New York State Comments on Proposed Rule: Summary of Benefits and Coverage and the Uniform Glossary, 45 CFR Part 147; 26 CFR Parts 54 & 602; and 29 CFR Part 2590.

General comments: New York appreciates the balance that the proposed rules attempt to strike between uniformity, ease of understanding, and accuracy in the summary of benefits and coverage and the uniform glossary. New York is also in favor of standardized coverage documents. Comments on specific provisions of the proposed rules are below. Thank you for the opportunity to submit these comments.

Content of Summary of Benefits and Coverage (SBC):

1. Should the SBC include premium or cost information and if so, the extent to which it should reflect the actual cost to an individual net any employer contributions and should this information include tiers? Also, how can the information be provided in a way that allows individuals and plan sponsors to make meaningful comparisons about the cost of coverage options?

- For the premium information to be helpful, it needs to be as accurate as possible. Ideally the information should provide the actual cost to an individual net any employer contributions and include tiers. The overall premium by tiers should be provided along with a statement that the amount may be reduced by employer contributions and individuals should contact their employers for more information. HHS should balance the significant benefit to consumers of requiring insurers to provide the premium net employer contributions, on one hand, with the cost to insurers of providing this information and the effect on premiums, on the other hand.

2. Can updated premium information be provided in another way that is easily understandable and useful, other than providing a new SBC?

- An insert page could be provided and the information could be posted on a web site.

- Please note that plans must make premium information available to consumers in an interactive format for plan management functions and for use with the electronic calculator. Perhaps these mechanisms can be used to provide updated premium information in a way that is easily understandable and useful.

3. Should the SBC reference the network and prescription drug formulary?

- Yes. We agree with the position taken in the NPRM. New York law has already put consumer protections in place by including requirements for disclosure of network and formulary information. Requiring the SBC to include this information gives New York state consumers access to the information in a single document.

4. Should the SBC include additional information (such as preexisting condition exclusions under the plan or policy, or status as a grandfathered plan)?

- Yes. New York law also includes requirements for disclosure of preexisting condition information.

5. Should services be added to or removed from the excluded services section of the SBC?

- New York has determined that hospice, prosthetics and orthotics are common benefits that are critical to consumers with specific health care needs and, if covered, should be included in the common medical event column under "special health need". If these benefits are not covered, they should be added to the excluded services section.

6. Is the disclosure that the list of excluded services is not complete adequate?

- Yes. The disclosure is adequate.

7. Is a statement that the SBC does not include all the coverage details of the policy sufficient?

- No. The SBC should remind consumers to check their policy. The SBC should also include a statement that, if there is a conflict between the SBC and the policy, the policy will govern.

8. Other comments:

- Offering the SBC no later than the first day of coverage puts beneficiaries at a disadvantage. Beneficiaries may not have enough time to compare costs/plans before their coverage begins if they are not notified of the changes until the first day of enrollment.

- The SBC should be organized so that the consumer understands what his/her costs are. Listing the premium first on the SBC may confuse a consumer; consumers may assume that the premium listed is their cost.

- It may be helpful to have the "Excluded Services and Other Covered Services" table to page 1 so that consumers understand the services they will receive. The focus should not only be on cost, but also on the services a consumer will receive.

- How will a consumer know what their costs are with their subsidy?

Coverage Examples:

1. Should there be additional coverage examples and if so, what?

- Consumer testing expressed a preference for more gender neutral examples. The breast cancer coverage example could be changed to a gender-neutral example for cancer.

2. Would it be desirable to permit plans to input specific information into a central internet portal for the examples to be available on the portal for access by individuals?

- Yes. It would be beneficial to enable individuals to access specific information, similar to the Fair Health web site.

3. Alternatively, should individuals be permitted to input information to generate coverage examples?

- Yes. There should be a tool for consumers to use to estimate what their costs will be based on different situations. This tool should be aligned with the plan selection tool that is being developed through the UX 2014 project, which includes a tool to calculate a consumer's costs based on his/her subsidy.

4. Are the update requirements reasonable?

- The annual update requirements are reasonable and provide plans sufficient time to update their SBCs. New York recommends using the 60 day timeframe required when plans make material modifications affecting the content of its SBCs as multiple timeframes for similar tasks may cause confusion.

Appearance of SBC:

1. How should the SBC be coordinated with other plan disclosure materials?

- New York has extensive disclosure requirements and HHS should permit insurers to coordinate the SBC with other disclosure materials.

2. Whether the statement in the SBC about the electronic availability of the uniform glossary should be modified to include information that it is also available in paper form upon request.

- Yes. The statement should advise consumers of the availability of the uniform glossary in paper.

- HHS should require that versions of the SBC in other languages are available in paper form as well as electronically.

3. Should flexibility be permitted in aspects of the presentation of the SBC?

- The specific language of the SBC and the manner and sequence in which the information is presented should be uniform.

- New York's use of the term grievance is different than how the term is used in the SBC and New York also has a utilization review process. Modification of that portion would be helpful as follows:

> Your Appeal Rights:
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> Your have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. This may be called a grievance or a utilization review decision. Call 1-800-XXX-XXXX or visit www.Xxxxxxxx.xxxxxx.com.
>
> An appeal is a request for your health insurer or plan to review a decision or grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.Xxxxxxxx.xxxxxx.com.

4. Other comments:

- The colored shading on the SBC is helpful to individuals with low-literacy. However, it is difficult to read when the SBC is printed in black and white.

- If posted online, the color contrast must comply with the Web Content Accessibility Guidelines 2.0.

- A TTY phone number should also be included in the footer.

- The information in the SBC should align with the design of the UX 2014 product. The data elements shown in the plan selection section should align with the SBC.

- Examples should not be embedded within the definition. For example, on page 2, the first bullet states, "Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service." The example can be revised to be two sentences as follows: "Co-payments are fixed dollar amounts you pay for covered health care. For example, you may pay $15 when you visit your doctor. "

- On page 4 of the SBC, under YOUR RIGHTS TO CONTINUE COVERAGE, the bullets should be reordered to destigmatize applying for health insurance.

- It might be helpful to present the "Questions and answers about coverage examples" before the actual examples.

- There should be directions at the beginning of the SBC on how to use it - how a consumer should use the SBC; how they can use the information to compare plans, etc.

Form and Manner:

1. Are clarifications needed with respect to the "readily accessible" standard (for example, do passwords or special software create a burden that would render documents not readily accessible)?
- Yes, passwords and special software will hinder access and should not be permitted.

2. Is it appropriate to allow plans to fulfill an individual's request in electronic form, unless the individual requests a paper form?
- No, requiring the insurer to communicate in the form and manner of the correspondence they receive from the consumer, or in the alternative requiring permission from the consumer to communicate electronically, is more protective of the consumer. Accordingly, the existing requirements should not be lessened.

3. Other comments:
- The electronic SBC should meet the standards outlined in the Web Content Accessibility Guidelines 2.0.

- The shading in the form is helpful for individuals with low-literacy. However, the contrast of the SBC in the electronic format should meet 508 standards. In the black and white version, it will be difficult to read the blue font on blue background.

Notice of Modifications:

1. Comments are requested on the 60 day notice requirement, including format.
- The notice requirement is essential to provide accurate information in a timely manner and is similar to New York timeframes.

Uniform Glossary:

1. Should definitions of claim, external review, maternity care, preexisting condition, preexisting condition exclusion period and specialty drug be included?

- Yes, these definitions should be included.

2. Should additional terms be added to the glossary or are any of the terms inaccurate or misleading based on a plan design?

- The definitions of "Preferred Provider" and "Non-Preferred Provider" are confusing and should be revised. The HHS draft definitions appear to encompass the more commonly used terms "participating provider" and "non-participating provider", as well as "in-network provider" and "out-of-network provider". These more commonly used terms typically refer to whether or not a provider has a contract in place with the health plan. The HHS draft definitions add the concept of a provider that may have preferred or non-preferred status with respect to payment for services without regard for whether or not there they have contracted with the health plan. These concepts may be confusing to consumers and HHS should provide clarification.

- Because not all of the above terms are used in every policy, we suggest that a statement be added to clarify that if a term is not relevant to a policy it does not need to be defined. It may be confusing to consumers to include definitions in a policy that do not appear in that policy.

3. Should the SBC state that the uniform glossary is available in paper upon request?

- Yes. Notice of availability in paper should be provided. There should also be a statement about the availability of the glossary in other languages. The glossary should be available in the same languages as the SBC.

4. Additional comments on the uniform glossary:

Content:

- Different types of plan options should be defined – e.g. Catastrophic, PPO, HMO, etc.

- "Preauthorization" should be changed to "Prior Authorization" as this a more commonly used term.

- The term "Disability" should be defined. The definition for "Disability" should provide consumers with information that if they are found to be disabled through a state disability review process, they may be eligible for additional services covered by Medicaid

- For the terms, "Habilitation Services", "Medically Necessary" and "Rehabilitative Services", the term "condition" should be added to the definition. As it reads now, therapies to care for conditions, such as Downs Syndrome, would not be covered.

- "Medically Necessary" should include maintaining function, not only preventing, diagnosing or treating an illness, injury, or disease or symptoms.

- Link definitions for “Habilitation Services” and “Rehabilitative Services” to “Medically Necessary”. The current definitions do not include maintaining function for certain conditions.

- “Referral” should be defined or incorporated into the definition for “Prior Authorization”.

- HHS should include an example for UCR.

- The example on Page 4 of the Glossary is confusing. It is unclear to the reader that this example is for a consumer who uses a Non-Preferred Provider. The UCR concept should be explained in this scenario.

- HHS should include a similar visual example for consumer accessing care with a “Participating Provider”. A consumer should be informed about the cost-savings of receiving care from a participating provider.

Format:

- It is confusing to have a bolded word within the definition. It may be unclear to the reader that the bolded word is defined elsewhere in the glossary.

- The key words should be in Arial font and the definitions should be in Times New Roman. Presenting the material in this way helps an individual with low-literacy understand the content.

- If the glossary is provided online, the color contrast must meet the standards outlined in the Web Content Accessibility Guidelines 2.0.

- On Page 4 of the Glossary, it may be helpful to have the scenario written out at the top of the page along with the visual to emphasize the relationship between the insurer and individual.

SUMMARY OF COMMENTS REGARDING THE NPRM AND THE SOLICITATION OF COMMENTS FOR THE SUMMARY OF BENEFITS AND COVERAGE AND THE UNIFORM GLOSSARY AND TEMPLATES, INSTRUCTIONS, AND RELATED MATERIALS

RELEASED 8/17/11

COMMENTS DUE 10/21/2011

SUMMARY OF BENEFITS AND COVERAGE AND THE UNIFORM GLOSSARY; PROPOSED RULES AND SOLICITATION OF COMMENTS (45 CFR PART 147)
COMPANION REGULATIONS (26 CFR PARTS 54 & 602; 29 CFR PART 2590)

Section/ FR Page	FEDERAL NPRM: SUMMARY OF BENEFITS AND COVERAGE AND UNIFORM GLOSSARY Description of Rule Provision	State Flexibility? Describe	Describe Proposed Comments (or note "None")
Part 147 § 147.200(a)(1) **52472**	**Overview** **Requires group health plans (and their administrators under ERISA), and health insurance issuers offering group or individual health insurance coverage to provide a written summary of benefits and coverage (SBC) for each benefit package.** **Provision of SBC by issuer to group plan:** - **Must provide SBC within 7 days of application or request for coverage information.** - **If there are changes, an updated SBC must be provided no later than the date of offer or first day of coverage.** - **Must provide SBC w/in 30 days of renewal.** **Provision of SBC by issuer and group plan (including its administrator under ERISA) to participants and beneficiaries:** - **Must provide SBC for each benefit package offered for which the participant or beneficiary is eligible.** - **Must provide SBC as part of enrollment materials or the first date the participant or beneficiary is eligible for enrollment.** - **If there are changes, an updated SBC must be provided no later than the first day of coverage.** - **Must provide SBC to special enrollees within 7 days of enrollment request.** - **Must provide a new SBC upon renewal.** - **Must provide SBC to participants or beneficiaries upon request w/in 7 days.** **Avoiding duplication (group):** - **Entity required to provide SBC satisfies the requirement if the SBC is provided, in a timely and complete manner, by another party.** - **If participant and beneficiaries are known to reside at the same address one SBC is sufficient.** - **SBCs issued upon renewal need only be for the benefit package in which the participant or beneficiary is enrolled, unless a request for additional benefit packages is made.**		

Section/ FR Page	FEDERAL NPRM: SUMMARY OF BENEFITS AND COVERAGE AND UNIFORM GLOSSARY Description of Rule Provision	State Flexibility? Describe	Describe Proposed Comments (or note "None")
	Insurer offering individual coverage: - **Must provide SBC within 7 days of application or request for coverage information.** - **If there are changes, an updated SBC must be provided no later than the date of offer or first day of coverage.** - **Must provide SBC w/in 30 days of renewal.** **Avoiding duplication (individual):** - **If policy covers more than one individual residing at the same address, one SBC is sufficient.**		
Part 147 § 147.200(a)(2)(i) **52473**	**Content** **SBC must include the following:** - **Uniform definitions of standard insurance and medical terms.** - **Description of coverage, including cost sharing, for each category provided by HHS.** - **Exceptions and limitations of coverage.** - **Cost sharing provisions, including deductible, co-insurance and co-pays.** - **Renewability and continuation provisions.** - **Coverage examples.** - **For coverage beginning on or after 1/1/14, a statement whether the coverage provides minimum essential coverage and whether the plan's share of total allowed cost of benefits meets applicable requirements.** - **A statement that the SBC is only a summary and that the plan document, policy or certificate should be consulted for governing contract provisions.** - **Contact information for questions and obtaining copies of plan documents.** - **If applicable, an internet address with network information.** - **If applicable, an internet address with prescription drug formulary.** - **An internet address for obtaining the uniform glossary.** - **Premium information.**		**Comments are requested on the following:** **1. Should the SBC include premium or cost information and if so, the extent to which it should reflect the actual cost to an individual net any employer contributions and should this information include tiers? Also, how can the information be provided in a way that allows individuals and plan sponsors to make meaningful comparisons about the cost of coverage options?** - **For the premium information to be helpful, it needs to be as accurate as possible. Ideally the information should provide the actual cost to an individual net any employer contributions and include tiers. The overall premium by tiers should be provided along with a statement that the amount may be reduced by employer contributions and individuals should contact their employers for more information. HHS should balance the significant benefit to consumers of requiring insurers to provide the premium net employer contributions, on one hand, with the cost to insurers of providing this information and the effect on premiums, on the other hand.** **2. Can updated premium information be provided in another way that is easily understandable and useful, other than providing a new SBC?**

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			- **An insert page could be provided and the information could be posted on a web site.** - **Please note that plans must make premium information available to consumers in an interactive format for plan management functions and for use with the electronic calculator. Perhaps these mechanisms can be used to provide updated premium information in a way that is easily understandable and useful.** **3. How can employers provide minimal essential coverage information to employees and Exchanges in a manner that minimizes duplication and burden?** **4. Should the SBC reference the network and prescription drug formulary?** - **Yes. We agree with the position taken in the NPRM. New York law has already put consumer protections in place by including requirements for disclosure of network and formulary information. Requiring the SBC to include this information gives New York state consumers access to the information in a single document.** **5. Should the SBC include additional information (such as preexisting condition exclusions under the plan or policy, or status as a grandfathered plan)?** - **Yes. New York law also includes requirements for disclosure of preexisting condition information.** **6. Should services be added to or removed from the excluded services section of the SBC?** - **New York has determined that hospice, prosthetics and orthotics are common benefits that are critical to consumers with specific health care needs and, if covered, should be included in the common medical event column under "special health need". If these benefits are not covered, they should be added to the excluded services section.**

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			7. Is the disclosure that the list of excluded services is not complete adequate? - **Yes. The disclosure is adequate.** **8. Is a statement that the SBC does not include all the coverage details of the policy sufficient?** - **No. The SBC should remind consumers to check their policy. The SBC should also include a statement that, if there is a conflict between the SBC and the policy, the policy will govern.** **9. Other comments:** - **Offering the SBC no later than the first day of coverage puts beneficiaries at a disadvantage. Beneficiaries may not have enough time to compare costs/plans before their coverage begins if they are not notified of the changes until the first day of enrollment.** - **The SBC should be organized so that the consumer understands what his/her costs are. Listing the premium first on the SBC may confuse a consumer; consumers may assume that the premium listed is their cost.** - **It may be helpful to have the "Excluded Services and Other Covered Services" table to page 1 so that consumers understand the services they will receive. The focus should not only be on cost, but also on the services a consumer will receive.** - **How will a consumer know what their costs are with their subsidy?**
Part 147 § 147.200(a)(2)(ii) **52474**	**Coverage Examples** **SBC must include coverage examples illustrating benefits for common scenarios or medical conditions.** - **HHS may identify up to 6 coverage examples.** - **HHS will specify the types of services, dates of services,**		**Comments are requested on the following:** **1. Should there be additional coverage examples and if so, what?** - **Consumer testing expressed a preference for more gender neutral examples. The breast cancer coverage example could be changed to a gender-neutral example for cancer.**

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	applicable billing codes and allowed charges for each scenario. - **HHS will update the information necessary to generate the coverage examples annually and issuers must update their SBCs within 90 days.**		**2. Would it be desirable to permit plans to input specific information into a central internet portal for the examples to be available on the portal for access by individuals?** - **Yes. It would be beneficial to enable individuals to access specific information, similar to the Fair Health web site.** **3. Alternatively, should individuals be permitted to input information to generate coverage examples?** - **Yes. There should be a tool for consumers to use to estimate what their costs will be based on different situations. This tool should be aligned with the plan selection tool that is being developed through the UX 2014 project, which includes a tool to calculate a consumer's costs based on his/her subsidy.** **4. Are the update requirements reasonable?** - **The annual update requirements are reasonable and provide plans sufficient time to update their SBCs. New York recommends using the 60 day timeframe required when plans make material modifications affecting the content of its SBCs as multiple timeframes for similar tasks may cause confusion.**
Part 147 § 147.200(a)(3) **52474**	**Appearance** **SBC must:** - **Be a stand alone document.** - **Be in the form determined by HHS.** - **Use terminology understandable by average person.** - **Not exceed four double sided pages.** - **Not use smaller than 12 point font.**		**Comments are requested on the following:** **1. How should the SBC be coordinated with other plan disclosure materials?** - **New York has extensive disclosure requirements and HHS should permit insurers to coordinate the SBC with other disclosure materials.** **2. Whether the statement in the SBC about the electronic availability of the uniform glossary should be modified to include information that it is also available in paper form upon request.** - **Yes. The statement should advise consumers of the availability of the uniform glossary in paper.** - **HHS should require that versions of the SBC in other**

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			languages are available in paper form as well as electronically. **3. Should flexibility be permitted in aspects of the presentation of the SBC?** - **The specific language of the SBC and the manner and sequence in which the information is presented should be uniform.** - **New York's use of the term grievance is different than how the term is used in the SBC and New York also has a utilization review process. Modification of that portion would be helpful as follows:** **Your Appeal Rights:** **Your have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. This may be called a grievance or a utilization review decision. Call 1-800-XXX-XXXX or visit www.Xxxxxxxx.xxxxxx.com.** **An appeal is a request for your health insurer or plan to review a decision or grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.Xxxxxxxx.xxxxxx.com.** **4. What issues will arise from use of the template for different coverage designs (for example tiered networks or plans that use different issues for different categories of benefits)?** - **The template is sufficient.** **5. Are changes needed in terminology for group health plans or self-insured plans?** - **The terminology is appropriate for group health plans.**

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			6. Other comments: - **The colored shading on the SBC is helpful to individuals with low-literacy. However, it is difficult to read when the SBC is printed in black and white.** - **If posted online, the color contrast must comply with the Web Content Accessibility Guidelines 2.0.** - **A TTY phone number should also be included in the footer.** - **The information in the SBC should align with the design of the UX 2014 product. The data elements shown in the plan selection section should align with the SBC.** - **Examples should not be embedded within the definition. For example, on page 2, the first bullet states, "Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service." The example can be revised to be two sentences as follows: "Co-payments are fixed dollar amounts you pay for covered health care. For example, you may pay $15 when you visit your doctor. "** - **On page 4 of the SBC, under YOUR RIGHTS TO CONTINUE COVERAGE, the bullets should be reordered to destigmatize applying for health insurance.** - **It might be helpful to present the "Questions and answers about coverage examples" before the actual examples.** - **There should be directions at the beginning of the SBC on how to use it - how a consumer should use the SBC; how they can use the information to compare plans, etc.**
Part 147 § 147.200(a)(4) **52474**	**<u>Form and Manner</u>** **SBC from Issuer to Plan may be provided in paper form or, if following conditions are satisfied, electronically:** - **Format is readily accessible.** - **Provided in paper form upon request for free.** - **If provided as an internet posting, the issuer timely advises plan that the documents are available on the internet and provides the internet address.** **SBC from Plan to Participant or Beneficiary may be provided in**		**Comments are requested on the following:** **1. Are clarifications needed with respect to the "readily accessible" standard (for example, do passwords or special software create a burden that would render documents not readily accessible)?** - **Yes, passwords and special software will hinder access and should not be permitted.** **2. Is it appropriate to allow plans to fulfill an individual's request in electronic form, unless the individual requests a paper form?**

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	paper form or may be provided electronically if plan conforms to ERISA or the electronic disclosure provisions in Part 147. **SBC from Issuer to Individual must be provided in paper or, may be provided electronically if:** - **The individual applies or makes request for information electronically.** - **The issuer requests individual to acknowledge receipt.** - **The electronic form is readily usable by the general public.** - **If SBC is posted on the internet, it is prominently displayed.** - **The issuer provides a paper copy upon request.** **An issuer, offering individual coverage, that complies with the Federal Web Portal requirements, is deemed to comply with requirement of issuing an SBC to an individual requesting information prior to application but must still issue an SBC at time of application.**		- **No, requiring the insurer to communicate in the form and manner of the correspondence they receive from the consumer, or in the alternative requiring permission from the consumer to communicate electronically, is more protective of the consumer. Accordingly, the existing requirements should not be lessened.** **3. Are the safeguards sufficient to ensure receipt of an electronic SBC?** - **Yes. The safeguards should be sufficient.** **4. Other comments:** - **The electronic SBC should meet the standards outlined in the Web Content Accessibility Guidelines 2.0.** - **The shading in the form is helpful for individuals with low-literacy. However, the contrast of the SBC in the electronic format should meet 508 standards. In the black and white version, it will be difficult to read the blue font on blue background.**
Part 147 § 147.200(a)(5) **52474**	**Language** **SBC must be issued in a culturally and linguistically appropriate manner pursuant to 45 CFR Part 147.136(e).**		**Comments are requested on how to provide the SBC in non-English languages.**
Part 147 § 147.200(b) **52474**	**Notice of Modifications** **If plan or issuer makes material modifications affecting content of SBC that is not in the most recently provided SBC, and that occurs other than in connection with a renewal, it must provide notice of the modification to enrollees 60 days prior to the effective date of the change.**		**Comments are requested on the 60 day notice requirement, including format.** - **The notice requirement is essential to provide accurate information in a timely manner and is similar to New York timeframes.**
Part 147 § 147.200(c) **52475**	**Uniform Glossary** **The plan or issuer must make available a uniform glossary which must include definitions for the following terms: allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance,**		**Comments are requested on the following:** **1. Should definitions of claim, external review, maternity care, preexisting condition, preexisting condition exclusion period and specialty drug be included?** - **Yes, these definitions should be included.**

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	habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and such other terms as HHS determines are important to define (including any exceptions to those benefits).		**2. Should additional terms be added to the glossary or are any of the terms inaccurate or misleading based on a plan design?** **- The definitions of "Preferred Provider" and "Non-Preferred Provider" are confusing and should be revised. The HHS draft definitions appear to encompass the more commonly used terms "participating provider" and "non-participating provider", as well as "in-network provider" and "out-of-network provider". These more commonly used terms typically refer to whether or not a provider has a contract in place with the health plan. The HHS draft definitions add the concept of a provider that may have preferred or non-preferred status with respect to payment for services without regard for whether or not there they have contracted with the health plan. These concepts may be confusing to consumers and HHS should provide clarification.** **- Because not all of the above terms are used in every policy, we suggest that a statement be added to clarify that if a term is not relevant to a policy it does not need to be defined. It may be confusing to consumers to include definitions in a policy that do not appear in that policy.** **3. Should the SBC state that the uniform glossary is available in paper upon request?** **- Yes. Notice of availability in paper should be provided. There should also be a statement about the availability of the glossary in other languages. The glossary should be available in the same languages as the SBC.** **4. Additional comments on the uniform glossary:** **Content:** **- Different types of plan options should be defined – e.g. Catastrophic, PPO, HMO, etc.** **- "Preauthorization" should be changed to "Prior Authorization" as this a more commonly used term.** **- The term "Disability" should be defined. The definition**

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			for "Disability" should provide consumers with information that if they are found to be disabled through a state disability review process, they may be eligible for additional services covered by Medicaid - For the terms, "Habilitation Services", "Medically Necessary" and "Rehabilitative Services", the term "condition" should be added to the definition. As it reads now, therapies to care for conditions, such as Downs Syndrome, would not be covered. - "Medically Necessary" should include maintaining function, not only preventing, diagnosing or treating an illness, injury, or disease or symptoms. - Link definitions for "Habilitation Services" and "Rehabilitative Services" to "Medically Necessary". The current definitions do not include maintaining function for certain conditions. - "Referral" should be defined or incorporated into the definition for "Prior Authorization". - HHS should include an example for UCR. - The example on Page 4 of the Glossary is confusing. It is unclear to the reader that this example is for a consumer who uses a Non-Preferred Provider. The UCR concept should be explained in this scenario. - HHS should include a similar visual example for consumer accessing care with a "Participating Provider". A consumer should be informed about the cost-savings of receiving care from a participating provider. **Format:** - It is confusing to have a bolded word within the definition. It may be unclear to the reader that the bolded word is defined elsewhere in the glossary. - The key words should be in Arial font and the definitions should be in Times New Roman. Presenting the material in this way helps an individual with low-literacy understand the content.

Section/ FR Page	FEDERAL NPRM: SUMMARY OF BENEFITS AND COVERAGE AND UNIFORM GLOSSARY Description of Rule Provision	State Flexibility? Describe	Describe Proposed Comments (or note "None")
			- **If the glossary is provided online, the color contrast must meet the standards outlined in the Web Content Accessibility Guidelines 2.0.** - **On Page 4 of the Glossary, it may be helpful to have the scenario written out at the top of the page along with the visual to emphasize the relationship between the insurer and individual.**
Part 147 § 147.200(d) **52475**	**Preemption** **State laws that require an issuer to provide an SBC that supplies less information are preempted.**		
Part 147 § 147.200(e) **52475**	**Failure to Provide** **An issuer or non-federal governmental health plan that willfully fails to provide this information is subject to a fine of not more than $1,000 for each failure (each covered individual counts as separate offense). HHS will only enforce this provision if they determine the State has failed to substantially enforce it.**		
Part 147 § 147.200(f) **52475**	**Effective date – March 23, 2012**		**1. Comments are requested as to the timing of implementation.** **2. Comments are requested as to whether any special rules are necessary to accommodate expatriate plans.**