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Community Service Society | Fighting Poverty Strengthening New York

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Secretary Timothy Geithner
Department of the Treasury

Secretary Hilda Solis
Department of Labor

Secretary Kathleen Sebelius
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Department of Health and Human Service
P.O. Box 8016
Baltimore, MD 21244-1850

Re: RIN 1210-AB52; CMS-9982-P; REG–140038–10

Dear Secretary Sebelius:

The Community Service Society (CSS) of New York writes to comment on the notice of proposed rulemaking (NPRM)on the Summary of Coverage and Benefits Form and Uniform Glossary promulgated under Section 2715 of the Patient Protection and Affordable Care Act (ACA). CSS is a 168 year-old non-profit organization that seeks to address the root causes of economic disparity. Our mission is to promote policies that advance the economic security of working low-and moderate-income New Yorkers by bringing their perspectives to the policy conversation. We work to expand access to affordable, quality care for all New Yorkers, through advocacy and consumer assistance. Community Health Advocates (CHA), New York's state-designated Consumer Assistance Program, is administered by CSS. Over the past ten months, CHA has helped over 30,000 New Yorkers find and use health coverage.

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We commend the Departments for developing standards for Summary of Coverage and Benefits Form (SBC) and Uniform Glossary that will make it much easier for consumers to understand and compare the benefits offered by different plans. We endorse the comments submitted by Consumers Union and the National Health Law Program. Our comments are informed by our experience working with consumers on-the-ground. CHA has helped consumers evaluate and choose plans, and helped consumers navigate the plans they have, for 12 years. CHA staff reviewed the SBC and Glossary and contributed to these comments.

1. All private health plans and health insurance issuers should provide SBCs

The NPRM states that the requirement to provide an SBC applies to group health plans and health insurance issuers offering group or individual health insurance coverage. When consumers use the same form across these settings, as the ACA requires, they can build on their experience with the forms each time they enroll in or use coverage. After the Exchange is implemented, many families will have mixed insurance status – some family members will qualify for public programs, while others will qualify for employment-sponsored coverage, subsidized commercial coverage, or will have to purchase individual coverage at full price. Consumers will also move from one form of coverage to another; one study found that as many as half of newly eligible consumers will have eligibility shifts between Medicaid and Exchange coverage within a year.[1] Consumers should be able to find the same information in the same format, regardless of whether the plan they are looking at is available through the individual market, or an employment-based plan. The vast majority of privately insured people – 150 million non-elderly Americans in 2011 – are covered by employer-sponsored group health plans.[2] These consumers should receive the protection offered by this rule.

Recommendations: We agree that all private health plans should be required to 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. Insurance issuers should also provide SBCs for plans offered to consumers who qualify for public programs. Many states contract with private carriers to administer public health programs. For example, New York State has moved most Medicaid beneficiaries to managed care plans and contracts with commercial carriers to provide subsidized coverage through the Family Health Plus and Healthy NY programs, as well as the NY Bridge Plan (New York's Pre-Existing Conditions Insurance Plan). All of these public health plans should be required to provide SBCs to consumers. The NPRM should also require FEHBP plans to provide this information for federal employees, retirees, and their dependents.

[1] B.D. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," 30 HEALTH AFF. 228-36 (2011).
[2] 2011 KFF Employer Health Benefits Survey, available at http://ehbs.kff.org/

a. All employers should use the SBC template

The proposed rule requests comment on whether the SBC should be incorporated into the Summary Plan Description (SPD) that ERISA now requires.

Recommendations: CSS recommends that the NPRM require all insurers to use the standard template for the SBC that is established through this regulatory process. Providing the SBC as a separate document enables consumers to identify the SBC among other plan documents easily. By the time a consumer calls CHA for help navigating coverage, they have often lost or discarded the plan information they received from an employer or carrier because it was too confusing. The SBC should be a document that consumers find useful enough to retain and easy to identify. The NPRM should require insurers to provide the SBC on a different color or texture paper than the other documents. The SBC should also be clearly marked with a note at the beginning or in a header stating "This document has important plan information. Keep it in a safe place."

b. 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 NPRM 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) which requires employers to provide written notice to employees whether the group health plan has an actuarial value of at least 60 percent. In addition, the NPRM 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.

c. Private health insurance issuers concerns about cost are unfounded

The NPRM should reject plans' cost concerns about producing this form. We agree with the NPRM approach, in which 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.

The benefits to consumers will be substantial. Requiring all plans to use the same form will make it easier for Navigators to help consumers, many purchasing coverage for the first time, to efficiently sort through their options and find the best plan for their family. Once

consumers have coverage, whether through the Exchange or through work, advocates at Consumer Assistance Programs will be able to help consumers understand how to use their coverage more effectively. Consumers and advocates can quickly determine through these materials whether a consumer's plan meets the required minimum essential benefits standard.

2. Effective date for compliance with SBC requirements

The NPRM seeks comment on the feasibility of timely implementation of Section 2715 requirements. 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. And Consumer Assistance Programs will benefit from having time to familiarize staff and clients with the SBC before 2014. CHA has already begun preparing for the huge increase in need for consumer assistance that we expect to see when the New York Exchange goes online. Implementing SBC by March 23, 2012 will allow CHA advocates to begin using the forms to educate consumers before this influx begins. And timely implementation of Exchanges and other key reform initiatives will require the availability of information contained in the SBCs.

Recommendation: We strongly urge prompt publication of a final rule with the requirements of this section taking effect no later than March 23, 2012, as the ACA requires. 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.

3. Providing the SBC to consumers: timing

The NPRM outlines the requirements for when an insurance issuer must provide the SBC to a participant or potential participant in a plan. It requires 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 provides details about when an issuer must provide the SBC to a group health plan or individual in a variety of situations.

Recommendations: We agree with the NPRM that 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 that 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 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.

- For individual plans, the SBC should be provided to prospective enrollees with any marketing materials, 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.
- The NPRM should require issuers to provide the SBC on request at any time to a consumer if they misplace, damage or lose the document.
- If an applicant's final premium quote is different than the premium cost information provided in the SBC the insurer should issue an amended SBC that provides the updated premium information for their plan.

4. Providing the SBC to consumers: format

The NPRM requires that the issuer provide an SBC in paper form. The SBC may be provided in electronic form if additional conditions are met, and must provided in paper form on request.

Recommendations: The NPRM should specify that paper form is the 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.

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 seven days of sending the electronic copy of the SBC.

We also recommend that the SBC for each benefit package offered by an 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 and may result in consumers requesting SBCs for fewer plans or insurance products.

SBCs posted on state Exchange websites and on healthcare.gov should be posted in a uniform format across issuers 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.

5. Literacy and language requirements

SBCs will not be useful unless all consumers, regardless of their primary language, disability status, or literacy level, are able to read and understand the information presented.

a. Plain writing

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 concepts commonly used in health coverage.[3] Plain writing is consistent with the requirement in Section 2715(b)(2) that the SBC "utilizes terminology understandable by the average plan enrollee." Using plain writing will make it easier for individuals to understand and compare plan features.

b. Consumers with visual disabilities

The NPRM does not address making the SBC accessible to consumers with visual impairments.

c. Language access

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 (hereainfter "appeal rules").[4] The appeal rules provide that, in counties in which at least ten percent of the population

[3] *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.

[4] 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).

residing in the county is literate in only the same non-English language, both translation and interpretation services must be provided upon request.[5]

We strongly oppose 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.

We recommend that the NPRM 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 consumers in the plan's service area or workforce, 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. It is also consistent with New York State law.

Further, the Departments should ensure that the translation is adequate and not done through machine translation, which does not produce accurate translations. Exchanges, QHPs, and others should use best practices as recognized by the American Translators Association (ATA) for translating documents,

The NPRM should adopt a 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.

The NPRM 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. This should be a requirement regardless of whether a translation threshold is met. Plans that operate in California are already required to do so and have adapted to this without undue burden.

[5] 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136(e).

The NPRM should indicate that the Departments will provide tagline language and translations for plan usage if plans did not wish to develop their own. 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.

The NPRM should require that, once a consumer has requested materials in another language, all subsequent communications with that consumer should be in the non-English 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 interpretation – 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.

Recommendations: Before the Secretary authorizes the SBC and uniform glossary, HHS should:

- contract with recognized literacy/plain writing experts to test the proposed SBC and uniform glossary templates for language, structure, and layout
- focus test the revised forms with the intended audience
- make appropriate revisions

The rules should require insurers and plans to include a tag line explaining that the SBC is available in alternative formats for people with low vision or blindness including Braille, large print and audio, and explaining how to obtain a copy. All websites must be Section 508 compliant and compatible with assistive products, including screen readers that translate the content of a computer screen into automated audible output and refreshable Braille displays.

The Departments should also require plans to competently translate the SBC into any language which comprises five percent or 500 LEP individuals in the plan's service area or workforce. The NPRM should require plans to:

- provide oral language services – through competent bilingual staff or interpreters – for all LEP individuals with questions about the SBC
- provide taglines in 15 languages with all SBCs
- use HHS-provided translation of the SBC glossary into the top 15 languages

6. Ensuring accuracy

The NPRM should clearly state that a will be held harmless or permitted to obtain coverage if the consumer either obtains services in reliance on the SBC or seeks services for which the coverage is misstated in the SBC. 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. Monitoring the accuracy of SBCs is critical to ensuring that they accurately represent coverage options.

State consumer assistance programs can be very helpful in tracking the efficacy of the SBCs. 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. We encourage the NPRM to resource CAPs to fill this function through federal resources or federal Medicaid matching funds.

Recommendations: The NPRM should provide implementation and a compliance timeline for plans and issuers by March 23, 2012. It should require a consumer feedback line for complaints on the SBC itself. The NPRM should require state insurance departments to establish consistent guidelines, using state consumer assistance programs to assist in the compilation of complaints. In the case of individual insurance, state insurance departments should review the typical plan SBCs initially and when there is a material change to the SBC. Employers should be engaged in ensuring accuracy. State insurance departments, HHS and DOL should conduct coordinated and random audits on a periodic basis to test the SBC coverage examples.

7. New and modified disclosures

a. New disclosures should be added

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.

Recommendation: Consumer-test the language and best placement for the following <u>new</u> 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.
- Explanation of applicable pre-existing condition rules.

b. Is the coverage at or above 60 percent allowed costs (60 percent actuarial value)?

The NPRM seeks guidance on how the SBC should notify consumers whether an employer-sponsored plan provides 60 percent actuarial value. The 60 percent actuarial value threshold is a standard that is widely used by the ACA and one that consumers should become familiar with. 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 percent of the total allowed costs for the benefits listed in the policy" will NOT work.[6] Testing found that consumers "skipped over" this information or did not understand it. These testing results illustrate the value of rigorously consumer testing all warnings and disclaimers.

Recommendations: Consumer-test language and placement for the 60 percent disclosure. Disclosure language must reveal the purpose of the disclosure and use terminology understandable for most consumers.

c. 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 the 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: The NPRM should require plans to use successfully consumer-tested 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.

d. Does the premium exceed 9.5 percent of income?

The NPRM should require plans to notify consumers that they might qualify for subsidized coverage if the premium exceeds 9.5 percent of their income. If a consumer is offered

[6] *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

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 9.5 percent of income[7] 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: 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.

8. Additions and changes to the summary of benefits and coverage template

We support the many detailed recommendations provided in the Consumers Union and NHeLP comments. The following comments take into account our experience in helping consumers enroll in and navigate their coverage.

a. Include premium information on SBCs

Premium information should be included on SBCs for non-group health insurance policies for individuals and families and cost of coverage information be included for enrollees in group health plans. A primary purpose of the Affordable Care Act is to get insurers to compete on the basis of 'value' and 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.

Recommendation: The SBC must contain information about the health plan premium/cost of coverage for consumers.

b. Non-network providers providing care in in-network facilities

One of the most common preventable billing problems that CHA clients face is unexpected out-of-network charges incurred because the consumer did not understand the plan's

[7] Or "wages" if changed pursuant to http://hr.cch.com/news/benefits/092011.asp.

requirements, or because the consumer did not realize that a provider at an in-network facility did not belong to the plan network. As a common "trap" experienced by consumers, the SBC should take steps to address this.

Recommendations: The NPRM should require plans to use consumer-tested standard language to convey the warning that out-of-network specialists are often used by in-network providers. The NPRM should 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. The NPRM should include an example of an in-network ER visit, combined with an out-of-network ER physician, unless consumer testing shows another example would better meet this need.

c. Coverage examples

Consumer testing of the prototype coverage examples found the examples to be extremely valuable to consumers.[8] They provided a sense of how much the plan would pay for certain conditions – information that consumers couldn't calculate on their own. In light of their value to consumers, the NPRM should require the inclusion of six medical scenarios in the SBC beginning immediately in 2012. 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, rehab services, etc. Selection of coverage illustrations should show consumers how these coverage differences work under each plan.

We strongly oppose changing the NPRM to allow insurers to provide only raw information about coverage features that consumers would then use to generate their own

[8] 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.

coverage illustrations. This would be unfair and would ensure that few if any consumers would ever be able to obtain this information. The NPRM 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 would also strongly oppose this change. 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.

Recommendations: The NPRM should require inclusion of six medical scenarios in the SBC beginning immediately in 2012. Six examples should be chosen for their relevancy to as wide and diverse a population as possible. The NPRM should also 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.

9. Additions and changes to the glossary of health insurance and medical terms

a. Additional terms

Consumer testing[9] 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.

Several consumer testing studies[10] 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." We also suggest adding a consumer-tested definition of "covered

[9] *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

[10] 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

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: The NPRM should require 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. The NPRM should also 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

b. Definition of "medical necessity"

The definition of medical necessity in the NPRM should 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 problem. Some states have statutory definitions of "medical necessity" that should be substituted in those states.

Recommendation: The definition of medical necessity should be amended to add the word "condition" in listing, as follows "… illness, injury, disease, condition, or its symptoms…"

10. Additions and changes to the insurer instructions

The NPRM instructions for insurers on how to populate the SBC remain unclear in some respects. We support the many recommendations made in the Consumers Union and NHeLP comments. Our comments, below, reflect our experience with the needs of consumers in New York State.

a. Timing instructions

The NPRM instructions to insurers do not clearly explain that the insurer must provide the form to consumers who are shopping for insurance. Insurers might argue that they are only required to provide the SBC when a consumer expresses an intention to enroll. The instructions also do not clarify when an insurer must make the form available on an electronic site.

Recommendation: The NPRM should 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 throughout the document. Moreover, the NPRM should 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 NPRM should include language that makes it clear that a policy or certificate holder can request a copy of the SBC and receive it at no charge, if they lose their original copy.

b. Recommendations regarding networks and provider information:

The NPRM should clarify the instructions regarding networks and provider information. Consumers need to understand what providers a plan provides access to, and at what cost, before choosing a plan.

- Consumers must be told the name of the network to search under when accessing the insurer's 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.
- This section should require plans to indicate what percentage of the providers who are in-network speak languages other than English, broken down by language. The website they are referred to should allow consumers to sort providers by language.
- Information about out-of-network charges 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 common problem, especially for people with Exclusive Provider Organization plans that do not pay anything at all for out-

of-network care. The information that a carrier provides in this section should reflect any State law governing the plan, as State laws vary widely on this issue.

- 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.

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

In sum, while we are encouraged that some elements of the Proposed Rule will enhance consumer information and understanding, we believe that a number of improvements can be made. If you have questions about these comments, please contact Elisabeth Benjamin at ebenjamin@cssny.org or (212)614-5461 or Carrie Tracy at (212)614-5401. Thank you for consideration of our comments.

Sincerely,

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