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October 21, 2011

Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Washington, DC
Submitted electronically via the Federal Rulemaking Portal: http://www.regulations.gov

Re: Proposed Rule for Summary of Benefits and Coverage and the Uniform Glossary (CMS-9982-P) and Summary of Benefits and Coverage and the Uniform Glossary–Templates, Instructions, and Related Materials Under the Public Health Service Act (CMS-9982-NC)

Dear Secretary Sebelius,

The Minnesota Council of Health Plans (Council) appreciates the opportunity to comment on the proposed rules for the Summary of Benefits and Coverage and the Uniform Glossary (CMS-9982-P) and Summary of Benefits and Coverage and the Uniform Glossary–Templates, Instructions, and Related Materials Under the Public Health Service Act (CMS-9982-NC).

The Council represents seven nonprofit health plans, which serve more than four million members. Member companies include Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan and UCare. The health plans have pioneered an approach to health care that has improved quality and consumer satisfaction and expanded access to health care throughout Minnesota.

The Council offers the following comments on SBC requirements for individual and group products for your consideration.

The effective date needs to allow for the time necessary for implementation.
The Council urges HHS to allow health plans the time necessary to implement the Summary of Benefits and Coverage (SBC). The Affordable Care Act of 2010 (ACA) and the proposed rule require that the SBCs be in use by March 23, 2012. However, that timing was based on the requirement that the Secretary develop standards no later than March 23, 2011. The intent of the ACA was to allow issuers and employers at least a year to come into compliance. This would have been very tight timing given the challenges inherent in introducing new formats, new content, new processes, and new time frames. However, given that the earliest a final rule will be published is the end of this year, including final templates and instructions, it is impossible for issuers and employers to meet an implementation deadline of March 23, 2012.

The Council recommends that the new SBC requirements go into effect as plans or groups are sold or renewed on or after January 1, 2014. Ideally, issuers should not be required to make these changes until the new market reforms under the ACA go into effect in 2014. With the implementation of the Essential Benefit Set, we

anticipate that there may be additional changes to this document that issuers and employers will need to make. Rather than recreate the form within a year of introduction, it would make sense to move the effective date of SBCs to January 1, 2014. At a minimum, the Council urges HHS to include an applicability date that is at least 12 months after the publication of the final rules in the Federal Register, with recognition of good faith efforts by issuers toward compliance.

Greater flexibility is needed in order to ensure meaningful SBCs.
In order to ensure that the SBC functions as a meaningful consumer tool, we believe it is important that health insurance issuers have the flexibility to modify the SBC to the extent that the template language is inaccurate or misleading.

The Council believes that without greater flexibility, health plans would be required to include language that does not accurately describe its operations. For example, page four of the SBC template directs a member to contact the state agency for appeals information. The Council is concerned that the language is confusing given that health insurance issuers will provide at least a first level of appeal and are the most appropriate initial contact for appeals information.

Additionally, Minnesota has two separate agencies that regulate appeals: the MN Department of Commerce regulates insurance appeals and the MN Department of Health regulates HMO appeals. For some products, it will be necessary to list both regulating agencies because the product has in-network benefits under a product regulated by one agency and out-of-network coverage under a product regulated by the other agency. The template in its current format does not allow for this type of variation.

The Council recognizes that SBCs are meant to provide a uniform means of comparing and selecting health insurance products across a broad and varied spectrum, and we appreciate the goal of maximizing uniformity in order to provide consumers with an effective means of comparison. However, a balance must be struck between uniformity and meaningfulness, the latter of which is greatly diminished if the information provided in the SBC is not accurate. Therefore, we recommend that the final rule provide health plans with greater flexibility to tailor the SBC to the extent needed to provide consumers with meaningful and accurate information.

Premium information should not be included in SBCs.
The proposed rule adds a requirement that premium amounts be included in the SBC despite the fact that this is not required under the ACA. The addition of premium amount to the form is a significant issue for health plans. This essentially requires an issuer to produce an individualized SBC for each request because of the rating variations in today's market. While under the market reforms that go into effect in 2014 these rating variations are limited, there will still be rating variations allowed in 2014 for family size, geographic location, age, and smoking status. Additionally, a product that is offered with different deductible options would require a separate SBC be produced for each deductible level offered. The Council believes it was not the intent of the law to require issuers to produce multiple SBCs for each product offered.

The Council recognizes the need to provide consumers with the information necessary to make informed decisions, which includes the premium. However, it is unnecessary to include premium information in the SBC because issuers and groups already provide consumers with a finalized premium rate once rates are finalized.

Removing the requirement that premium information be included in the SBC would greatly reduce an unnecessary burden on health plans, and still provide consumers with useful and actionable information.

If premium information is required, then at a minimum premium information should not be required for the group market.

The Council supports the policy goal to provide consumers with meaningful information to make informed decisions. However, the total premium amount is not meaningful to employees because this is generally not the amount the employee must pay. Issuers generally do not collect information on employer contribution. Health plans would have to reconfigure their administrative systems to capture and report this information at great administrative expense. In fact many employers consider the employer contribution amount to be company confidential information and prefer to communicate this directly to their employees. Therefore, not only is this information that an issuer generally does not have access to, but it is also information already effectively and efficiently provided to individuals by their employers. In addition, requiring the issuer to include the full premium amount (employer and employee contribution combined) on the SBC could lead to confusion for employees, resulting in the employee actually declining coverage when they see the total premium amount listed without reference to the employee share of premium. In order to reduce confusion, the Council recommends that, at a minimum, premium not be included on the SBC for group health plans.

If premium information is required, in the event that the only change between the initial and final SBC is the premium, then issuers should be allowed to communicate this information in another format.

At a minimum, the Council recommends that where the only change in an SBC is the final premium quote, then issuers should be allowed to communicate this final quote in another format without the requirement to produce a new SBC. In today's market, a direct communication is sent to an individual or group that gives the final premium quote. Even once SBCs are implemented, this is expected to remain a necessary document in order for an applicant to have the opportunity to decide whether to accept the coverage and pay the first month's premium in full and for the applicant to obtain the necessary information on how and when to submit payment. Requiring a new SBC when the final premium quote is the only change is likely to create unnecessary confusion without adding any value for the consumer. As such, the Council recommends that if the premium amount is required in the SBC and the only change between the initial and final SBC is the premium, then this information could be communicated in another format – not through a new SBC.

If premium information is required, this requirement should be deferred to 2014.

In all cases, the Council recommends that any requirement to include premium information should be delayed until 2014 when rating variations are limited. This would reduce confusion for applicants and members and reduce administrative costs to produce and implement the SBC requirements.

Plan issuers should be allowed to fulfill SBC requests in electronic form.

Section 2715(d)(2) of the ACA states that issuers, plan sponsors, and plan administrators may comply with the requirement to provide an SBC by delivering the SBC in either paper or electronic form. The Council strongly supports this flexibility, recognizing the progress many plans have made in controlling administrative costs by moving away from paper-based transactions systems. Therefore, we respectfully request that the provision in section 5a on page 52449 of the preamble, requiring that electronic delivery of the SBC for group health plan coverage meet the Department of Labor's electronic disclosure requirements, be removed in the final rule, or at a

minimum be modified to allow issuers to deliver the SBC electronically unless an individual opts-out and requests paper delivery.

The cost-savings associated with electronic delivery of the SBC are significant. Therefore, we believe it is appropriate (and consistent with section 2715(d)(2) of the ACA granting electronic delivery options for SBCs) to allow issuers to fulfill an individual's request in electronic form regardless of the format in which the request was made, unless the individual requests a paper form. This is consistent with current practice by many issuers for policy delivery, and to the extent that individuals are not inundated with numerous pieces of paper, we believe it is the more consumer-friendly option as well.

Minimize administrative costs by requiring a new SBC to be sent only when necessary to inform the purchaser of significant changes.

The Council recognizes the need for purchasers to be fully informed of plan options. However, if there is no change in benefits, providing a new SBC does not provide additional value to the member. For example, the requirement that a new SBC must be sent to a special enrollee covered under a group health plan is not always necessary. In cases where there is more than one plan option within the group coverage, this makes sense. However, when there is only one plan option available to a special enrollee, a new SBC should not be required because the benefits will not change. As discussed above, any change in premium amount, such as due to the need for the enrollee to move from a single plan to a single plus one plan, should continue to be communicated directly by the employer in a format separate from the SBC. The Council recommends that if benefits do not change, issuers should not have to send a new SBC.

Furthermore, an issuer should not be required to track which version of an SBC an individual has received in order to know when a new SBC must be produced. To minimize administrative costs and reduce consumer confusion, an issuer should only be required to send an SBC at the time of application and a new SBC when the final offer of coverage is provided if there is a change from the original SBC. This would ensure the consumer has the necessary information to make a decision upon application and again before deciding to accept the final offer of coverage. And it would not prevent an individual from receiving an updated SBC at any time upon request.

To avoid unnecessary costs and confusion, SBCs should not be required for every coverage option available to a purchaser.

The Council understands the need to ensure consumers have actionable information about available coverage options. As proposed, the requirement to provide a separate SBC for every plan option will result in unnecessary confusion to consumers. Plan options could include different cost sharing levels and different coverage tiers based on family size, which would result in a significant number of separate SBCs being produced. Not only is this requirement impractical and unnecessarily onerous, but it will have the unintended consequence of overwhelming the purchaser with numerous SBCs that have only slight differences, such as premium amount or deductible levels.

The Council recommends that all cost sharing levels and coverage tiers for a plan be included on a single SBC. This will minimize unnecessary confusion among different SBCs that show only slight differences for the same benefit package. Additionally, to further reduce confusion, the Council recommends that issuers be required to only provide an SBC for one plan option and provide additional SBCs for other plan options upon request.

HRAs should be fully exempt from the SBC requirements.
The Council recommends that health reimbursement accounts (HRAs), as defined by the Internal Revenue Service, that are integrated with other group health coverage be permanently exempted from the SBC requirements. As proposed, the SBC requirements do not address the unique characteristics of defined contribution accounts that are integrated with health coverage. As such, the Council believes that SBCs are unsuitable for use with HRAs.

In the event this requirement remains in the final regulation, the Council recommends HRAs be temporarily exempted from the SBC requirements, allowing for more time to address the differences of these products.

To minimize consumer confusion, the Uniform Glossary disclaimer should be strengthened to not only recognize differences in contract terms but also differences in state law definitions.
The Council greatly appreciates the position within the proposed rules to keep the glossary separate from the terms of the contract and summary plan description. However, we want to raise the ongoing and underlying concern that, to the extent that a state law defines a term differently from the definition in the glossary, it creates confusion and may drive an increase in appeals and external reviews.

In Minnesota, one example of this would be the definition of "reconstructive surgery." In the Uniform Glossary, it is defined as: "Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions." Under Minnesota Statutes, §62A.25, the same term is defined as:

> "Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician."

The Council is concerned that this difference in the definition of terms could create an expectation of coverage that is different from what is actually offered. While the Uniform Glossary and the SBC do include disclaimers, we believe this is a fundamental difference between state and federal law that could result in consumer confusion and may result in increased administrative costs due to more appeals and external reviews. The Council recommends a strengthening of the disclaimer that specifically recognizes the differences not only with contract terms but also potentially with the laws of different states.

The Minnesota Council of Health Plans appreciates the opportunity to offer our comments on these proposed rules for the Summary of Benefits and Coverage. If you have any questions about this letter or if we can provide further assistance, please contact me at 651.645.0099 ext. 14 or brunner@mnhealthplans.org.

Sincerely,

Julie Brunner, Executive Director
Minnesota Council of Health Plans