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Summary of Benefits and Coverage and Uniform Glossary

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General Comment

See attached file(s)

Attachments

Comments- NPRM and Template Docs 10192011fv

Section I. Comments on the Proposed Rule for the Summary of Benefits and Coverage and the Uniform Glossary

Provisions within the Proposed Rule highlighted in red below are addressed.

1. Part (a)(2)(ii) *Coverage examples*. (A) Number of examples. The Secretary may identify up to six coverage examples that may be required in an SBC.

Comments:

- a. In the interest of efficiency and economics as well as avoiding consumer confusion, it is our recommendation that no more than three uniform Coverage Examples are provided in the SBC documents. Provided the included benefit scenarios represent a common range of medical conditions and ‘Sample care’ examples that are meaningful to the average consumer and that the scenarios are uniform among carriers/plans.
 - b. For plans with multiple network options, e.g., (e.g., preferred, non-preferred and out-of-network/non-participating, etc.) the proposed SBC document including the three coverage examples incorporated into the NPRM, pages 52491 and 52492, indubitably will exceed the maximum allowed length of four double-sided pages. Furthermore, additional benefit scenarios will increase the number of pages required and the cost of producing the SBC documents forcing insurers out of compliance.
 - c. ‘Coverage Example Narratives’ for the three proposed benefit scenarios are posted on HHH’s Web site along with the general instruction guide for completing the coverage examples portion of the SBC. (See <http://cciiio.cms.gov>. http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_template_blank.xls). These are not referenced in the NPRM or the Draft Instruction Guides. Please clarify and identify the target audience of the Narratives.
2. Part (a)(3) *Appearance*. A group health plan and a health insurance issuer must provide an SBC as a stand-alone document in the form authorized by the Secretary and completed in accordance with the instructions for completing the SBC that are authorized by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee (or, in the case of individual market coverage, the average individual covered a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font.

Comments :

- a. RE: “a stand-alone document:” the SBC should be permitted to be incorporated into the Policy, Certificate of Coverage or SPD provided to newly enrolled members. This is a current and standard practice of many insurers and allows all important policy related documents to be bound together for ease of access and use.
 - b. RE: provision of the SBC in the “form authorized by the Secretary” and “presented in a uniform format”, we recommend the Departments issue template documents to assure uniformity. Attempts to create template documents that ‘resemble’ the models promulgated by the NAIC workgroup will inevitably result in a lack of uniformity as a result of varied interpretation.
 - c. RE: use of “terminology understandable by the average plan enrollee:” Please clarify and specify (e.g. a required reading level; or limiting to prescribed terminology.)
 - d. For plans with multiple network options (e.g., preferred, non-preferred and out-of-network/non-participating, etc.) the proposed SBC document will indubitably exceed the page limit constraint resulting in non-compliance if an insurer adheres to the directions in, for example, the Draft Instruction Guides, Important Questions/Answers/ Why This Matters Chart section as well as non-use of ‘one-word answers’ or semicolons.. Please review and revise.
3. Part (a)(4) *Form*.(i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as e-mail or an Internet posting) if the following three conditions are satisfied— (A) The format is readily accessible by the plan (or its sponsor); (C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or e-mail that the documents are available on the Internet and

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provides the Internet address.

Comments:

- a. Please clarify and define “readily accessible format.”
 - b. Please clarify by specifying and defining “timely.”
4. Part (a)(5) *Language*. A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the **thresholds and standards of § 147.136(e) of this chapter are met as applied to the SBC.**

Comments:

- a. Please provide template documents in those languages identified as meeting the requirements set forth in relevant regulations addressing “culturally and linguistically appropriate.”
- b. Costs associated with translating the SBC documents must be taken into consideration in the one-time start-up or maintenance cost calculations published by the Departments. Departments can issue translated template materials in a far more cost effective manner than that of the insurers. Additionally, without publication of standardized template non-English versions of the SBC, it is reasonable to expect that ‘versioning’ will vary and thus initiate confusion or deviation, depending on the translator. Please consider.

Section II. Comments on the Draft Instruction Guide for Group Policies

1. Pages 1 and 2, Requirements to provide/deliver the form

- a. This section, in contradiction to the requirements of the NPRM, implies that the SBC is to be delivered within seven days following enrollment. The NPRM contains no such requirement. Please clarify.
- b. The language in the second paragraph of this section states,
"...these instructions acknowledge that eligible employees receive information about their health insurance primarily through their employer."

When, in contrast, the instructions in the next paragraph, paragraph a., state,

"When an insurer, or a representative of an insurer meets in person with the eligible employee..."

Eligible employees do receive information about their health insurance primarily through their employer, and it is unlikely that they would meet with an insurer or representative of an insurer. This creates confusion for the user. Please clarify the purpose of the statement.

- c. Paragraph a.1) states,
"A printed copy deposited in the United States mail, postage pre-paid, within seven (7) days of the request;"

This implies that a copy of the SBC may be deposited in the U.S. mail within seven days of a request. Paragraph a.1) should be revised to read more clearly and be consistent with the requirements of the NPRM.

- d. Paragraph c. states,
"For an enrollment application that is completed over the phone or through the mail, the insurer, or a representative of the insurer, shall offer a printed copy of the completed form within seven (7) days to the address provided by the eligible employee."

An eligible group employee is highly unlikely to enroll over the phone or via postal mail, and is unlikely to be communicating directly with an insurer at the time of enrollment, hence, creating confusion to the user. Please clarify intent/purpose for statement.

- e. Any discussion of permitted methods of delivery that include electronic distribution should further describe the requirements for compliance with 29 CFR 2520.104b- 1.

2. Page 3, General Instructions

- a. Bullet 2 states,
"For initial forms (provided to employees in the pre-selection stage), insurers may provide both single and family information for each category, where applicable (e.g. premium, deductible, out-of-pocket limit and annual limit). For example, for the deductible category, the Answer column may show "\$2,000 Individual" in the first line, and \$3,000 Family" in the second line". For final forms (provided to employees after selection), insurers should only include information for the relevant plan."

Please clarify the intent of the second sentence above, and the distinction between the information required for "initial forms" and "final forms". Specifically, the word 'plan' as used throughout the Instruction Guide refers to a 'policy' or 'type' of plan. For example, on page 3, the instructions under 'Filling out the form', state,

[Top Left Header (Page 1)],

Bullet 1,

"First line: Show the plan name and insurance company name in 16 point font and bold";

[Top right Header (Page 1)],

Bullet 2, paragraph 1,

"After the words "Coverage For", indicate who the policy is for (such as Individual, Individual + Spouse, Family). The insurer will use the terms used by the policy, but should ensure that the term used will make it easy for the eligible employee to compare similar types of plans.";

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Bullet 2, paragraph 2,

“After the words “Plan Type,” indicate the type of insurance plan, such as HMO, PPO, POS, Indemnity, or High-deductible.”

The word ‘plan’ as used in ‘final forms’ implies something different. The example provided for ‘initial forms,’ permits interpretation that the SBC delivered with a Certificate to an enrollee should reflect only the ‘level of coverage’ selected, i.e., Individual versus Family.

If this is the intent, we strongly oppose this approach. Similar to SBCs in the individual market, such a provision would require each SBC provide an ‘enrollee specific’ Certificate of Coverage for each enrollee in each group. This provision would be incredibly taxing (both financially and labor-related) on the insurer when taking into consideration the number of enrollees served in the group market.

Further, we believe that providing only single/individual cost-sharing information, where applicable, is a disservice to enrollees. This lack of complete information would force all group enrollees to request a new, complete, SBC to know the cost impact of, for example, adding a dependent(s) to their coverage during the course of a policy year. We strongly believe that providing complete cost-sharing information from the start of coverage clearly addresses the legislative intent of the Uniform Summary of Benefits and Coverage as well as the intent of the NPRM (informed decisions).

b. **[Top Left Header (Page 1)],**

Bullet 1 states,

“First line: Show the plan name and insurance company name in 16 point font and bold. Example: “Maximum Health Plan: Alpha Insurance Group”.

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52487, shows the plan name and insurance company name in the opposite order. Please clarify.

3. Page 4, **General Instructions for the Important Questions chart**

a. **[1. What Is The Premium?, Answers column]**

Paragraph a.1) states,

“Insurers will include the following statement: “Please contact your employer for your share of the premium amount.””

In contrast, paragraph a.2) a) states,

“For small groups whose premiums are based on table rates, the complete rate table should be attached with a reference in the Premium box to refer to the attached rates.”

Please clarify as to which format is to be implemented.

4. Page 5, **General Instructions for the Important Questions chart**

a. **[1. What Is The Premium?, Why This Matters column]**

Paragraph c. states,

*The insurer must always insert the following language: “The **premium** is the amount paid for health insurance.”*

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52487, reflects additional language which reads:

“This is only an estimate based on information you’ve provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.”

The above language is only referenced in the Instruction Guide for Individually Purchased or Non-Group Policies. Please clarify.

b. **[2. What Is The Overall Deductible?, Answers column]**

Paragraph b. states,

“If there is a calendar year or policy period deductible, answer with the dollar amount and indicate whether it is based on a calendar year, or policy period. For example: “\$5,000 for calendar year” or

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“\$5,000 for policy period”.”

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52487, does not reflect “calendar year” or “policy year” in relation to the deductible. Please clarify.

c. **[2. What Is The Overall Deductible?, Answers column]**

Paragraphs c. and d. read as follows,

“c. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language specifying major categories of covered services that are NOT subject to this deductible. For example, “Does not apply to preventive care and generic drugs”.

d. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language listing major exceptions, such as out-of-network coinsurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, “Out-of-network coinsurance and copayments don’t count toward the deductible.””

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52487, reflects only part of the language required by paragraph c., and none of the language required by paragraph d. Please clarify.

5. Page 6, **General Instructions for the Important Questions chart**

a. **[3. Are There Other Deductibles for Specific Services?, Answers column]**

Paragraph d. states,

“If the plan has less than three other deductibles, the following statement must appear at the end of the list: “There are no other deductibles.””

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52487, does not reflect this language. Please clarify.

6. Page 7, **General Instructions for the Important Questions chart**

a. **[6. Is There An Overall Annual Limit On What The Insurer Pays?, Answers column]**

Paragraph c. states,

“If the answer is “No”, the insurer should state, “No. This policy has no overall annual limit on the amount it will pay each year.””

The Sample Completed SBC incorporated into the NPRM, page 52487, Appendix A-2, only reflects “No.” Please clarify.

7. Page 8, **General Instructions for the Important Questions chart**

a. **[7. Does This Plan Use A Network of Providers?, Answers column]**

Paragraphs b., e., and f., read as follows,

“b. If the plan does use a network, the insurer must briefly explain its network policy. For example “Yes, this plan uses preferred providers. You may use health care providers that aren’t preferred providers, but you may pay more.”

e. ER and other exceptions to non-preferred provider requirements should add that information to answer field.

f. Plans should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).”

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52487, does not reflect the language required by these instructions. Paragraph e. appears to be missing language, or is an incomplete sentence. Please clarify.

The degree of information required by these instructions, especially in the case of plans with multiple network options, will result in the SBC exceeding the maximum size of four double-sided pages, thereby increasing the cost of providing the SBC. The value of including this information is debatable in this section of the document, as the differences in cost sharing between in-and out-of-network providers is

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reflected in the 'Covered Services, Cost Sharing, Limitations and Exceptions' section. Please clarify the redundancy.

8. Pages 8 and 9, General Instructions for the Important Questions chart

a. [9. *Are there services this plan doesn't cover?, Why This Matters* column]

Paragraphs b. and c. instruct insurers to reference the page number for the '*Services Your Plan Does Not Cover*' box.

The Sample Completed SBC incorporated into the NPRM, page 52487, Appendix A-2, references only the section name, not the page number. Please clarify.

9. Page 10, Covered Services, Cost Sharing, Limitations and Exceptions

a. [Chart Starting on Page 2, 2. Your Cost columns]

Paragraph e.1) states,

"When referring to coinsurance, include a percentage valuation. For example: 20% coinsurance.

When referring to co-payments, include a per occurrence cost. For example: \$20/visit or \$15/prescription."

This is inconsistent with the information shown in the Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52488. Under the 'Services You May Need' column, PCP and Specialist visits reflect \$xx **co-pay**/visit; and Generic drugs reflects \$xx **co-pay** (retail/mail order), rather than 'per prescription' (emphasis added). Please clarify.

10. Page 13, Your Rights to Continue Coverage

a. Bullet 2 states,

"you or your employer commit fraud or intentional misrepresentations of material fact"

The Sample Completed SBC incorporated into the NPRM, Appendix A-2, page 52490, reflects "*you commit fraud.*" Please clarify.

11. Page 13, Your Grievance and Appeals Rights

a. Bullet 1, sentence 2, states,

"You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance."

This does not read correctly, and should be revised to read,

*"You have the right to file a written complaint to express your dissatisfaction or **to appeal a denial of coverage for claims under this health insurance.**"*

12. Page 13, Your Grievance and Appeals Rights

a. Bullet 2 directs the reader to contact the 'state office of health insurance customer assistance.' The instructions for this section should take into consideration states where the Appeal process is managed by the health plan first, then escalated to a state office or Appeals panel. Please review and clarify.