumers’ ability to use the SBC.

RECOMMENDATION: Augment the insurer instructions, as needed, to reflect the recommended changes described in the above comments. Make the new instructions clear, unambiguous and provide examples of acceptable language.

Regarding non-group instructions used to implement *existing* features of the SBC:

Requirements to provide/deliver the form (page 1)

²⁸ Sara Rosenbaum, ‘Medical Necessity’ Definition Threatens Coverage for People with Disabilities, Health Affairs Blog (Sept. 16, 2011 @ 9:13am), at <http://healthaffairs.org/blog>.

We must anticipate that requirements to provide the form will be interpreted as narrowly as possible. We recommend strengthening this section as follows:

- In the first paragraph of this section it says the form must be provided “to an applicant, to the Policyholder, and to the policyholder at renewal.” In (a) of this section it talks about when the insurer or agent meets with a “potential applicant.” In the General Instructions section under the subsection labeled “(1) What is the Premium,” it talks about how a carrier should fill out the form in the case of a consumer shopping for plans who has yet to fill out an application. These are critical distinctions. If the first directive is the one that applies, then carriers will define “applicant” very narrowly and will say they don’t have to supply the form until someone actually starts filling out--or perhaps even finishes but hasn’t submitted--an application.

RECOMMENDATION: Define, at the beginning of the instructions, the phrase “enrollees and potential applicants” as those enrolled in coverage as well as those shopping for coverage, and using this phrase through out the document. Moreover, clarify when in the process of applying and agreeing to actually purchase coverage an applicant must be given the form and at what point the form can include an estimated versus actual premium cost. The questions raised below should be addressed before final instructions are issued.

- Also under (a), gives options for what happens when an insurer representative meets in person with the potential applicant. It’s not altogether clear exactly at what point the form has to be supplied. Can the requirement to supply the form be met by: supplying it to the consumer only after he/she has decided what plan to apply for (relying up until that point on the insurer’s glossy materials) but not when simply shopping for insurance; when the person actually starts filling out an application; after the application is filled out but before it is submitted; after it is submitted but before the policy is issued?
- On a related note, (a) allows for various ways for an insurer representative to get a copy of the form to the potential applicant. But the start and end dates and their relation to an actual submission of an application are unclear. For example, it says an electronic copy delivered to an email address provided by the individual is an acceptable means of delivery. But within what timeframe must it be delivered? If the applicant has lots of health problems, could the insurer take a week or two to do this? Same with hand delivery.
- Subsection (b) discusses electronic applications. It says the insurer must make the form available on the electronic site. But at what point in the process? **We recommend that the instructions be augmented to require it to be the first step in the process.** It also says the insurer must require the applicant to acknowledge receipt of the form as a necessary step to completing the initial application process. We don’t want the experience to mimic that happens when you order tickets online; you’re on your sixth screen of answering questions and submitting things like credit card information, and then it says click this box to indicate you’ve read the terms and conditions. You’ll just go ahead and click it.
- Subsection (c) has the same problems as noted above with respect to subsection (a).
- Subsection (e) discusses what happens at renewal. It says that the form has to be provided along with renewal documents. **We recommend defining “renewal documents.”** Will the consumer get the form before he/she signs renewal papers or when his/her renewal is confirmed?

RECOMMENDATION: Add language that makes it clear that a policy or certificate holder can request a copy of the SBC and receive it at no charge, if they lose their original copy.

General Instruction, (pages 2-3)

RECOMMENDATIONS:

- 1st bullet. If this form will ever be completed (or partially completed) by an agent, the first line should direct insurers or representatives of insurers to fill out the form accurately and in good faith.
- 4th bullet. Based on the rest of the content in the general instructions section and the instructions for completing the important questions chart, the information on listing in-network and out-of-network data belongs in the instructions for the important questions chart. To be consistent with many of the instructions in the important questions section, this information should be repeated for each applicable row in the important questions section (What is the overall deductible? Are there other deductibles for specific services? Is there an out-of-pocket limit on my expenses? And other applicable questions). Also, on instructions page 9, 2b, we see for the first time a note to insurers that consumer testing shows consumers understand the terms in-network and out-of-network better. This important information should be included in each section where insurers are granted flexibility to use the plan's terminology.
- Bullet 5, bottom of page 2. The directions say all the items on page 1 must always appear on page 1, the chart rows on page 2 may extend to page 3 if space requires, and the chart rows on 4 may appear on page 4. Many things could make these sections longer and instructions should account for this eventuality (an insurer cannot meet the formatting, font, description of benefits requirements in the space provided). However, consumer testing shows that consumers want to be able to line up the forms so they can comparison shop. **During redesign perhaps allow more room at the bottom of each section so there is some flexibility in length without losing the convenience of being able to line up the pages of two different health plans. Consumer testing should be used to determine the best balance.**
- Second bullet on page 3. Insurers are directed to "use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual." **We recommend more precision. Consistent with the discussion above, HHS should define "plain language," "culturally and linguistically appropriate," and "understandable by the average individual"? In the spirit of this requirement, we recommend striking "utilize" and replacing with "use".**

Important questions chart (pages 4-8):

RECOMMENDATIONS:

- Under '(1) What Is The Premium?' **precisely define the term "base premium."** It needs to be absolutely clear to the carrier filling out the form what "base premium" means and how a carrier arrives at this figure so that all carriers do it the same way.
- 2h (page 5): **Provide an example of how policy period information (instruction 2.b) and individual/ family deductible detail are to be combined.** For example:

Individual \$2,000 for calendar year

Family \$4,000 for calendar year.

A second example may need to be used to show in-network and out-of-network amounts, in addition to period information and individual family designations. Additional consumer testing may be needed to find a method that is understandable to consumers.

- 3g (page 6): The language provided -- “because you don’t have to meet deductibles for specific services, this plan starts to cover costs sooner” -- won’t always be true. If a plan has a \$2,500 overall deductible, but only a \$300 pharmacy deductible, a person who only gets prescription medicine in the policy year will have their Rx coverage start much sooner (after only \$300) with a separate Rx deductible than they would if the Rx coverage was under the overall deductible of \$2,500. **Replace this phrase with a more accurate phrase. Perhaps something like: “You must meet only your overall deductible, above, before the plan begins to pay for the covered services you use.”**
- 4.c (page 6): This subsection says what to do if there are other types of annual limits, such as annual or plan limits on visits, etc. If applicable, the carrier is supposed to add on the second line, “Other limits apply—see the chart that starts on Page 2.” The generic use of the term “limits” is confusing, as these are two different types of limits: a limit on my out-of-pocket expenses (a good thing for me) and a limit on what the plan will pay for certain services (a bad thing for me). **Recommendation: clarify what type of limit, using a phrase that has been tested with consumers. Separate, within the document, discussion of “good” limits (like out-of-pocket limits) from bad limits (annual benefit limits) Does the 4© directive belong in the next section (5), “What Is Not Included in the Out-of-Pocket Limit?”**
- **On page 7, add to instructions 6b and 6c the instruction “Do not respond with a one-word answer.”**
- 7c (page 8): The instructions here grant insurers flexibility to use either the terms preferred/non-preferred or in-/out-of-network providers. 7c provides instructions for just the Answers column. **The instructions should clarify whether insurers can alter the relevant text in the Important Questions column (Does this plan use a network of preferred providers?) and Why This Matters column. We recommend that the same method of referring to in/out-of-network providers be used throughout the document. We also strongly recommend that the terms most easily understood by consumers (in-network/out-of-network) be used whenever possible.**
- 7d (page 8): For consumers to accurately be able to assess the network, they must be told the *name* of the network to search under when accessing the insurers website (or phone number). Often insurer websites display several different networks and the consumer must select the applicable network when running a search to get the correct list of preferred providers for their policy. Also, this section should require plans to indicate what percentage of the providers in-network speak languages other than English, broken down by language. (ex: 50% of providers speak Spanish, etc.). The website they are referred to should allow consumers to sort providers by language.
- 7e (page 8): **This instruction should be written as a complete sentence and should provide the exact language or example language that can be used to satisfy the requirement in 7e, so that language is as consistent as possible across different SBCs. The instructions could provide a list, as in 5b, of what *must* be included, and what *may* be included, if applicable.**

- **7f (page 8): This instruction should provide the exact language or example language that can be used to satisfy the requirement in 7f, so that language is as consistent as possible across different SBCs. This should be made clearer and bolded or otherwise highlighted. Many consumers are surprised by an out-of-network bill from a provider working at an in-network facility. This is a huge problem, especially for people with EPO plans that do not pay anything at all for out-of-network care. We also recommended including an example of this in a *Coverage Examples* scenario.**

7.f This subsection says plans “should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).” It is not true in certain states, like Colorado, that enrollees will be charged more in this case. Colorado has a law that says all care provided in an in-network facility is considered in-network. **Perhaps the general instructions could say, “This is how you are to answer the questions unless it would conflict with state law,” and then give an example like Colorado.**
- **7g (page 8): Delete the phrase: “Plans use the term in-network, preferred, or participating for providers in their network.”** 7c instructs insurers to use the plan’s language when differentiating between in- and out-of-network providers. If the insurer does as instructed and customizes the entire form to use plan’s terminology, the phrase is not needed as it refers to terms not used by the plan. Insurers should use only one the terms in the list of three provided (in-network, preferred, or participating) so that the same one term is used consistently throughout the document. The glossary should explain that the terms are interchangeable.
- **7.h (page 8):** The instructions say that if the plan doesn’t use a network of providers, then under “Why This Matters,” the carriers should write in, “Your costs are the same no matter which providers you see.” This is confusing as, of course, the providers you see may well affect your costs, particularly where there is co-insurance. This statement only makes sense if you make clear that this is as opposed to plans that have in- and out-of-network providers. **Consumer test a clearer phrase, perhaps a sentence that reads “Since this plan does not have preferred and non-preferred providers, the providers you choose won’t affect your cost-sharing provisions.”**
- **Question 8 (page 8): As in other sections, 8 should provide the exact language that should be included in the answers column along with the “yes” or “no” answer. It should also remind insurers not to use a one word answer.**
- **8b and 8c (page 8): Like other similar sections, these sections should provide exact language or example language to use, to help ensure consistency across SBCs.**
- **9a (page 8): This appears to be the only section in the chart where insurers are instructed to provide a one-word yes or no answer. We recommend making this response a little more useful by making the ‘yes’ answer read “Yes. See page 4.” (or page 3 as appropriate).**
- **9b (pages 8-9): There should be an instruction for insurers that don’t have excluded services OR additional covered services. The current instruction won’t work if the “other covered services” box on page 4 is empty.**
- **9c (page 9): The current instruction isn’t really an explanation of “why this matters.” Consider instead: Excluded services are services you must pay for. See page 4 for a list of some excluded services.”**

“Covered Services, Cost Sharing, Limitations and Exceptions” (page 9)

Guidance regarding the “Information Box” and the fourth sub-bullet in that box says that for non-network plans, insert “The providers you choose won’t affect your costs.” This is confusing as, of course, the providers you see will affect your costs.

RECOMMENDATION: Consumer test a clearer phrase, perhaps a sentence that reads “Since this plan does not have preferred and non-preferred providers, the providers you choose won’t affect your cost-sharing provisions.” The final phrase should be consistent with 7.h above.

“Chart starting on page 2” (page 10)

Under “(2) Your Cost columns” in (e)(2) of this section, the example doesn’t fit. This section is all about inserting co-insurance and co-payment amounts. The example given is, “Yes, \$5,000 deductible for prescription drugs and \$2,000 for physical therapy.”

RECOMMENDATION: provide a new example.

“Your Rights to Continue Coverage and Your Grievance and Appeals Rights” (Page 13)

The second sentence of the grievance bullet on the example SBC does not read correctly: “You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance.”

RECOMMENDATION: Consider whether the “or” should be an “over” or “with a”? Or should the words “to protest a” be included before “denial”?

It appears the grievance bullet directs consumers to call the insurer to file a written complaint, and the appeal section directs the consumer to call the office of health insurance customer assistance, but the instructions do not provide direction.

RECOMMENDATIONS: The instructions need to spell out how to correctly populate these two bullets with the contact information of different entities. The instructions need to direct an insurer how to adapt the text in the appeals line (need wording other than “state office of health insurance customer assistance) and what contact information to fill in if a state does not have an office of health insurance customer assistance that helps consumers with appeals. Should consumers in states without customer assistance offices that help with appeals be directed to HHS?

“Coverage Facts” (pages 13-15)

RECOMMENDATION: Following the fourth paragraph, include these additional instructions:

- Patient costs do not include premiums
- Patient’s condition is not an excluded preexisting condition
- All services and treatments start and end in the same policy period
- There are no other medical expenses for any member covered under the plan; out-of-pocket expenses are based only on treating the condition in the example
- The patient receives all care from in-network providers

There are no instructions related to the questions and answers about Coverage examples. Insurers may only need to know that they should use the text, font, graphics, and colors provided in the

example SOC exactly, which is covered in the general instructions. It probably makes sense to at least acknowledge this section in the instructions and direct its placement on page 6, or on the back of the coverage example illustrations.

Group Instructions

RECOMMENDATION: The proposed instructions for group plans would allow the plan to provide the SBC to the employer rather than the employees. We believe it is essential that the SBC reach each covered employee, and the instructions should be modified accordingly. Recommendations for the non-group instructions (above) should be adapted for group.

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 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 jointly by HHS and DOL. 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.