



October 21, 2011

Office of Health Plan Standards and Compliance Assistance  
Employee Benefits Security Administration  
Room N-5653  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

Center for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Service Act

Dear Director Maguire and Dr. Berwick:

AARP is pleased to provide comments on the proposed rule on “Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Service Act”. We have been a long-time supporter of greater accountability through transparency of information on provider performance, efficiency, resource use, and cost of care and price information, coupled with informed decision making. The materials discussed in the proposed rule are critically important to ensure that consumers selecting coverage will have information that is easily accessible, understandable and adequate to inform their choices. Providing individuals with a plain language summary of benefits and coverage as well as a uniform glossary will help them better understand the available health coverage options.

### **Effective Date**

Section 2715 of the Public Health Service Act (PHS) directs group health plans and health insurance issuers to comply with the Summary of Benefits and Coverage (SBC) requirements beginning on or after March 23, 2012. While AARP believes that plans and issuers should be able to comply with this deadline, we recognize that the time period between the publication of the final rule and effective date may be too short for some to achieve full compliance. Therefore, we would support some flexibility by giving plans and issuers up to 6 months after the later of either the promulgation of the final rule or the start of the first open enrollment period following the promulgation of the final rule to meet the SBC requirements.

## **Distribution**

AARP believes that the summary plan description (SPD) and SBC should be provided to consumers as separate documents. This would simplify communication and make the information more understandable for the consumer. The SPD and SBC are vastly different documents, and individuals will use each for different purposes. The SPD contains plan rules, financial and other information about the operation and administration of the plan, whereas the SBC solely describes the benefits and coverage options under the applicable plan or coverage. Typically, SPDs are lengthy and extremely technical. In contrast, §2715 of PHS Act requires the SBC to be limited in length to 4 pages and written in language that is understandable to the average plan enrollee. The SPD and SBC should be provided during a consumer's initial enrollment period, the open enrollment period, and during any special enrollment periods that may occur during the year. The SBC should be available to individuals whenever they have the opportunity to enroll or re-enroll in a plan. The document provides information designed to help consumers understand plan provisions and compare available options and to inform their enrollment decisions.

Providing these documents electronically to those consumers who have computer access and have consented (as required by regulation) to receive this information electronically will simplify the distribution process and minimize distribution costs. However, it is important to remember that for many consumers, electronic access may not be best. For this reason, we believe that the agencies should require that SBCs be available in hardcopy as well so that consumers can request to receive free paper copies of the SPD and SBC, should they prefer. Consumers receiving this information from their employer or plan sponsor should be able to receive the SBC and SPD in which ever form they prefer (i.e., electronic or hardcopy) without charge, and with no reprisals, regardless of their choice.

If information provided in the SPD or SBC changes prior to the effective date for coverage, we believe the plans and issuers have the obligation to notify individuals of the change as soon as possible but no later than two weeks before the effective date. In the case of electronic copies, because of the ease of electronic communication, when changes are made, AARP recommends that plans and issuers be required to provide a complete SPD and SBC with the changes highlighted so that consumers can easily identify them.

## **Content**

The statute outlines nine required elements to be included in the SBC. After receipt of comments, the National Association of Insurance Commission (NAIC) proposed an additional four elements. We believe these additional elements are standard and represent reasonable information that should be made available to the individual. The additional NAIC elements would require issuers to disclose information and resources that can assist individuals and will enhance their decision-making.

We believe the information provided in the SBC should be available on the plan or issuers' website. The regulation should specify that consumers should be able to download, print, or otherwise obtain the information without charge, and with no reprisals.

As the preamble notes, prior to enrollment periods for coverage in 2014, HHS will have to add language to the SBC that tells consumers whether or not a plan satisfies the requirement for individuals to have minimum essential coverage. Consumers will need to know if they enroll in a particular plan whether they will have satisfied that requirement. It will be critical that SBCs alert consumers if a plan does not satisfy the requirement for minimum essential coverage at the time they are making their enrollment decisions. These statements should be incorporated into the SBCs for all coverage offered in the individual, small group, and large group market as well as by all self-insured plans. Whatever type of coverage a person is offered (e.g., major medical, limited benefit, discount plans, etc.), they must be told clearly prior to enrollment whether it offers minimum essential coverage.

### **Cost of Coverage**

It is important for consumers to have ready access to all the information they need to make informed decisions about their coverage, including accurate information on how much each option will cost them. AARP believes it is necessary to offer consumers standardized, comparative information on each available coverage option. In the "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" proposed rule, HHS proposes to codify the statutory requirement for Exchanges to have an electronic calculator to assist individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions. AARP strongly supports codification of this requirement in the regulations. Consumers must have information to assist them in estimating what their health care costs are likely to be. AARP believes that a link or reference to this calculator should be added to the SBC in order to bring attention to the resources and tools on the Exchange websites. Absent this information, individuals who may be eligible for premiums and cost sharing subsidies may be deterred from enrolling in a particular coverage option because the plan seems unaffordable to them based on premiums that do not reflect subsidies.

### **Coverage Examples**

Under the proposed regulations, the coverage examples will illustrate how benefits provided under the plan or coverage for common benefits scenarios will be applied. The agencies are proposing to provide individuals with 6 coverage examples in the SBC. Currently, the agencies have accepted the recommendation of NAIC to include examples of a normal delivery, treating breast cancer, and managing diabetes. We encourage HHS when selecting the additional examples to address conditions experienced by a broad swath of the population, including mothers, children, people with chronic conditions (including those with multiple conditions), and older persons. The conditions selected for illustration should be high impact conditions that are relevant to the populations described.

The National Quality Forum recently proposed a list of high impact conditions for Medicare beneficiaries as well as children that would be a helpful resource in selecting the conditions.

### **Limited English Proficiency Access**

The SBC and the uniform glossary are the most important documents that individuals will use to inform their decisions on coverage options. Given ACA's requirement that all persons need to select a plan and the SBC will be the key information resource in this selection, it is unrealistic to expect individuals to make informed choices if they are unable to understand the materials that convey critical information about benefits, cost, and coverage. The proposed regulation uses the number of persons in a county (who are not proficient) to determine the threshold for providing the glossary and SBC in other languages to persons who are not proficient in English. We believe that the 10% county threshold is inconsistent with the intent of the statute to provide more complete information to a larger number of enrollees. Instead we suggest that the threshold be 5% of a plan's enrollees. This is consistent with 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. Given that plans and insurers are already following these guidelines for Medicare and our suggested standard will make for consistency with other federal requirements, we do not believe that this will be unduly burdensome.

DOL regulation, 29 CFR § 2520.102-2(c), requires group health plans to provide those participants who are not proficient in English with language access services. The threshold for these services depends on the size of the plan as well as the number and percentage of persons who are proficient in English. Assuming DHHS retains the county as the unit of analysis, even if a particular county does not meet the current threshold requiring language services under the proposed regulation, some workforces may meet the DOL thresholds. Accordingly, at a minimum, to the extent that the group health plan's administrator or sponsor is requesting language access services to comply with DOL regulation, 29 CFR § 2520.102-2(c), the final rule should include a provision requiring group health coverage providers to offer translation services in languages that do not meet the requisite NPRM threshold for an applicable non-English language under the proposed thresholds, if requested by the plan administrator or sponsor. Moreover, to the extent that an administrator or sponsor requests language services for their workforce, even if the workforce does not meet the DOL or interim rule thresholds, we submit that group health coverage providers should be required to offer such services.

Regardless of which standard is employed, we note that once a glossary and/or SBC is prepared in a language (English, Spanish, Vietnamese, etc.), it should be relatively easy and inexpensive to make it available to any person who is interested by posting it on the issuer's website or providing it in paper upon request. There should be no reason to limit this information to only those individuals who have limited English in specifically identified counties.

Director Maguire and Dr. Berwick

October 21, 2011

Page 5

Finally, this proposed rule raises the legal question of whether an issuer's failure to provide this information to people with Limited English Proficiency would violate federal and state civil rights laws as well as the ACA itself. HHS should clarify that nothing in the ACA rules absolves issuers and group health plans from complying with Title VI of the Civil Rights Act of 1964 prohibitions against discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation, while §1557 of the ACA ensures the provision of competent and comprehensive language services to people with LEP. We note that regardless of the ACA requirements, issuers still must comply with other statutes. Accordingly, as the agencies finalize the SBC and uniform glossary, we urge you to be mindful of the need to address the challenge of making the materials available and accessible for LEP individuals—a population group that is typically disadvantaged and vulnerable.

### **Appearance**

The way information is presented to consumers is often as important as the content itself. There is research evidence demonstrating that formatting and presentation can either ease or complicate the cognitive burden of understanding information. Therefore, an important function for the agencies is to ensure that materials developed for consumer use are meeting the needs of the populations they are intended to inform. Although templates underwent consumer testing, it will be necessary to continue to refine them to be certain that the information presented is clear and useful. Ongoing testing using appropriate research methods should occur to ensure that the summary of benefits and coverage chart is user friendly to a large range of consumer participants. AARP would be pleased to continue working with the agencies in order to continue to improve the model disclosure form. If the agencies revise the form substantially, AARP believes that it should be subject to notice and comment periods.

Thank you for the opportunity to comment on this important matter. If you have any questions, please feel free to contact Leah Cohen Hirsch on our Government Affairs staff at 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David Certner  
Legislative Counsel and Legislative Policy Director  
Government Affairs