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October 21, 2011

Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
Washington, D.C.

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)

Submitted electronically via the Federal Rulemaking Portal: http://www.regulations.gov

Dear Secretary Sebelius,

HealthPartners appreciates the opportunity to comment on the Notice of Proposed Rulemaking regarding 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). HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation, providing care, coverage, research and education to improve the health of our members, patients and the community. Founded in 1957, the HealthPartners (www.healthpartners.com) family of healthcare companies serves more than one million medical and dental health plan members. The HealthPartners family of healthcare organization employs more than 800 physicians, including 300 primary care providers. Through more than 50 medical clinics, 17 dental clinics and 4 hospitals in Minnesota and Western Wisconsin, we provide integrated health care focused on achieving the Triple Aim – simultaneously optimizing the experience of the individual, the health of the population and the cost of care.

In framing our responses to this proposed rule, HealthPartners is committed to providing useful, transparent and timely information to our prospective and existing members. Below we provide two general comments and several specific comments related to various requirements in the rule.

General Comments:

1) **Effective date of provisions should allow for implementation time**

   HealthPartners 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, the timing set forth by the ACA 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 one year to comply with the new requirements. 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, including final content, templates and instructions will be published is less than five months from the required compliance date, issuers and employers will not be able to fully meet an implementation deadline of March 23, 2012.

HealthPartners recommends that the new Summaries of Benefits and Coverage go into effect as plans or groups are sold or renewed with an effective date of January 1, 2014. We recommend that the SBC changes be implemented when 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 required in the SBC that issuers and employers will need to make. Rather than recreate the form within one year of introduction, we encourage the department to consider changing the effective date of SBCs to January 1, 2014. In the alternative, we urge HHS to include an applicability date that is at least 12 months after the publication of the final rules in the Federal Register and recognize issuers' good faith efforts toward compliance.

2) Electronic provision of materials should be prioritized

HealthPartners has engaged in significant efforts over the last several years to drive toward paperless options for our members to the extent permissible under the Department of Labor's electronic disclosure safe harbor. We have implemented Secure Web Mail capabilities for our members to access key benefit and coverage documents, online provider directories and other important member information. Our members appreciate this stewardship of resources.

Plan issuers should be allowed to fulfill SBC requests in electronic form. The cost-savings associated with electronic delivery of the SBC are significant. 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 (opt-out). This is consistent with current practice by many issuers for policy delivery.

We are working hard to keep our administrative costs low to make premiums more affordable for enrollees. The more required documents that we can distribute to members/consumers electronically the more environmentally sustainable, efficient and cost-effective we can be and, to the extent that individuals are not inundated with numerous pieces of paper, we believe it is the more consumer-friendly option.

Specific comments on Summary of benefits and coverage and uniform glossary (DOL §2590.715–2715; IRS §54.9815–2715; HHS § 147.200)

As a consumer-governed organization, we reviewed the proposed regulation with our members in mind. Our comments identify areas where we believe the proposed rule adds only minimal value to our members' experience while adding administrative expenses that unnecessarily increase costs for everyone.

- ***Summary of benefits and coverage – Provision of SBC - Special Enrollees (§2590.715-2715(a)(1)(ii)(D))***

  HealthPartners 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 enrollee. 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 below, any change in premium amount, such as when an enrollee changes from a single coverage to a single-plus-one coverage, should continue to be communicated directly by the employer in a format separate from the SBC. We recommend that if benefits do not change, issuers should not have to send a new SBC. We recommend this to both reduce consumer confusion and to keep administrative costs low.

- ***Content - Premium (§2590.715-2715(a)(2)(i)(M))***

1. The proposed rule adds four new elements that were not required under the ACA. Most challenging among these is the requirement that premium amounts be included in the SBC. The proposed rule requests comments regarding whether the SBC should include premium or cost information. **We strongly recommend that premium not be included in the SBC – especially not for group health plans**.

   HealthPartners 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 cost information once rates are finalized. Removing the requirement that premium information be included in the SBC would greatly reduce unnecessary burden on health plans, and still provide consumers with useful and actionable information.

   If premium information is required, at a minimum, it should not be required for the group market. In the group market, we believe that the total premium amount is not meaningful to consumers as that is not the amount they pay for coverage. Through the new W-2 reporting requirement, enrollees can learn what that amount is if they are interested. We are concerned that members may be confused and actually decline coverage when they see the total premium amount listed without reference to the amount the employer contributes.

   What is truly important is the amount that the employee will have to pay for their portion of the premium (total premium less employer contribution). However, plans generally do not collect information on employer contribution. In fact many employers consider this to be company confidential information and prefer to communicate this directly to their employees. Therefore, it is not information that an issuer has access to.

   It seems clear that the Departments appreciate this challenge. The "Instructions" for the SBC (page 52496) indicate that both the initial form and final form include in the "answer' column the statement : "*Please contact your employer for your share of the premium"*. This is in recognition of the facts above. Given the issues with contribution and the potential for consumer confusion of providing the total premium, **we recommend that total premium NOT be included on the SBC for group health plans.** At the very least, the final rule should clarify any inconsistency between what is proposed in the rule and what is reflected in the Appendix and the Instructions – currently issuers lack a clear picture of how or if premium should be included in the group market SBCs.

2. The same section of the preamble specifically request comments on whether there is an easily understandable and useful way to communicate final premium quotes, other than sending a new SBC. We suggest the following approach in the individual market. We do not present an

option for the group market as we advocate above that premium should not be included on group health plan SBC.

For individuals, HealthPartners sends a direct communication (electronic or paper) to applicants with the final premium quote. This simple and direct communication allows an applicant to clearly recognize the final premium quote in order to decide whether to accept the coverage and explains to the applicant how to pay the first month's premium. Replicating the full SBC to simply communicate the final premium may actually cause more confusion for members because it will not be clear to a member receiving "second" full SBC without closely comparing the documents, what has actually changed. Even if an issuer is required to send the full SBC a second time, the issuer would likely also send a communication to address the final premium offer and how and when accept coverage and submit payment. Therefore, sending a full SBC is not a "value add", but rather an additional expense and source of confusion for applicants. We recommend that **if the only change between the initial and final SBC is the premium level in the individual market, then that change should not be required through a delivery of a new full SBC.** Issuers may decide that that is the way they wish to communicate the change, but it should not be required.

- ***Summary of benefits and coverage and uniform glossary-Each Benefit Package (§2590.715-2715(a)(1))***

  We have concerns about the requirements that every mention of a different plan option with a prospective applicant or agent would trigger a requirement to send a new SBC (each which would include a different calculated premium). Typically, when a consumer or agent contacts an issuer to discuss plan options, they discuss a variety of options with many questions about benefits and costs. In a paper environment, this requirement is impractical and infeasible. We recommend that the issuer and the caller be allowed to mutually agree what SBCs will be most useful and that only those agreed upon SBCs need to be sent. As an alternative, if a plan complies with HealthCare.gov filings then the issuer should only be required to fulfill the SBC for the plan applied for after the issuer receives a paper application. (Note: Electronic submissions are by their nature different and issuers will be able to meet the pre-application requirements in an online environment).

- ***Uniform Glossary* ((§2590.715-2715) (c)**

  HealthPartners greatly appreciates the position within the proposed rules to keep the glossary separate from the terms of the contract or summary plan description. However, we want to raise the **ongoing and underlying concern that, to the extent a state law defines a term differently from the definition in the glossary, it may create confusion and drive an increase in appeals and external reviews.**

  In Minnesota, one example of this is 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."

HealthPartners is concerned that this difference in the definition of terms could create an expectation of coverage that is different than what is actually offered. And although the Uniform Glossary and the SBC include disclaimers, we believe that this fundamental difference between state and federal law definitions will result in consumer confusion and increased administrative costs due to more appeals and external reviews. We **recommend that**:

- the glossary terms as defined in the proposed rule be mandated only when there is not an existing state law definition that will suffice, OR
- the glossary's disclaimer be strengthened to specifically recognize differences not only with contract terms, but also potentially with the laws of some states.

- ***HRAs should be fully exempt from the SBC requirements.***
  HealthPartners 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 health reimbursement accounts (HRAs). In the event this requirement remains in the final regulation, we recommend that HRAs be temporarily exempted from the SBC requirements, allowing for more time to address the differences of these products.

- ***Costs and Resources***
  Finally, we want to express our concern that the estimated cost and hour burdens illustrated in the proposed rule are low – particularly in light of the tight timeline for implementation, the requirement that the SBC must be a standalone document and the number of documents that must be supplied on paper and at an increased frequency. Our current process puts all materials together into one document as a cost-savings mechanism for required mailings and our machinery does not accommodate separate standalone pieces. We have done our own estimate of costs and that analysis indicates that the costs would be significantly higher than those projected in the proposed rule.

HealthPartners appreciates the opportunity to offer our comments on the proposed rules for the Summary of Benefits and Coverage. If you have any questions or if we can provide further assistance, please feel free to contact me.

Sincerely,

Donna Zimmerman
Senior Vice President, Government and Community Relations, HealthPartners