



Kaiser Foundation Health Plan, Inc.  
Government Relations

Submitted [electronically](http://www.regulations.gov) to <http://www.regulations.gov>

October 21, 2011

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

Re: Proposed Rule on *Summary of Benefits and Coverage and the Uniform Glossary, CMS-9982-P*

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the above-captioned proposed rule issued in the *Federal Register* on August 22, 2011. Kaiser Permanente is the largest private integrated healthcare delivery system in the U.S., delivering health care to approximately 8.9 million members in nine states and the District of Columbia. Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 35 hospitals and over 450 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente's members. Kaiser Permanente also includes Permanente Dental Associates, a multispecialty dental group in the Northwest.

We would like to emphasize that most of the concerns discussed in this letter were raised, in some form, to the National Association of Insurance Commissioners (NAIC). However, NAIC was very clear that its charge was to make recommendations on the substance of the Summary of Benefits and Coverage (SBC), and that issues related to the difficulty of implementation, or its costs, would more properly be raised with HHS. We respect the limited jurisdiction that the NAIC had in this process. That fact, however, reinforces how critical it is that HHS, the Department of Labor and the Department of the Treasury take full cognizance of the magnitude of the tasks this rule will impose. As we will discuss, even minor data points required in the rule can carry enormous practical difficulties in creating the SBC that the ACA describes. We urge HHS to seriously consider what the NAIC expressly did not: the practical consequences and costs of each part of this rule, balanced against the value to consumers.

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## **1. Effective Date/Implementation**

### **A. Under the ACA, issuers must have 12 months after the rule is final to implement its provisions.**

The Affordable Care Act (ACA) explicitly sets out a twelve-month span between the date the Department of Health and Human Services (HHS) approves final rules for the creation and distribution of the mandated Summary of Benefits and Coverage (SBC) and the date it will be issued to consumers. We believe the final rule must observe that timeframe. Equally important, we urge HHS to communicate to issuers as soon as possible that they should not immediately expend additional and intensive resources trying to develop SBCs that meet a March 23, 2012 effective date.

Section 2715(d) provides that issuers shall provide the SBC beginning 24 months after the enactment of the ACA. As the proposed rule notes, that would make the requirement effective March 23, 2012. The proposed rule specifically requests comment on this matter.

The 24-month period in 2715(d) does not stand alone in the statute. Its language specifically ties it to the “standards developed by the Secretary under subsection (a).” Under subsection (a), ACA requires the Secretary to develop those standards “[n]ot later than 12 months after enactment” of ACA: March 23, 2011. As the background cited in the proposed rule shows, the Secretary was not able to meet that deadline. The NAIC had not yet completed its work by that date, and only transmitted its final materials to the Secretary on July 29, 2011. Those materials were then considered by the Secretary and provided the foundation for the current proposed rule.

The comment period for this rule does not end until October 21, 2011. Assuming HHS could review all comments, prepare responses and include any changes to the rule one month after the deadline in the rule, no final rule could be expected until late November at the earliest – and, of course, given the sensitivity of many issues HHS will have to consider, and the volume of comments it can expect, it could take much longer to conclude its deliberations. It is with those standards, once they are finalized, that all insurers will have to comply. Until they are formally adopted in law, insurers have no specific, uniform standards to execute.

We believe that a mere four months to implement an enormously complicated and highly detailed new set of documents is unworkable; and four months is the most optimistic implementation period we can envision, given the current status of this rule.

The problem is exacerbated by the fact that the ACA anticipates consumers will place heavy reliance on these documents in making health insurance decisions. The summaries are intended to provide consumers with some of the key information they will need. There can be no doubt that Congress intended the SBCs to contain reliable and fully accurate data that would provide the basis for meaningful consumer choice.

Consequently, in order to properly implement the SBC that Congress crafted, insurers must have adequate time to (a) know precisely what will be required of them; (b) create and adapt systems and processes to assure all data elements and variables are accurate; and (c) properly test the resulting system to guarantee that the final documents can be produced within the proper timeframe and provided to consumers as expected.

We believe that the best reading of the ACA would require an implementation date twelve months after the Secretary has established a final rule. Because circumstances beyond the Secretary's control caused a delay in the Secretary's compliance with the time frame in subsection (a), it is both imprudent and counterproductive to read the time frame in subsection (d) as fixed when the precedent time frame in (a) has been extended through no one's misconduct.

This is a minimum time frame to effectively provide accurate and reliable SBCs. However, we also acknowledge the broader concerns expressed by others who support an 18 month implementation period after finalization of the rule, or full implementation in 2014, so the SBCs can be designed one time, and will be able to include the effects that the rest of the ACA will create.

Finally, we urge HHS to communicate any decision regarding implementation to issuers as soon as they possibly can in whatever form is appropriate. Many issuers, including Kaiser Permanente, are currently expending scarce resources trying to determine how they could possibly meet the March 23<sup>rd</sup> deadline that is now in the proposed rule. Without some immediate assurance that the date does not conform with the ACA, issuers are in the position of having to prepare for an unrealistic deadline.

## **B. The SBC should be rolled out in three stages.**

In addition, we believe that the most practical way to roll out the SBC is in three stages. Since the SBC will have the most value for individual consumers, the first stage of the SBC implementation would be for that market segment. This has the advantage of targeting the people who need the information most immediately, and comprising a population that has a manageable size.

The next stage would include SBCs for small groups. This is a far larger population, and will involve much more system complexity. Once the framework of the SBC has been stabilized for the individual market, the added intricacies and difficulties of adding third parties to the SBC process can be better understood and executed.

The final stage would bring the SBC to all consumers, including those in large groups. We believe that this kind of gradual implementation will be both a more effective and efficient way to create the necessary systems and processes, and will greatly reduce the possibility of errors by providing issuers a way to work through initial problems related to each of the different populations who will receive the SBC.

## **2. Pre-Sale Rate Quotes**

The proposed rule requires issuers of group policies to provide an SBC to a group "upon application or request for information about the health coverage as soon as practicable, but in no event later than seven days following the request." (45 CFR 147.200(a)(i)(A)). However, the text of ACA provides that an SBC shall be provided to "a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate." (ACA sec. 2715 (d)(1)(C))

The cited language in the ACA is more suited to the way that group insurance policies are negotiated and entered into than the proposed text of the regulation. The rule should use the

exact wording in the ACA: The SBC should be provided to employers “. . . at the time of issuance of the policy or delivery of the certificate.”

Providing the SBC at the time of application makes sense for individuals. When an individual comes to us, or when an employee approaches us when their group plan is in open enrollment, the ability to lay several SBCs side-by-side will provide them the choices they will have in a readable and comparable format. They will be able to compare benefits, coverage and risk sharing from several issuers, and make a meaningful choice that is right for them.

By contrast, employers have a bigger picture in mind when they come to us to purchase health insurance. The information that will end up in the SBC is certainly part of that picture, but the dynamics of their particular group and its needs are also at play. When looking for health insurance, employers typically come to Kaiser Permanente with the key facts about their situation, and the expectation that we will provide them a range of options to consider. This gives us the flexibility to design plans that provide meaningful choices to each employer, and it gives employers the ability to negotiate with us, among the available options. Employers frequently request last-minute changes, and under some state laws, such as California’s (discussed below in section 4), they have the right to change their coverage even after it has been issued. This raises the question of the value of the SBC to employer applicants, as opposed to individuals. Requiring issuers to produce an ever-evolving set of SBCs for them as we would for individuals would require the expenditure of time and resources during a negotiating process that would provide little benefit to anyone.

In addition, the current proposal may ultimately have the unintended consequence of forcing issuers into offering less flexibility to employers. If the rule requires an SBC for each quote an issuer gives an employer, and new SBCs with each iteration of the negotiating process, it could discourage the ordinary negotiations that lead to agreeable results. As each new problem is resolved in sequential negotiations, new SBCs will need to be produced. This places an unnecessary cost on one of the fundamental realities of health insurance in the group world.

We do not believe Congress intended to provide this level of interference in the everyday negotiations between insurers and employers, or to provide a disincentive to meaningful negotiations between issuers and employers. If employers feel a sample SBC would be valuable for some reason prior to conclusion of the negotiations, they have the right, under the current language, to request one.

### **3. Premium Cell**

The proposed rule specifically asks for comments on the inclusion of premium information in the SBC. Kaiser Permanente has serious concerns about this proposal.

As the rule’s introductory note points out, the ACA does not require this information in the SBC. While it is essential information for consumers, the question is whether the SBC is the proper format for quoting premiums.

Pursuant to the ACA, the SBC is intended to be what its name states: a summary of benefits and coverage, not a cost-comparison document. We believe that the inclusion of this information

within the SBC was not intended in the ACA, and makes the document something considerably different than envisioned in the law.

In the individual market, where risks must still be underwritten, the cost for the applicant cannot even be ascertained prior to the completion of the application process. As community rating principles come into effect, this problem will become less acute in the individual market, but for any implementation date prior to 2014, this is a substantial concern.

While the rule will permit some flexibility for group premiums, the necessity for creative solutions such as the use of rate sheets, demonstrates the same problem. Congress did not intend the SBC to be a cost comparison document, and trying to include this information in an SBC inevitably leads to problems.

#### **4. Notification of Changes**

Kaiser Permanente notes that laws in some states, such as California, permit employers to make changes to small group policies after the effective date (see California Health and Safety Code section 1357.04(c), providing employers can make changes to coverage for up to 30 days after the effective date).

We believe there is sound policy in rules such as California's that provide needed flexibility to small employers and their employees, and would urge that such laws be preserved. Under the preemption language in the regulations, we are unclear whether such rules would be preempted by the notification timelines in the current proposal. If laws such as California's are preempted, it would place an unnecessary and unwarranted burden on the decision making timelines for small employers. And to the extent they are allowed to remain in effect, the rule should reflect that fact by adjusting the timelines for provision of the SBC to include any time past the policy's effective date when an employer makes a final decision about benefits changes.

#### **5. Electronic formats**

Kaiser Permanente supports the rule's several references to electronic information formats. As one of the nation's leaders in the use of electronic medical records, we believe the SBC and related documents are well suited for electronic transmission to customers. We recommend the consistent use of the more inclusive term, "electronic formats."

The current use of narrower terms like "internet addresses" or "email" may interfere with emerging technologies. For example, many consumers now have smart phones that, in addition to an Internet browser and an email function, also have the ability, through individual applications, or "apps," to access information that is not, precisely, at an "Internet address," nor is it technically delivered by email. Kaiser Permanente has already developed its own app so consumers can locate the nearest KP facility, and we expect that consumer adoption of this kind of technology will almost certainly increase in the coming years.

Too narrow a definition of electronic formats in the regulation can discourage or hinder the advance of this kind of technology, or others that may emerge, such as more sophisticated forms of text messaging.

## 6. Policy Period

In the top right hand corner of the form pictured on p. 52481 of the Federal Register, the SBC requires a “policy period” designation. We ask that this be deleted. It is not required by the ACA, and will create excessive administrative burdens and costs without any real benefit for consumers.

This seemingly inconsequential data point illustrates how enormous complexity can be hidden in small details. Kaiser Permanente has twenty-two small group standard plans in our District of Columbia market to meet our customer’s needs. In 2010 Kaiser Permanente doubled the maintenance of benefit summary documents available to consumers to accommodate groups that had been grandfathered in under ACA, bringing the total standard plan documents to forty-four.

Kaiser Permanente offers two coverage periods per month, one that begins on the first of the month and one that begins on the fifteenth of the month. Currently we indicate the plan year (e.g. 2011) on benefit summary documents used by employers and their employees to simplify administration.

With this new requirement to provide a specific policy period on the SBC, we will need to restructure our systems to provide the following SBC documents:

22 standard plans times 2 (both grandfathered and non grandfathered plans) = 44 standard plans  
44 standard plans times 12 months = 528 variations  
528 variations times 2 (one set for policies beginning on the 1<sup>st</sup> of the month and one set for policies beginning on the 15<sup>th</sup> of the month) = 1,056 variations of SBC documents.

And this is only for documents for our customers in the District of Columbia jurisdiction. Much larger states, such as California, may involve even more variations on this single piece of data. More important, this is before we would include any other data variables in the SBC. All of the mandated variables will provide far more value to consumers in the SBC, and the cost and value will be proportionate.

While it is possible that a well-designed system could generate these forms electronically without undue burden and cost, the rule requires SBCs to be available on paper as well. Our current business model allows us to provide physical copies of our forms to brokers. However, the SBC will be another matter entirely. Because it is both (a) unique for each consumer; and (b) must be available in a physical paper format, we have very serious concerns about the cost and burdens that will be required to comply with requirements such as this. We are long past the days of handwritten forms for contracts as important as health insurance coverage. Electronic provision of this form will be difficult, but is susceptible of responsible management, given adequate time to develop appropriate systems. But the paper requirement transforms innocuous data points like policy period into a challenge that is not always obvious.

As with the premium information, this is information that, while of interest to consumers, is not required by the ACA, and goes beyond the summary of benefits and coverage that the ACA requires the SBC to include. It too requires far more effort to provide in this document than any

benefit it would offer. Like the premium, this is information that should be provided in a more appropriate format and time, where the costs of providing it will be minimized.

## **7. Coverage Examples**

Kaiser Permanente has concerns that the coverage examples will be confusing and possibly misleading to consumers, and may set up expectations about costs despite the proposed cautionary language. In addition, we currently expect that this will be the most expensive part of the SBC for us to implement and produce. Consequently, we strongly agree with the suggestion in the NPRM discussion, and as we proposed earlier for the SBC in general, this part of the SBC should be phased in stages.

While the current proposal states explicitly that the coding and pricing information necessary to create and execute the coverage examples will be posted at the CCIIO website, it does not yet seem to be there. This suggests that it may not be posted during the comment period. The lack of that critical information during this stage of the rule development leaves issuers in the dark about what to expect for this portion of the SBC, and what costs and resources will be needed for it. Given the lengthy discussions at the NAIC of the multiple difficulties that will be involved in the coverage examples, we are deeply concerned about what will be required in the final rule.

It will not be until that coding and pricing information is available that we will be able to cogently provide comment on it, and its impact on our operations and creation of the SBC. However, we do know that different insurers include different functions within the three proposed coverage examples, a fact that was repeatedly discussed at the NAIC hearings. Lacking guidance on what, specifically, all insurers will have to include in doing their cost calculations, there is, as yet, no way we will know what apples we will be comparing to other insurers' apples. Yet that is the very reason that the coverage examples were included in the ACA.


This is another area where a great deal of work will be necessary to perform a unique task under the ACA with no precedent in the business world, one that demands accuracy and comparability. It will take time to do this properly, and we urge here, as we did with the SBC in general, that this task be rolled out in stages: first for the individual market, where it will have the most value, then to the small group market, and finally in the large group market.

The individual market will obviously be the segment where the possibilities of consumer misunderstandings will be most visible soonest, and where they can be most directly monitored. We propose a 9-12 month trial period providing the coverage examples to this group. In this way, the potential costs of error or failure can be minimized, and issuers can learn how to address consumer concerns, problems, misunderstandings or communication hurdles.

## Conclusion

Kaiser Permanente appreciates the opportunity to offer these thoughts, and looks forward to any discussions that may be requested as the proposed rule moves toward implementation. If you have any questions or would like to discuss this further, please contact me at 510-271-6835.

Sincerely,

A handwritten signature in black ink that reads "Anthony A. Barrueta". The signature is written in a cursive style with a large, sweeping initial 'A'.

Anthony Barrueta  
Senior Vice President  
Government Relations