



October 21, 2011

Via Electronic Submission

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-9982—P**
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Sir or Madam:

The Center for Medicare Advocacy, Inc. is a 25 year old national organization dedicated to the provision of fair access to health care for all Americans, especially older people and people with disabilities who have Medicare and Medicaid. The Center provides direct services to individuals and provides legal and other advocacy assistance and materials to attorneys and other advocates who help individuals get the health care they need. In addition, the Center engages in substantial state and national public policy advocacy in both legislative and administrative arenas. Through its work with Medicare supplemental insurance policies (Medigaps), and Medicare Parts C and D, the Center has had considerable experience with private health insurance plans and the informational needs of individuals both in making choices about those plans and in using benefits offered by them. The Center is part of the Connecticut CHOICES program, which is Connecticut's State Health Insurance Assistance Program (SHIP) authorized by federal law to assist Medicare beneficiaries with their insurance choices. The Center is pleased to have this opportunity to comment on the proposed rule concerning Summary of Benefits and Coverage and the Uniform Glossary to be used in implementing the Patient Protection and Affordable Care Act (ACA).

Our comments include specific recommendations, designated as such, at the end of each section. We have also identified recommendations mentioned in the text by *italicizing* them.

Section 2715 of the 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).” The SBC will be perhaps the most important document consumers will obtain to allow them to compare, select, and understand their health insurance 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 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. For example, in our experience, Medicare beneficiaries find comparing Medigap plans – which are standardized and designated by letter – far easier than comparing Medicare Advantage and Part D plans which are not standardized.

The proposed rule 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 and their helpers as possible, and that consumers’ ability to use the form is monitored and improved over time.

All private health plans and health insurance issuers should provide 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.

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. “Learning” the form also helps those who help others to choose plans by allowing them to become expert in how to read the single form and understand the information it is providing.

Application of requirement to all health plans, including employer-sponsored plans

Provision of the uniform 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.¹ 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 disclose in a summary plan description (SPD) information to enrollees about covered benefits and enrollee rights and responsibilities. However, over the years the SPD has developed into a bulky, complex document that few consumers can understand. Other summary information provided by employers (for example, at open season) is inconsistent. A body of research documents that consumers do not understand how their health insurance works or what it covers. As a result, too often consumers may 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.² The SBC provides consumers with illustrations of how coverage works for illustrative treatment scenarios – including one for breast cancer treatment described in the proposed rule. Consumer testing found these illustrations to be very helpful to consumers. No such illustrations are routinely provided today under SPDs. Working Americans and their families should not be deprived of this information.

Requiring the SBC for all private health plans is also important because 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 would close that gap. *We urge that FEHBP plans also provide this information for federal employees, retirees, and their dependents.*

SBC serves other important consumer information needs

In addition to helping consumers understand their health insurance options and how their health insurance works, in 2014 the SBC will give consumers critical information they need to know and document 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. All consumers, including those enrolled in employer-sponsored group health plans, will need such information to prove they are enrolled in minimum essential coverage; in addition, consumers will need information about their group health plan's actuarial value and its cost in order to determine whether they may be eligible for subsidies offered through the exchange. Further, consumers whose job-based health

¹ 2011 KFF Employer Health Benefits Survey, available at <http://ehbs.kff.org/>

² 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>

plans do not constitute affordable minimum essential coverage will need documentation of this fact in order to seek adequate coverage and subsidies in the Exchange.

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 is the subject of other information employer reporting requirements under the ACA. *The Administration should clarify that provision of 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.

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. The SPD has become so bulky and legalistic that few consumers today find it practical to rely on this document for understandable information about how health coverage works. 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.³ Similarly, in the Medicare context, beneficiaries tend to find the combined Annual Notice of Change/Evidence of Coverage (ANOC/EOC) document cumbersome. The short, concise SBC will be easier for consumers to keep handy, consult frequently, and understand. *While employers certainly should be able to deliver the SBC in the same envelope used to deliver the SPD, the SBC must remain freestanding and not buried within a larger, unwieldy document.*

Private health insurance issuers' concerns about cost

The main argument for incorporating the SBC into the Summary Plan Description (SPD) would be to reduce employer costs. However, it is unlikely that employers would necessarily 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.

There has also been discussion as to whether it is too costly for health insurance issuers to produce this 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 this new version (the SBC) is merited. However, the summaries provided today by employers

³ http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf

and insurers are not standardized and do not include the *Coverage Examples*. Under the SBC approach, the government dictates the form, content, appearance and “location” (i.e., rules for distribution) of the labels. It is precisely these standards, absent today, that assure that the information aids consumers in understanding and interpreting differences in health insurance offerings and making informed choices.

In particular, some have pointed to the cost of producing the new Coverage Examples, referred to as Coverage Facts Labels in the ACA. Producing the Coverage Examples Health Insurance labels requires insurance producers and employer plans (or their TPAs) 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 costs are also low relative to the number of policy holders and relative to the number of people shopping for coverage (i.e., seeking to compare coverage options) annually.

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 reform, 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. In that research, Maestas demonstrates that “the implied aggregate welfare loss is approximately \$798 million or \$484 per policyholder.” That estimate, based on 2004 data, is for the much smaller Medigap market – a market featuring fewer shoppers and in which products are standardized (but prices vary widely). It is not too great a leap to suggest that the welfare gains to nonelderly consumers shopping for health insurance in the private insurance market (which is not standardized) will be far greater — far in excess of the \$50 million estimated annualized cost.

RECOMMENDATION: Costs considerations do not outweigh benefits. Adhere to the requirement in the ACA and require all private health insurance plans and issuers to use the same form. We further urge that FEHBP plans provide this information for federal employees, retirees, and their dependents, to ensure even greater uniformity across consumers with group and non-group coverage.

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. Drafts of the SBC and coverage illustrations were tested with plans and consumers to validate both costs and benefits of this new information resource. The Administration, in turn, took another four to five months to consider the NAIC's March 2011 recommendations before publishing its proposed rule this summer. In light of the thorough work undertaken by so many to design the SBC, we urge timely implementation. *We further urge the Administration to engage in ongoing efforts to monitor the costs and benefits of the SBC as it is implemented and to make future refinements and improvements based on such monitoring.*

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 coverage 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.⁴ Consumers will appreciate this Administration's leadership in forcing the private market to provide better and more understandable health insurance information and this, in turn, will likely enhance public support for health reform overall.

In addition, timely implementation of Exchanges and other key reform initiatives will require 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 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. Delayed implementation threatens progress on these other fronts.

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 this section of the proposed regulation, which specify 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

⁴ 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.

the SBC should be provided when the issuer renews or reissues the policy, any time an applicant or group plan requests it, whenever application materials 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.

- 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 but no later than the first date coverage is effective. 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.*
- For individual plans, the SBC should be provided to prospective enrollees with any marketing materials and 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.

We recommend that the insurers additionally be required to provide the SBC along with marketing materials for a plan that may be provided to prospective plan applicants. Applicants do not always review all of the materials they are provided and in these cases it is important that the first documents a prospective applicant reviews describe the terms and benefits of the plan accurately.

We concur with the rule's proposal to make the SBC available – either in the case of special enrollment or when an SBC is requested at a time other than enrollment periods - within seven days and believe this gives consumers sufficient time to review the information. We understand the concern some insurers have about the potential administrative burdens if a significant number of consumers make requests for SBCs outside of the enrollment period. While we do not believe most consumers will want or need an SBC at other times we suggest that the Departments monitor the number of requests during the first year to determine whether changes in the policy are warranted.

We also want to ensure that the requirement that issuers provide the SBC upon request at any time should permit consumers to request an additional copy of the SBC for their plan if they misplace, damage or lose the document.

If an applicant's final premium quote is different from the premium cost information provided in the SBC the insurer should issue an amended SBC that provides the updated premium information for their plan. In 2014, when the prohibition on health status rating in the Affordable Care Act becomes effective, there will be less frequent changes in premium information. Once this provision is effective insurers should provide premium information for each plan based on age, smoking status and geographic location.

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 for a plan that may be provided to prospective employers and individual applicants. For group plans the SBC should be provided to each employee at the beginning of the open enrollment season and to new employees as soon as possible after a hire but no later than the first date coverage is effective. If any information included in the SBC changes, including premium information, insurers should be required to issue an amended SBC 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?

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. The proposed regulation includes a draft template for the SBC. This template creates a standard format that is uniform across plans, allowing consumers and their helpers to more easily compare the benefits of each insurance product. *We therefore recommend that insurers be required to use the standard template for the SBC that is established through this regulatory process.* Providing the SBC as a separate document also is crucial to the intended purpose of the SBC. This enables consumers to identify the SBC among other plan documents easily. As noted earlier, 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. SPDs often are voluminous and legalistic, and do not provide consumers with a straightforward summary of their benefits under their plan. For consumers who find an SPD to be daunting, the SBC will provide a critical alternative. The documents plans currently provide, such as the SPD, are also not made available to consumers when they are selecting a plan and therefore do not provide any help in the plan comparison process.

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. *Specifically, we recommend that insurers provide the SBC on a different color or texture paper than the other documents. The SBC should also 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.”*

Inclusion of premium information

The proposed rule follows the NAIC recommendation that the SBC should display prominently – in the top right corner of the first page – the premium or cost of coverage for policyholders/group health plan enrollees. The proposed rule also notes, however, that premium information is not a specific statutory requirement under Section 2715 and requests public

comment on whether such information should be included. *We emphatically recommend that premium information should be included on SBCs for non-group health insurance policies for individuals and families. Further, we emphatically recommend that cost of coverage information be included for enrollees in group health plans; that is, the SBC should indicate the cost of coverage to employees and their dependents net of the employer contribution to the premium.*

The premium, or monthly cost of coverage, is critically important information to consumers. It is not possible to select among health plan options without this information. 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 that is key to determining eligibility for subsidies in the Exchange. Premium (and other cost-sharing information) in the SBC also must 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.

RECOMMENDATIONS: The SBC should be provided as a stand-alone document and should be made visible among other plan documents by using a different color or texture paper. Insurers should be required to use the standard SBC template. 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.” The SBC must contain information about the health plan premium/cost of coverage for consumers.

Form 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. Through discussion on this regulation with state health care consumer assistance programs, we have learned that though consumers frequently submit requests for assistance through program websites, they often have low computer literacy and do not provide email addresses for online communication. 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. According to 2010 U.S. Census Bureau Internet usage statistics, almost 40 percent of households with an annual income between \$25,000 and \$34,999 that report using the Internet do not have a computer with Internet access in their home. Of households with an annual income of less than \$15,000, more than 60 percent who reported that they use the Internet do not have computers

with Internet access in their home.⁵ This indicates that though consumers may be able to submit requests for assistance and plan documents electronically, they may not have consistent access to a computer and the Internet. *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.* If issuers do not have to comply with this requirement, they must at least be required to send a paper copy of the SBC to any applicant or enrollee who requested it via the internet and did not acknowledge receipt, as required in section 4(A)(i) of the proposed rule, within 7 days of sending the electronic copy of the SBC.

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 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 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.

RECOMMENDATIONS: The SBC should be provided in paper form as a default option, unless the applicant or beneficiary 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, even when they make a request for information and plan documents via the Internet. If issuers are permitted to provide the SBC electronically to applicants or plan enrollees who submit requests for information or plan documents online and the applicant or enrollee does not acknowledge receipt of the SBC, then issuers must be required to automatically send a paper copy of the SBC to the consumer within 7 days of sending the electronic copy of the SBC. 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.

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

⁵ U.S. Census Bureau, "Table 1155: Household Internet usage in and outside of the home by selected characteristics: 2010" (Washington: U.S. Census Bureau). Accessed online on September 30, 2011 at <http://www.census.gov/compendia/statab/2012/tables/12s1155.pdf>.

concepts commonly used in health coverage.⁶ Plain writing is consistent with the requirement in Section 2715(b)(2) that the SBC “utilizes terminology understandable by the average plan enrollee.”

As defined in the Plain Writing Act of 2010, plain writing is writing that is clear, concise, and well-organized.⁷ By October 13, 2011, Federal agencies must write all new or substantially revised documents in plain writing.⁸ 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, and strived to meet “plain language” requirements but strongly advised that testing and assessment be done in consultation with representative consumer organizations.⁹ A review of the current SBC by ThoughtForm provides illuminating examples of how the SBC could be designed to be clearer.¹⁰ We support the NAIC’s recommendation.

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) focus 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 provides that the summary of benefits and coverage (SBC) should be presented in a “culturally and linguistically appropriate manner.” The Departments have attempted to satisfy this statutory mandate by incorporating the rules for providing appeals notices pursuant to section 2719 of the ACA (hereinafter “appeal rules”).¹¹ 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.¹² In the preamble to the

⁶ 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>.

⁷ 5 U.S.C. § 301 (3)(3).

⁸ 5 U.S.C. § 301 (4)(b).

⁹ 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.

¹⁰ http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf

¹¹ 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).

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

SBC rules, the Departments expressly state, though, that nothing in the proposed regulations should be construed to limit rights conferred by Federal or State civil rights laws, including Title VI of the Civil Rights Act of 1964, which prohibits recipients of Federal financial assistance from discriminating on the basis of race, color, or national origin. 76 Fed. Reg. 52450 (Aug. 22, 2011). This requires recipients of Federal financial assistance to take “reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons.” *Id.*

The Center strongly opposes applying the same standards to this rule. The Departments propose to severely limit limited English proficient (LEP) persons’ access to arguably the most important document regarding their health insurance to which they will have access, the document that allows them to compare plans, shop for plans, and understand the terms and limitations of the plan in which they enroll. We contend not only that this is unwise, but also that it violates PHSA § 2715, Title VI and Section 1557 of the ACA.

Title VI and Section 1557 of the ACA Require Broader Access for LEP Individuals

Unlike the appeals rules, the proposed SBC rules 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 advanced payment tax credits. 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 as that standard is much higher than standards currently adopted by the Departments of Justice and Health and Human Services in their “LEP Guidances” (see www.lep.gov) and the Department of Labor in its regulations governing group plans for the provision of notices of appeals.

It is well documented that language barriers affect access to health care. The Institute of Medicine has stated that:

Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.¹³

It is, thus, critical that consumers have access to vital information about their insurance plan in a language in which they are conversant.

¹³ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002)(citations omitted).

The Departments acknowledge the complexity of selecting and understanding a health plan. For example, the Departments have required that a copy of the uniform glossary be made available to all individuals to whom a SBC is provided in recognition of the fact that even English-proficient consumers may have difficulty fully understanding the terms of art contained in the SBC. If insurance is complicated enough so as to require a uniform glossary even for those for whom English is not a challenge, there can be no question that understanding the SBC is likely to pose an even greater challenge to those who are LEP.

Thus, the Departments recognize the importance of the SBC as is at the crux of ensuring access as it is the most basic document that is focused on providing individuals information to understand what services are or are not covered by different plans and helping individuals make informed decisions about what plan to select. Yet somehow it is not viewed as critical for LEP individuals since the requirements to translate this document are so high that it will only be translated into Spanish for a small segment of Spanish-speakers and virtually no other languages. If this critical information is not accessible to LEP individuals, it will only further affect LEP individuals' access to care as they will be unable to make informed decisions about selecting a plan.

This is exactly the kind of discrimination that Title VI and Section 1557 are supposed to prohibit. Although the Departments have not yet issued proposed or final regulations interpreting Section 1557, the Department of Health and Human Services has, over the years, issued guidance on LEP under Title VI.¹⁴ This Guidance built upon Executive Order 13166, which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons.¹⁵ In that Guidance, HHS recognized that “[t]he more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed.”¹⁶ The Guidance provided 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. If these criteria were practicable for all recipients of Federal financial assistance for more than eight years, why are they suddenly impracticable for insurers participating in an Exchange? 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. The proposed regulations adopt a 10 percent per county threshold for the provision of oral communication assistance, again ignoring longstanding interpretations of Title VI.

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

¹⁴ “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” 68 Fed. Reg. 47311 (August 8, 2003).

¹⁵ This Executive Order was reaffirmed on June 28, 2010 and again on February 17, 2011.

¹⁶ 68 Fed. Reg. 47314.

such as enrollment handbooks might not have to be translated *as long as the vital information contained in such documents is translated*.¹⁷ Surely, a double-sided four-page SBC that contains basic plan information is both vital and short. Indeed, it may be the most vital information a consumer receives from and/or about their health plan. If HHS believes that its own LEP guidance is necessary and appropriate to implement Title VI in other contexts, those same thresholds should apply to the SBC (and to appeal notices, as well). The failure of a plan to comply with these rules violates Title VI and Section 1557 of the ACA.

Public Policy Concerns Militate in Favor of Stronger Rules for LEP Individuals

The adoption of a 10 percent per county threshold is not useful for determining thresholds for translation. First, as a practical matter, county demographics may not be reflective of a plan's demographics because a plan may market specifically to particular ethnic/cultural/language groups in a county, a region or nationally, or may serve employers that have high LEP populations, and thus have greater numbers of LEP enrollees than a given county in which the plan operates. We strongly believe that a plan must track data on its LEP enrollees and provide translated notices when the thresholds that we recommend below are met for plan enrollees.

Second, the appeal rules omitted a numeric threshold for plans participating in the group market and merely require translation of notices when 10% of a county's population is LEP. Again, this fails to recognize that plan demographics may differ from a county. As recognized in the appeal rules, very few counties meet the 10% threshold generally, and only 6 counties meet the threshold for any language other than Spanish. Existing DOL regulations as well as LEP Guidance from the Department of Justice as well as HHS (see http://www.lep.gov/guidance/guidance_index.html) recognizes the need for a dual standard for translating documents and includes both numeric and percentage thresholds. We believe that the statutory requirement for providing notices in a culturally and linguistically appropriate manner must have some meaning; indeed, it provides a strong rationale for enhancing current guidelines rather than weakening them. By deleting the numeric threshold, the standard for providing translated notices is now weaker after enactment of the ACA than before and will provide fewer covered individuals with language assistance.

We therefore recommend that the Departments adopt a combined threshold utilizing the existing DOL regulations and DOJ/HHS LEP Guidances. We suggest that the threshold should be 500 LEP individuals or five percent of a plan's enrollees, whichever is less. The five percent is utilized in both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans.

Further, the Departments must ensure that the translation is competent and not done through machine translation which does not produce competent translations. "Machine translation" refers to the use of a computer program to automatically translate information from one language to another. At this point in time, neither free nor commercial machine translation programs provide sufficiently accurate translations to rely upon for use with LEP patients. Thus Exchanges, QHPs, and others should be prohibited from using machine translation to develop

¹⁷ 68 Fed. Reg. 47319.

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.

As some plans may undertake specific marketing and outreach activities to particular ethnic/cultural/language groups, we also recommend that the Departments adopt a secondary requirement to provide language services to any language group to which the plan specifically markets. This must be *in addition to* the basic thresholds. This standard would recognize that a plan could not conduct marketing and outreach to enroll LEP members and then fail to provide assistance when those members need additional information.

We also strongly believe that the Department should require plans and insurers to provide taglines in at least 15 languages with the SBC, informing LEP enrollees of how to access language services. The request for 15 languages is based on existing government practice. The Social Security Administration, through its Multilanguage Gateway <<http://www.ssa.gov/multilanguage/>>, translates many of its documents into 15 languages and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish <<http://www.cms.gov/EOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>>. For example, some of the forms Medicare will be translating that involve benefit coverage include “Dialysis Facility Compare”, “Medicare’s Nursing Home Compare”, “Medicare’s Home Health Compare”, “Medicare: Getting Started”, “Welcome to Medicare”, “Get Help With Your Medicare Costs: Getting Started”.¹⁸ This should be a requirement regardless of whether a translation threshold is met, again to ensure that enrollees are informed about how to obtain assistance when questions or issues arise. Plans that operate in California are already required to do so and have adapted to this. As one example, Standard Insurance Company sends an insert with all Coverage of Benefits documentation that includes taglines. The tagline used by this insurer states:

“No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or xxx-xxx-xxxx. For more help, call the CA Department of Insurance at xxx-xxx-xxxx.”

Taglines by themselves are an effective and cost-efficient manner of informing LEP individuals and will help assist plans in determining in which languages additional materials should be provided. And to reduce costs to plans, the Departments can provide tagline language and translations for plan usage if plans did not wish to develop their own.

We do want to emphasize, however, that taglines must be accompanied by an English SBC so that individuals have a record of communication and may be able to obtain information from advocates or others about its content. Providing oral information or a tagline is insufficient to meet the requirement of providing enrollees with SBCs.

¹⁸ See CMS, Office of Equal Opportunity and Civil Rights, FY 10 CMS Strategic Language Access Plan Outcome Report, Appendix: Vital Documents/Forms to Translate, available at <https://www.cms.gov/EOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>.

We also recommend that the Departments require that, once a consumer has requested materials in another language, all subsequent communications with that consumer should be in the non-English language. For a variety of reasons, plans should be collecting data on their enrollees' language needs, both to ensure services are available as well as providing culturally and linguistically appropriate information. As one example, Standard Insurance Company recently sent enrollees a Language Assistance Survey to gather data on enrollees' language needs. Once an LEP enrollee identifies his language needs, the plan should track this information and not require the enrollee to continue to request information in that language.

*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 PHSA § 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 PHSA § 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.

Practical Considerations Do Not Weigh Against Language Access

The appeal rules mention that some commenters cited the “high cost associated with implementing translation requirements pursuant to California State law and the low take-up rates of translated materials in California.” We trust that they similarly would object to a broader rule pertaining to the SBC, as well. A review of the comments by California health plans to the July 2010 regulations shows that plan cost estimates are exaggerated and up-take estimates are unclear.

1. Cost of compliance

California health plans must provide written translations of numerous “vital documents,” including applications, consent forms, letters containing important information regarding eligibility and participation criteria, notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal and notices advising LEP enrollees of the availability of free language assistance and other outreach materials, the explanation of benefits (EOB) or similar claim processing information if the document requires a response, specified portions of the plan's disclosure forms regarding the principal benefits and coverage, exclusions, limitations, and cost-sharing requirements.¹⁹ Here,

¹⁹ See California Department of Managed Care, Comment on FR Doc # 2010-18043, Doc. ID No. HHS-OS-2010-0019-0041, Sept. 21, 2010.

we are concerned only with the translation of one double-sided four-page document – a minute fraction of what health plans are required to translate under California law. Thus, when health plans refer to the costs associated with the implementation of the California Language Assistance Program, they are referring to a much more comprehensive program that includes costs unrelated to the scope of the SBC rules – or even the appeal rules. Additionally, the thresholds in the CA law are much lower than the IFR – one percent for a plan with 300,000-1,000,000 members and three quarters of one percent for a plan with over 1,000,000 members. Thus California plans have to translate both a wider variety of documents as well as into a greater number of languages and thus one cannot conclude that the costs of complying with California’s law are a good comparison for costs of complying with a more limited IFR focused on limited translation of notices of appeals and external review into fewer languages.

In addition, the costs identified by California plans include implementation costs, which are not ongoing costs, such as initial translation of the SBC. Also, the cost for California plans likely includes implementing tag and track IT systems since they must collect language data on enrollees.²⁰ So if California plans also operate in other parts of the country they will have much smaller costs in expanding the use of this software. Finally, in California, the Department of Managed Health Care translated taglines for health plans to save costs.²¹

2. Take up estimates

When California health plans refer to “low take-up rates” of translated materials, in their comments to the July 2010 regulations, it is unclear which materials they are referring to since they are required to translate the extensive list of “vital documents” referenced above. Also, not all California health plans are complying with the state law language access requirements; a California report shows deficiencies by health plans in advising enrollees of language assistance and includes a list of the number of complaints recorded.²² There may be actually be more complaints than those listed in the report since, if a plan is not providing enrollees with the proper notice in their language, they may not know that they can call the HMO helpline to file a complaint.

In contrast, the SBC is one document that will be provided to all prospective and actual enrollees in a plan. Near-universal take-up is fair to assume since all individuals will be required to enroll in a plan, and the SBC is the most basic and vital document describing the terms of the plan. Thus, even if we were to give credence to the claims of low take-up rates, the analogy to the SBC is inapposite and unconvincing.

²⁰ The greatest challenge so far has been setting up and reworking existing information technology (IT) systems to support the collection and management of data on members’ primary written and spoken languages.

<http://www.ahrg.gov/populations/languageservicesbr.pdf>.

²¹ California DMHC funded and posted on its public website the translation of a language assistance notice in Spanish, Chinese (traditional), Arabic, Armenian, Khmer, Farsi, Hmong, Korean, Laotian, Russian, Tagalog, and Vietnamese. See California Department of Managed Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at

<http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf>.

²² California Department of Managed Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at

<http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf>.

3. Translation at the plan's request

Many employers and plan sponsors know that they employ a large number of LEP workers and should be able to request translation of information, including SBCs, by health insurance issuers. If an employer or plan sponsor knows that the number of LEP workers meets the thresholds we recommend (five percent or 500 LEP individuals in a plan), the health insurance issuer should be required to provide translated notices at the request of the employer or plan sponsor. This would help ensure the intent of the law to ensure access to the SBC in a culturally and linguistically appropriate manner without adding any additional burden on employers. Most employer and plan sponsors do not have large enough market power to negotiate the addition of a new translation practice by an issuer which is why the translation does not occur now. We expect there are many employers and plan sponsors that want the plan enrollees to receive the full benefit that is being paid for, which includes knowledge of the plan's benefits and coverage information.

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: Require plans to competently translate the SBC into any language which comprises five percent or 500 LEP individuals in the plan. Require plans to provide oral language services – through competent bilingual staff or interpreters – for all LEP individuals with questions about the SBC. Require plans to provide taglines in 15 languages with all SBCs.

Ensuring Accuracy

The proposed regulations recognize that as plan coverage documents like summary plan descriptions (SPDs) “have increased in size and complexity—for example, due to the insertion of more legalistic language that is designed to mitigate the employer's risk of litigation—they have become more difficult for participants and beneficiaries to understand.” 76 Fed.Reg. 162. The proposed regulations go on to state that most SPDs are written at a first-year college level. The SBC, written in plain language and available to both group and non-group purchasers, will thus likely be the consumer's most accessible source of coverage information about the plan. The accuracy of the SBCs is, thus, critical.

Two issues arise regarding the accuracy of the SBCs: 1) the importance placed by the proposed regulations on the reliance by consumers on the accuracy of the SBCs; and 2) the monitoring--both frequency and substantive--and enforcement by state insurance departments, HHS and DOL as to the accuracy of the SBCs.

An accuracy requirement is needed because consumers will rely on SBC

As to the reliance issues, although for group coverage, 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

We think 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. Given the importance that the Departments acknowledge that consumers will place on the SBC, 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.

Those who assist individuals in choosing health plans report many instances in which summaries of benefits supplied by a plan have conflicted with an SPD or certificate of coverage. Advocates have successfully helped consumers who relied on a summary of benefits document that misstated coverage. In almost every case, the insurer has acknowledged the error and honored coverage. We think the insurers already understand the importance of the accuracy of an SBC, and therefore, should expect to be responsible for inaccuracies in the SBC that lead to consumer coverage complaints.

Monitoring and Enforcement

Monitoring of the accuracy of SBCs is critical to ensure that they accurately represent coverage options.

Recommendations: First, we suggest that the Departments provide implementation and a compliance timeline for plans and issuers by March 23, 2012, as well as require a Consumer feedback line for complaints on the SBC itself. Consumer assistance programs could be helpful to collect and report such complaints.

Second, since state insurance departments are responsible for enforcing the SBC provisions against health insurance issuers, we recommend that the state insurance departments establish guidelines consistent with those that we suggest be established by the Departments, using state consumer assistance programs to assist in the compilation of complaints.

Third, state insurance departments that have the statutory discretion can use it in the first instance by approving SBCs at the same time they approve certificates of coverage for individual and group plans. They can also require that revised SBCs be submitted for approval. In the case of individual insurance, the state insurance departments should use their authority to review the typical plan SBCs initially and when there is a material change to the SBC.

Fourth, Enforcing the accuracy of self-insured SBCs might also require the assistance of employers, something that should be explored and addressed by these regulations.

Fifth, as part of the evaluation of the accuracy of the coverage examples being accurately completed, we recommend that state insurance departments, HHS and DOL conduct coordinated and random audits on a periodic basis to test the SBC coverage examples. We believe that this is the best way to ensure that the examples are working over time. Audits should include testing that incorporates inaccurate entries to ensure that coverage examples react to inaccurate entries and inform consumers of the inaccuracies. Audits should also account for accurate entries but incorrect results.

Finally, 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 CAPs 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.

New/Modified Disclosures for SBC

Existing and Proposed Disclosures for 2012

As a primary document that will be viewed by most consumers enrolling in health coverage, the SBC is well suited to providing key health insurance disclosures to consumers. In addition to the disclosures already included or contemplated for 2014, we recommend that a few additional disclosures could provide great benefit consumers shopping for coverage.

Too many warnings/disclosures, poorly worded or poorly placed, will detract from consumers' ability or willingness to use the SBC form.²³ HHS should carefully test existing and

²³ See <http://www.bis.gov.uk/files/file44367.pdf> or http://findarticles.com/p/articles/mi_hb3250/is_2_35/ai_n28879116/

proposed disclosures to assess the critical tradeoff between providing consumers with valuable information and protections versus making the form unappealing.

Beyond the specific plan features, the SBC includes information about using the health plan, such as information on grievances and appeals. There are also 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, without making an otherwise helpful document unappealing, consumers must be able to comprehend the warning and it must be clear how it affects them and whether there is an action they can take to reduce the potential danger to themselves.

The SBC should also include a statement explaining that plans are required under state and federal law to pay out-of-network providers a reasonable rate and that consumers have the right to information on out-of-network rates paid by their plan. States should be able to require modifications to this statement to ensure that it reflects state requirements. For instance, where there are state law requirements, the notice should inform consumers of restrictions on charges of out-of-network providers and/or tell consumers that they should call their state Department of Insurance for further information about restrictions

RECOMMENDATION: Consumer-test the language and best placement for the following new disclosure requirements:

- **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 needs but under law 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.**
- **[placeholder for whether and how a plan should disclose pre-existing conditions exclusions]**

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.

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. It is not explicitly required that this coverage meet a specific actuarial value threshold.

However, the coverage offered by employers with at least 50 full-time-equivalent employees is required to meet certain conditions, or employers may face penalties.²⁴ For full-time employees and their dependents, employers must provide coverage that covers “essential benefits,” has an actuarial value of at least 60 percent, and charge premiums that cost less than nine and one-half percent of employees’ household incomes.

To help consumers understand whether or not the coverage meets these requirements, the ACA requires 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;

RECOMMENDATION: The detailed recommendations in this section should be effective with SBCs describing plans that are effective January 1, 2014, although consumer testing of the phrases should occur much earlier.

Is the Coverage at or above 60% Allowed Costs (60% actuarial value)?

The 60% actuarial value threshold is a standard that is widely used by the ACA and one that consumers should become familiar with. Hence, we recommend that this disclosure be required for all plans (non-group, group, grandfathered, non-grandfathered), as envisioned by the ACA.

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.²⁵ 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 plan was not stable and could vary a great deal. Additionally, they were unfamiliar with the term “allowed cost,” and guessed (incorrectly) that only certain types of treatments would be covered. Finally, many participants overlooked the term “at least.” So, instead of understanding “this plan pays *at least* 60% of total allowed costs,” participants would typically read it as “the plan pays 60%.”

These testing results illustrate the value of rigorously consumer testing included warnings and disclaimers.

²⁴ 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.

²⁵ *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

RECOMMENDATIONS: Consumer-test language and placement for the 60% disclosure. Disclosure language must reveal the purpose of the disclosure and use terminology understandable for most consumers. Alternate phrases for testing could include: “This plan offers coverage that is at or above federally recommended minimums.” Alternatively, include the phrase “This health plan is below federally recommended minimums. You may want to consider other coverage options.” ONLY when the value is below 60%, reflecting the fact that there is no specific action for the consumer to take when above the 60% threshold.

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 they quickly convey the relative strength of the coverage of their health plan options. This small, but 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 on plans that are effective January 1, 2014 or later.

Does the premium exceed nine and one-half percent 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. There is not a ready way for the SBC to indicate whether the premiums exceed nine and one-half percent of income for an individual consumer, 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: For large Group plans that are effective January 1, 2014 or later, in the “Why this Matters” box, for the premium line, consumer test a phrase such as: If your household income is below [insert an amount that is the employee premium amount/.095], you may be able to get help purchasing coverage in your state’s exchange. See [website] for details.

Additions and Changes to the Summary of Benefits and Coverage Template

Facility Fees charged for Office Visits

Some consumers report that their local hospital acquired many local physician practices and now charges a facility fee for routine office visits. The SBC only includes facility fees for inpatient and outpatient care.

RECOMMENDATION: Query insurers and consumer assistance groups as to the prevalence of this type of charge and consider whether a modification to the form is needed.

Non-network providers providing care in In-Network Facilities

A leading complaint heard by consumer assistance plans is that patients were caught off guard when they received large bills from out-of-network providers providing care in an in-network facility. As a common “trap” experienced by consumers, the SBC should take steps to address this. We note that the Insurer Instructions include a requirement that health plans highlight that some out-of-network specialists are often used by In-network providers (instruction 7f). This important warning has not been consumer tested and standard language has not been provided.

RECOMMENDATIONS: Consumer test standard language to convey the warning that some out-of-network specialists are often used by in-network providers. Require the use of this standard language by insurers as appropriate in instructions. 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 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.²⁶ 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 to three initially and to a maximum of six. *In light of their value to consumers, however, we recommend that the Departments require inclusion of six medical scenarios in the SBC beginning immediately in 2012.*

²⁶ 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

Selection of coverage examples

When selecting the treatment scenarios to include, 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, rehabilitation 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' 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 would support a phased in requirement for this component of the SBC. Specifically, we would agree that 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, coverage illustrations would only be required 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.

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 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 would hardly be reasonable to expect consumers to know how 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 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 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, must be responsible for generating coverage illustrations.

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

Consumer testing²⁷ found that a number of the definitions contained in the glossary were unclear, often because the definitions used additional terminology that they did not understand, e.g. the definition of “coinsurance” relied on “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.

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. Incorporating more examples of the concepts may help.

Several consumer testing studies²⁸ have demonstrated that key terms are missing from the glossary. In addition, many consumers are not familiar with the phrases “network,” “preferred,” or “participating providers.” While very brief descriptions of particular services may suffice for purposes of a general glossary of terms, we also suggest adding a consumer-tested definition of “covered services,” something like “the care, services, treatment and other measures that your health insurance or plan will pay for or cover. Covered services are defined in the insurance policy.”

RECOMMENDATION: Add consumer-tested definitions for “network,” “preferred,” or “participating providers” (and explain that they are similar in terms of their import for consumers), “covered services,” and the following 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
- Prescriptions – retail vs. mail-order
- medical underwriting
- prescription drug “tiers”
- specialty drugs
- formulary

²⁷ *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

²⁸ 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

Definition of “medical necessity”

We recommend that the definition of medical necessity 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 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.”²⁹ 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...”

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 do not 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 above.

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

Requirements to provide/deliver the form (page 1)

We must anticipate that requirements to provide the form will be interpreted narrowly as possible. 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

²⁹ Sara Rosenbaum, ‘Medical Necessity’ Definition Threatens Coverage for People with Disabilities, Health Affairs Blog (Sept. 16, 2011 @ 9:13am), at <http://healthaffairs.org/blog>.

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.

This section, also under (a), gives options for what happens when an insurer representative meets in person with the potential applicant. It is 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? The same questions arise with respect to 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 do not want the experience to mimic what happens when you order tickets online; you are on your sixth screen of answering questions and submitting things like credit card information, and then a command says click this box to indicate that you have read the terms and conditions. You will just go ahead and click it.

Subsection (c) has the same problems as noted above with respect to subsection (a). Further, 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?

Consumer assistance programs report that losing/misplacing insurance forms is actually quite common.

RECOMMENDATION: Add language that makes clear that policy or certificate holders 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, *this 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.

RECOMMENDATION: 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.”

RECOMMENDATION: Consistent with the discussion above, HHS should provide more precision and 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”.

- *Consider using lower case letters, instead of bullets, so that it is easier to reference and modify this section.*

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 this 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.

RECOMMENDATION: Replace this phrase with a more accurate phrase. Perhaps something like: “You must only meet 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 an enrollee) and a limit on what the plan will pay for certain services (a bad thing for an enrollee).

RECOMMENDATION: Clarify what type of limit, using a phrase that has been tested with consumers, for example, “benefit 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.

RECOMMENDATION: 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/out) 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. (Eg.: 50% of providers speak Spanish, etc.) The website to which they are referred 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 note: including all of the information required in the instructions will take up much more room than is available in the space provided. *We recommend consumer testing to identify the standard phrases that are understandable to the average consumer.*

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. *Amend the general instructions to 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, this phrase should not require terms not used by the plan. Insurers should use just the applicable term in the list of three provided (in-network, preferred, or participating) so that the same one*

- 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.

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."

- Question 8 (page 8): *As in other sections, 8 should provide the exact language that should be included in the answers column with either a 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-networked 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 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.

RECOMMENDATION: 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. Consider whether consumers in states without customer assistance offices that help with appeals should 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.

Improving the SBC 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.

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

Conclusion

We thank you for this opportunity to comment. We believe the Medicare beneficiary experience with private plans offered through Parts C and D, on issues from information provision, marketing, and enrollment through plan appeals, provides a great reservoir of information to help shape the implementation of the ACA. We are encouraged by this proposal and hope that CMS will see the value in the recommendations that the Center and many other consumer advocacy groups are offering.

Sincerely,



David Lipschutz



Patricia Nemore