

October 21, 2011

The Honorable Kathleen Sibelius  
U.S. Department of Health and Human Services  
Centers for Medicaid and Medicare Services  
Attention: CMS-9982-P  
Attention: CMS-9982-NC

Submitted via the Federal Regulations Web Portal, <http://www.regulations.gov>

Re: Proposed Rule Regarding “Summary of Benefits and Coverage and the Uniform Glossary”

Re: Solicitation of comments on “Templates, Instructions, and Related Materials Under the Public Health Service Act”

Dear Secretary Sibelius,

We appreciate the opportunity to provide comments on the proposed rule concerning “Summary of Benefits and Coverage and the Uniform Glossary, published in the *Federal Register* Monday August 22, 2011, at 76 FR 52442, and on the separate solicitation of comments on “Templates, Instructions, and Related Materials Under the Public Health Service Act,” published the same day at 76 FR 52475. We are submitting these combined comments separately under each docket. The issues and problems involved cut across both proposals, and cannot be addressed or solved in either proposal taken alone. Our comments and recommendations draw on what we have learned in our work for the past 32 years developing, implementing, evaluating, revising, and improving CHECKBOOK’s ground-breaking *Guide to Health Plans for Federal Employees* health plan comparison tool, and on other research and experience we have as a provider of consumer information.

The proposed rule would, in essence, require health insurance issuers to provide an accurate written summary of benefits and coverage (SBC) as well as a uniform glossary of term to individuals applying for or enrolling in either a group or individual plan. The SBC must contain uniform definitions, descriptions of coverage and cost sharing for each category of benefits identified by the Secretary in guidance, describe exceptions to and limitations of the coverage, describe the “cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations,” provide coverage examples, include other information, and include a “statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage.” The SBC must be in a uniform format, use understandable terminology, and may not be more than four double-sided pages in length.

The proposed rule then says that insurance firms must provide “contact information for obtaining a copy of the plan document, policy, or certificate of insurance (such as a telephone number” and “Internet address)” and an “Internet address (or similar contact

information) for obtaining a list of providers.” It would require the same for drug formulary information.

The proposed rule later says that the SBC “may be provided in paper form” or, alternatively, “electronically (such as an email or an Internet posting).”

Overall, we think that these proposals do a fine job. The statutory goal underlying the entire proposed rule and proposed templates and related materials is “that consumers may compare health insurance coverage and understand the terms of their coverage” and it is clear from these proposals that you have taken this goal seriously and addressed it capably. Nonetheless, the requirements as proposed are flawed in several respects. We propose specific solutions to remedy each flaw.

**A. Internet Access.** The rule should require that all SBCs (and glossaries) be prominently available on the Internet, with no alternative allowed in lieu of Internet access. As written, the proposed rule only requires that the Internet be used to inform consumers as to where to obtain these documents. This may not be the intent, but as worded the language appears to allow issuers to force consumers to go through a laborious process of contacting issuers to request mailed copies.

Internet copies for download should be provided in the commonly used Portable Document Format (PDF) or plain text (TXT) format, as appropriate. The files should be offered online at a site level that would be found by common search engine spiders (not hidden as “deep links”), and hence show up in search engine results, for at least two commonly used search engines, including as examples at least Google and Bing. There should be a unique link to each SBC that a carrier offers, not a link to a database or list of documents. Documents should display readably in commonly used browsers (including as examples at least Internet Explorer, Safari, Firefox, and Chrome), with this list and relevant version numbers of each to be updated as appropriate by HHS. In other words, any resident of any place in America should be able, in seconds, to find and download any relevant SBC from any carrier, using any computer and browser commonly used in America. No telephone calls, no mail inquiries, and no prior enrollment, should be allowed as preconditions to document access. Without this requirement, no consumer seeking to compare one, two, three, ten, or twenty plans BEFORE enrollment will be able to conveniently and quickly do so. Likewise, any other potential user of this information, including State Exchanges themselves, competing plans, news reporters, consumer advocates, plan comparison tools, and navigators should have the same ready access. Accordingly, regulatory requirements for SBC document availability should require unconditional Internet access for SBCs meeting the specifications above, to any potential reader or user.

You may wish to require telephone, email, paper, postal mail or other forms of access in addition to, but never in lieu of, Internet access. Internet is the only universal (including help from friends or family or local librarian), quick, and easy method of consumer access.

This requirement, of course, imposes no cost or paperwork burdens of any consequence on any health carrier or plan. If a paper copy has to be prepared, it will always have been prepared electronically in some form of software, and an electronic version for Internet access requires only seconds to replicate in printable document form. In fact, it is certain to reduce the cost of providing information compared to the proposed rule since it is far less expensive to provide information by universal Internet access than by individual mail or telephone and mail responses. The easier is Internet access, the lower the volume of alternative and more expensive types of document provision. No carrier or plan could object to this disclosure requirement unless its true motive was to make it difficult for consumers to get accurate and timely information.

This access requirement should be unconditional and without “permission” or “conditions of use” restrictions. For example, news media and others should be able to download SBCs without any legal promises or limits, any prohibitions on commercial use, or any other restrictions of any kind. Only immediate, unconditional, and universal access meets the statutory objectives of the Affordable Care Act and the Administration’s transparency goals. No carrier or plan could object to this disclosure requirement unless its true motive was to make it difficult for consumers to get accurate and timely information.

Second, a similar mandatory and unconditional Internet access requirement should be imposed for provider directories and formularies. In the case of these listings, the plan should be required to include a searchable database online, available to any user without any preconditions. For example, a newspaper or consumer advice agency or Navigator or Exchange itself should be able to download physician information from each plan in a geographic area, and provide that information to the public in a way that allows consumers to see which plan networks include their physicians. Again, this requirement is essentially costless and cannot be reasonably opposed unless the plan’s intention is to deny consumers access to conveniently accessible information that minimizes time demands on consumers. It is exactly the kind of burden reduction reform that the President has mandated on all Federal regulations, past or proposed. Printed-paper directories should be allowed, but not required. Again, this more consumer friendly alternative will reduce plan costs.

Third, a similar set of Internet access requirements, without any preconditions, should be imposed upon the “plan document, policy, or certificate of insurance.” It is impossible for a 4-page summary to contain all of the information that many, if not most, consumers may need. For example, in the Federal Employees Health Benefits Program (FEHBP), a model of useful consumer information, brochures for local plans average about 65 pages in length. *Medicare & You*, the equivalent Medicare document is about 140 pages long for 2012, not counting lists of plans. Only in the brochure can a potential (or actual) enrollee find such information as the amount allowed for hearing aid purchases and whether that coverage is available for both children and adults, the number of visits allowed for chiropractic (or whether chiropractic is even covered), the procedures to be followed to obtain medically necessary drugs not on the formulary, limitations on frequency of colonoscopy, whether acupuncture is covered, which infertility treatments are covered, whether nurse midwives are covered, limitations (if any) on durable medical equipment replacement, whether or

not the plan covers college students not located within its primary area for non-emergency care, and hundreds of other details that cannot possibly be covered in a 4-page summary. Ideally, you would require (as is done for the FEHBP) a uniform format for the insurance policy details. Absent that, at the very least plans should be required to make whatever document(s) the State requires and all supplemental information they provide enrollees just as easily accessible online as the SBC, on the same terms and conditions laid out above. Put another way, any potential enrollee should have easy Internet access to all information on plan terms and conditions that would be available post-enrollment. Only with all this information readily available online will many enrollees be able to make an informed choice. We think it essential that it be required because in the real world (e.g., on the Massachusetts Exchange) all carriers do not do so.

**B. Minimum Content of the SBC.** The proposed rule says that SBC content must only meet certain length and readability standards, a vague list of required content as to coverage and cost sharing, and HHS “guidelines.” This is unacceptable. We comment below on specific flaws in the proposed guidelines. Here we comment on the regulatory requirements.

Of particular importance, the rule (not just the templates) should require premium information. There is a fundamental ambiguity in this proposed rule in combination with the proposed templates. The templates (but not this rule) say that the SBC should include the premium. But the premium may vary by age of enrollee, family size, and geographic location. Just which premium is the printed SBC supposed to contain? And how will consumers know which SBC to request, if the carrier sponsors one benefit design under one plan name that may allow for a thousand different premiums? For example, in the Massachusetts exchange plan premiums for a given plan vary by head of household age, spouse age, number of children up to 10, and by zip code. Is a carrier supposed to print hundreds of SBC variations to account for just these combinations and variations, for each of the dozens of plans it may offer?

The preamble quite reasonably asks how best to solve this potentially massive complexity and expense for plans, and potential confusion for enrollees (how will they know which SBC to ask for?) is substantial. A partial solution is to have all premiums listed on an annual basis, rounded to the nearest hundred dollars. That will reduce potentially thousands of combinations and permutations to a substantially smaller number.

We see no perfect solution, but providing for a separate schedule of premiums, on a separate one-page document, should be required. (See for example the page at the back of FEHBP brochures that lists multiple premiums for a given plan.) The fact that the statute neglected to allow for this problem should not prevent HHS from a sensible solution such as this.

The Internet requirement we recommend can help substantially, since Internet documents can be printed on demand. Specifically, potential enrollees can be asked to select from a menu of family sizes and ages, and enter a zip code, to get the appropriately specified SBC premium information. But they must be allowed to see a full schedule, or they will not be able to find in a simple way plans with options that they may wish to consider, such as

whether to enroll the 25 year old child in the parent's plan or not, whether the husband and wife should enroll in two self only plans rather than a family plan, etc.

### **C. Specification of Deductibles, Cost Sharing, and Maximum Out of Pocket (OOP)**

**Limits.** Neither the proposed rule nor the proposed templates deal with the essential level of specificity needed for summaries to avoid misleading potential enrollees as to the actual costs they will face. Some plans include both medical and drug expenses in one deductible; some have separate deductibles for these. Some also have hospital per admission charges that operate, essentially, as a third deductible. Some catastrophic limits include the deductible, or one of the deductibles but not another, and some do not. Some catastrophic limits include drug or physician copays, some do not. These are not format issues but fundamental issues of information accuracy and transparency.

We believe that the only reasonable solution for these kinds of variations is for the rule (not just the template) to require that deductible descriptions and dollar totals list and include all deductibles and dollar amounts, and that catastrophic limit descriptions and dollar totals both list and describe the dollar amounts of all deductibles, admission charges and copayments not included in the otherwise claimed limit. In cases where copayments are theoretically virtually unlimited, the rule should require a specified number be included in the dollar calculation. That number should be high enough (such as 100 prescriptions, 100 physician visits, and 10 hospital admissions of 3 or more days) that it will not allow loophole-ridden catastrophic limits to look like bargains. Alternatively, the rule should state that the issuer should not be allowed to claim that there is a catastrophic limit if there is in fact no limit on these amounts. Without these regulatory requirements, SBCs will actively mislead consumers.

**D. Use of Annual Calculations.** The rule (not just the templates) should require that all plan cost sharing and premiums be presented as annual totals. Virtually all health insurance terms are ordinarily so presented, so this might seem unnecessary. But there is no reason to leave it ambiguous. And there is one entry in the proposed templates that directly contradicts this principal: premium costs should be presented as an annual figure, not a monthly figure. There are two reasons for this. First, and least importantly, more people are paid weekly and biweekly than monthly. There is no particular reason to use a monthly figure (other than that it is customary practice for individual policies that account for only a small part of the market) and it would be confusing to millions of consumers who do not pay monthly. Second, and most importantly, with all other figures (deductible, visit limits, catastrophic limit) presented as annual figures, presenting the premium as a monthly figure requires consumers to do complex algebra in their heads, or to get out a calculator, to understand their annual cost exposure. For example, does a plan with a monthly premium of \$600, an annual deductible of \$1,000, and a catastrophic limit of \$4,000 excluding deductible potentially expose an enrollee to higher or lower total annual expense than a plan with a monthly premium of \$300, an annual deductible of \$2,000, and a catastrophic limit of \$5,000 excluding deductible? Very few consumers can readily and accurately make such comparisons, and the answer in this example is counterintuitive. Yet it is vital for insurance purposes, since the total potential annual cost exposure under a plan obviously includes both premium and total OOP limit, including deductible. Notice that

in this example even if both stated OOPs included the deductible, the better buy plan would be the one with the higher stated catastrophic limit.

This recommendation does not preclude plans from providing both annual and monthly premium figures, but simply prescribes that at a minimum the annual figure be included.

**E. Coverage Examples.** These examples are potentially one of the most valuable features for consumers. But the proposed rule only allows for requiring six examples. The problem this creates is that six examples do not remotely encompass the range of possible health expenses enrollees may face. Indeed, within the three conditions presented there are an enormous number of treatment variations, e.g. at the lower end of the spectrum a lumpectomy for breast cancer, a nurse midwife for a pregnancy, or weight and diet management for diabetes. Towards the upper end of the spectrum, the breast cancer example does not include reconstructive breast surgery, the childbirth example cesarean section or other complications that may require weeks in a hospital pre- or post-partum, and the diabetes example possible complications such as amputations or blindness. Moreover, the percentage of plan enrollees facing any one of these conditions is likely to be on the order on one percent or less, except for diabetes. What coverage examples will work for the other 95 percent of enrollees? We have no specific solution to this problem, but recommend that the rule allow for a considerably higher number, such as 20 examples. It is also possible and desirable that these could be grouped and the rule should allow for this. For example, there are likely a large number of outpatient surgeries that fall in the range of \$5,000 in expense, plus or minus a thousand dollars. Plans could be required to calculate an average across these, and a single calculation presented for a broadly labeled group. Consumers only need to read one example—the one that most closely compares to their condition or problem—so that providing for more does not appreciably add to their burden. As for plans, if examples are well specified and deal with more common conditions the calculations should be relatively easy and inexpensive.

**F. Presentation of Deductibles and Out-of-Pocket Limits in SBCs.** Both the instructions for the SBCs in Appendix B-1 (76 FR 52499) and the example provided in Appendix A-2 (76 FR 52487) in our view fail to provide the consumer with essential information. The instructions allow, and the example provides, nothing more than a “list” of major exceptions. And the list is not even required to be complete. The instructions say that the list “**could** also include” (emphasis added) copayments not included in the limit. Moreover, the instructions say that if the plan has no out-of-pocket limit the SBC should say “this question doesn’t apply to this plan.”

These proposals present major problems to consumers either trying to understand one plan, or to compare two or more plans. First, of course the out-of-pocket limit question applies to all plans. It is essential information for all plans since the fundamental purpose of insurance is to protect consumers against catastrophic expense. If the plan has no limit, the instructions should require “no” in the Answer field and the written entry should say “this plan has no out-of-pocket limit on what you may have to pay as your share of the cost of covered services.” Saying the question does not apply implies “no problem” when the opposite is true.

Second, the SBC should be required to list all major exceptions, unconditionally, when network providers are used. And the requirement should be not only to list them, but also to include applicable dollar figures. For example, a plan with a claimed OOP limit of \$5,000 and an excluded deductible of \$2,000 should be required to enter in the Answer field: “Yes, \$5,000 plus \$2,000 deductible.” As addressed in our comment above, we recommend that a plan with unlimited exceptions, such as all copayments or all drug expenses (either of which could total tens of thousands of dollars) when using network providers should not be allowed to claim a catastrophic limit. But an alternative would be to require a dollar estimate for each unlimited item, such as \$3,000 for a plan with a \$30 copay, assuming 100 visits. If this approach is used, the instructions should specify the number of visits to be used, so such entries would be comparable across all plans.

Relatedly, the field on “what is not included” in the catastrophic limit includes some items, such as health care not even covered by the plan, that apply to most other entries as well. For example, such non-covered care, balance billing, and other items do not count against the deductible either. To handle the issue of non-network providers, all “Answers” should be stated as applying only to network providers. In cases where a plan actually does provide an additional limit for out of network care, this could be listed as an additional feature.

The entries and instructions for deductibles also fail to provide one necessary piece of information. Deductible entries should be required for hospital admission charges, e.g. “\$300 for the first three hospital admissions in a year.”

**G. Presentation of Premium Information.** The proposed template instructions require that employers provide monthly premium amounts. This will be immensely confusing for the tens of millions of employees paid biweekly. More fundamentally (see our comments above on the proposed rule), the proper entry should be the annual premium. Every other entry on the SBC is annual, and premiums should be no exception. Consumers should not be asked to do algebra in their heads to figure out, for example, the maximum annual cost exposure for the out-of-pocket limit and premium added together.

In addition, the handling of situations in which multiple premiums may apply leads to difficult presentation problems. For example, there are three different premium amounts that apply to full-time federal employees (general schedule, postal, and FDIC), and two family sizes, for six possible entries. In addition, former employees pay a full premium (a COBRA-like amount), and part-time employees pay different amounts, based on hours worked. Private employer plans and individual plans can involve even more possibilities. We recommend making the best of this situation by allowing (not mandating) issuers or employers to list up to six premium amounts on one SBC, and using a supplemental sheet for all other consequential possibilities. Only if this technique or a similar one is available will the entire system be easily manageable by employers. Otherwise, they might be forced to develop very complex sets of forms, and distribution systems, to cover potentially hundreds of situations (a cost not addressed in the RIA and information collection sections of the proposed rule).

**H. Format of Template.** Both the rule and template, as proposed, couch many of the presentational specification requirements in print media terms, as opposed to electronic media display criteria that would be applicable to computers, tablets, phones, and other information devices. For example, "...the summary of benefit and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font." In order to accommodate the unique display requirements of computers, tablets, phones, and other electronic devices, and provide consumers with the best possible use experience, we suggest language like "the issuer is authorized to modify the Secretary's form and instructions as appropriate for reader convenience online or through download, provided that the actual wording and content are unchanged."

In addition, we strongly recommend a reexamination of all proposed formatting and wording to allow for greater economy of presentation. In general, the proposal already does this very well. But there are still other possibilities. For example, "limitations and exceptions" need not be a fifth column, rarely used. Instead, any needed entries could be handled as a footer or footnote.

We appreciate the opportunity to comment on these proposals.

Sincerely,  
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