



UnitedHealth Group

October 21, 2011

Submitted Via Federal Rulemaking Portal: <http://www.regulations.gov>

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW Room 445-G
Washington, DC 20201

RE: CMS-9982-P; Notice of Proposed Rulemaking Related to the Summary of Benefits and Coverage and the Uniform Glossary

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Department of Health and Human Services, Department of Labor (DOL) and Department of the Treasury (collectively, the Departments) with our comments on the Notice of Proposed Rulemaking (NPRM or the Proposed Rule) related to the Summary of Benefits and Coverage and the Uniform Glossary (76 Fed. Reg. 52442, August 22, 2011). The NPRM implements provisions in the Patient Protection and Affordable Care Act (ACA or the Act), which requires group health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) that describes the benefits and coverage available to applicants and enrollees.

UnitedHealth Group is dedicated to making our nation's health care system work better. UnitedHealth Group's 87,000 employees serve the health care needs of more than 75 million Americans, funding and arranging health care on behalf of individuals, employers and government, contracting with more than 5,300 hospitals and 730,000 physicians, nurses and other health professionals. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan – serving one in five seniors nationwide – and the largest Medicaid health plan, supporting underserved communities in 24 states and the District of Columbia. Recognized as America's most innovative company in our industry by *Fortune* magazine, we bring innovative health care to help create a modern health care system that is more accessible, affordable and personalized for all Americans.

United strongly supports the goals of the Act to ensure that consumers have easy-to-understand information about the health care coverage options available to them. We currently provide our customers with summary materials and on-line tools that enable individuals, employers and their

employees to make informed decisions when selecting and using their coverage. Based on our extensive experience working with individuals, employers and all stakeholders in the health care delivery system, we believe the NPRM fails to achieve the goal of providing meaningful coverage information and additionally may cause more consumer confusion and uncertainty related to purchasing decisions. The NPRM creates significant risks and challenges for plans and insurers, and, as outlined below, the cost estimates relative to implementation for employers and insurers is significantly underestimated. We believe that the significant implementation hurdles, the uncertainty of the final rule compared to the NPRM, and the cost impact to employers and insurers with no proven corresponding value to consumers calls for significant changes to the Final Rule to achieve the goals of the Act.

Provide Sufficient Time for Implementation of Significant New Requirements

The March 23, 2012 compliance deadline is an extremely short timeframe to require group health plans and health issuers to implement the significant operational and technology changes proposed by the NPRM. We believe it is important to note that the ACA provided for a 12-month implementation timeframe between Department issuance of rules and the effective date of the requirements.¹ This 12-month period is the minimum amount necessary to implement the business process and technology changes necessary to implement Section 2715, and is dependent on the final requirements for the SBC and Coverage Example format, distribution requirements and many other factors.

Plans and issuers are unable to make needed changes for implementation without confirmation of the final rules. While we acknowledge that plans and issuers could proceed with implementation based on the proposed rules, we are concerned that this would require expenditure of resources based only on proposed requirements and for technology/operational changes that may prove inadequate or unnecessary.

For example, the proposed SBC template requires information not available at the time of SBC production due largely to the lack of consumer or customer information, including: premium amounts, references to state Offices of Consumer Assistance, references to availability of translated plan documents, and website links to policy, formulary, network and Uniform Glossary information. As discussed in our detailed comments, we believe the depth of information to be included in the SBC is not only redundant of current information already provided to consumers, but also could cause consumer confusion and frustrate the goals of the SBC. Significant reprogramming and process changes are required to pull this new data into the SBC, and the March 23, 2012 effective date does not provide adequate time to complete this implementation, let alone additional changes should the Final Rule modify the data elements.

We respectfully request that the Departments immediately issue guidance advising plans and issuers that the enforcement of all Section 2715 requirements will be delayed for at least 12 to 18 months following issuance of the final rule, consistent with the DOL's implementation of the final claims regulations in November 2000. This delay will provide the Departments and

¹ The Act provides that the Departments promulgate rules implementing a Final Rule within one year of enactment of the Act (on or about March 23, 2011). We request that the Departments explain the complex reasons they faced in issuing a Final Rule by the deadline. We think that such an understanding is relevant to, and supports the basis for, delaying implementation.

stakeholders further time to study other challenges raised by the NPRM. In addition, we urge the Departments to consider implementing the requirements – following the delay – by phase-in based on plan and policy renewal dates.

Undertake Review of Significant Open and Operational Issues Prior to Implementation

As you will see in our detailed comments below, we believe there are numerous, significant issues that the Departments should consider as they establish requirements for the SBC, Coverage Examples and Uniform Glossary. While we support the Act’s goals to enhance disclosure and improve consumer decision-making, we believe it is equally important to pursue these objectives in a manner that considers:

- Whether consumers will use and understand the SBC in a way that improves their ability to compare, choose and then use their insurance coverage;
- How the SBC will add to the coverage education and summary materials that consumers may already receive;
- How and when the SBCs will be produced during the coverage selection process and through various distribution channels;
- Whether consumers will understand the cost illustrations in the Coverage Examples or obtain more useful information through other plan tools;
- How to ensure that the SBC contents and delivery requirements are meaningful to consumers and do not add confusion to their selection decisions; and
- The potential cost impact of implementing the proposed requirements on employers and consumers.

In addition to considering these specific issues, we request that the Departments reevaluate the burden estimate developed as part of the Regulatory Impact Analysis required by the Paperwork Reduction Act (PRA). The Departments estimate \$50 million in annualized costs for the years 2011 to 2013 only, indicating that costs beginning in 2014 and later are difficult to project given the significant changes in the marketplace. We are concerned that the Departments’ analysis significantly underestimates the cost impact, based on our preliminary analysis and a survey conducted by America’s Health Insurance Plans (AHIP). The AHIP survey, which is detailed in their separately submitted comments, indicates that the cost impact may be three to four times the amount estimated by the Departments.

The Departments’ burden estimate and assumptions do not appear to accurately represent the impact of the Proposed Rule and the capital, technology and resource costs associated with implementation. We urge the Departments to consider the following:

- The burden hours estimated for industry start-up implementation and ongoing production are extremely low and already exceeded by the staff hours spent analyzing and preparing for implementation of the Proposed Rule. The Departments erroneously assume that “[b]ecause the SBC disclosures are closely related to disclosures that issuers and TPAs provide today as a part of their normal operations (e.g., information on premiums, covered benefits, and cost sharing), the incremental costs of compiling and providing such readily available information in the proposed, standardized format is estimated to be modest.” In fact, plans will be required to implement significant technology and business

process changes to pull information from multiple sources into the SBC and establish new distribution processes to meet the NPRM's requirements.

- The Departments' projected 90 million SBCs for distribution in 2012 underestimates the volume of new materials that must be produced, printed and mailed. Based on the Proposed Rule's distribution requirements and our preliminary internal estimates, we estimate that as many as 164 million SBCs could be produced for calendar year 2012. This estimate is conservative and does not include SBC distribution due to special requests.
- Capital costs are also underestimated based on the low SBC projection and failure to account for postage costs resulting from paper SBC distribution. While the Departments assumed that distributing paper SBCs would not incur mailing costs because the document would be sent with other plan collateral materials, the analysis did not account for the new requirement on issuers to deliver SBCs to both employer groups and their employees prior to enrollment. Because distributing enrollment materials to employees is typically handled by the employer rather than the insurer, requiring SBC distribution to employees during open enrollment would result in a new business process and mailing costs.

We urge the Departments to obtain additional information about the business, staffing and technology resources and costs necessary to implement the Proposed Rule. We believe that the cost impact and concerns raised above can be addressed through further discussions between the Departments and employers, consumers, insurers and other interested parties. Such discussions will also produce alternative approaches – including those recommended in our detailed comments – that would meet the Departments' objectives, reduce the cost impact to employers and subsequently to consumers, and result in a document that is beneficial to consumers and does not add confusion to the purchasing experience.

Summary of Additional Recommendations

In addition to these pressing concerns, we have outlined below our specific recommendations to the Departments, each of which is further detailed in the attached document. We would be pleased to provide additional data and information supporting the comments offered in this letter.

- Evaluate whether the proposed SBC template can accommodate innovation in health care benefit design;
- Use the Plan Finder website to provide plan information to consumers “shopping” for coverage, consistent with the language in the Act;
- Streamline SBC production by simplifying the proposed SBC template and enabling one SBC form for distribution;
- Remove premium information from the SBC as it is not required by the Act and cannot be presented in a manner useful to consumers;
- Establish a safe harbor permitting SBC distribution by employers, labor organizations and producers, consistent with current business practices;
- Establish rules that encourage electronic SBC delivery, consistent with the distribution of other important documents to individuals;
- Consider alternative means to provide Coverage Example information, including consideration of other technologies and existing plan cost estimator tools;

- Consider how the SBC requirements will work with coverage comparison and educational tools already provided in the large group and self-funded market segments;
- Confirm that certain plan changes are not subject to the 60-Day Advance Notice of a Material Modification;
- Ensure that SBC distribution allows for ongoing coverage selection and negotiation processes and does not limit employer group coverage choices;
- Ensure that the SBC, Uniform Glossary and Coverage Examples all retain clear disclaimer language indicating that the materials are for educational purposes only and do not replace or supersede the plan's policy documents;
- Evaluate use of the SBC in benefit carveout arrangements where multiple plans and issuers manage benefits;
- Maintain the Uniform Glossary on a government website, in order to ensure uniformity in the document;
- Clarify that states are not allowed to modify the SBC to facilitate uniform comparisons of benefits and coverage options;
- Exclude expatriate plans and executive medical plans from the SBC and Uniform Glossary requirements;
- Refrain from adding additional data elements to the proposed SBC template at this time;
- Establish reasonable parameters for providing the SBC upon request;
- Clarify SBC distribution requirements for individuals with conversion and continuation of coverage policies; and
- Revise instructions recommended by NAIC to reflect the issues outlined in the aforementioned comments.

Finally, we have also attached suggested technical changes to the SBC template, Coverage Example template and Uniform Glossary.

On behalf of the 75 million consumers served by UnitedHealth Group, we thank you for your thoughtful consideration of our comments. Please do not hesitate to contact me if you have any questions regarding our recommendations.

Sincerely yours,



Thad C. Johnson
 General Counsel
 UnitedHealthcare Employer & Individual

Attachments

**Detailed Comments Regarding the
Summary of Benefits and Coverage and the Uniform Glossary**

1. The Departments should delay and phase-in implementation of the Summary of Benefits and Coverage and Coverage Examples.

The Notice of Proposed Rulemaking (NPRM or the Proposed Rule) solicits input on the factors that may affect the feasibility of implementing these requirements within the timeframe (effective on or after March 23, 2012) generally provided for in the Patient Protection and Affordable Care Act (ACA or the Act). The Act also provides that the Departments will promulgate rules implementing this provision within one year of enactment of the Act (on or about March 2011). In fact, the Departments released the Proposed Rule on August 22, 2011 – only seven months prior to the Act’s specified effective date – and the employers and issuers still await final requirements.

The requirements in the NPRM will require group health plans and health issuers to implement significant operational and technology changes, which depend on final requirements regarding Summary of Benefits and Coverage (SBC) format, SBC content, production and distribution rules for different market segments, degree of flexibility in the SBC format, Coverage Example format and model, and many other factors. While all of these factors will require business process and technology changes, plans and issuers are unable to make these changes or deploy financial and staffing resources for implementation without confirmation of the final rules. While we acknowledge that plans and issuers could proceed with implementation in anticipation of a March 2012 compliance date, we are concerned that this would require expenditure of resources based only on proposed requirements and for technology/operational changes that may prove inadequate or unnecessary.

We believe it is critically important for the Departments to provide plans and issuers with sufficient time to implement changes necessary to develop and distribute the SBC and Coverage Examples, based on the final requirements published by the Departments. We respectfully request that the Departments provide for a delayed implementation and phase-in of the final requirements. In November 2000, when the Department of Labor (DOL) implemented the final claims regulations, it provided covered plans and issuers a period of 18 to 24 months to come into compliance. The additional time was granted in recognition of the costs and burdens of the new rules. Such an accommodation, among other possible ones, should be considered here.

Recommendation: In order to provide plans and issuers with the time necessary to implement the significant and necessary technology and business process changes, we recommend that the Departments consider the following approach:

- Provide for a non-enforcement period for 12 to 18 months following issuance of the Final Rule, during which time plans and issuers would be deemed compliant with all requirements of Section 2715 based on data submission to the Plan Finder. This deemed

compliance approach is based on the provision in the NPRM related to the individual market.

- Following the non-enforcement period, provide for a phase-in of SBC requirements upon policy or plan renewal dates.

2. The Departments should evaluate whether the proposed SBC template can accommodate innovation in health care benefit design.

The NPRM invites comments generally on the proposed SBC template, as well as the applicability of the SBC template for use with different types of plan or coverage designs. We appreciate the challenge faced by the NAIC Working Group and the Departments in developing a standard template to summarize coverage information, particularly with the limitations imposed by the statute (i.e., no more than 4 pages in length, at least 12-point font). However, we are greatly concerned that the proposed SBC template will not accommodate the tremendous variation in health care benefit design offered in today's marketplace to provide consumer choice.

For example, in response to customer demand, United offers a tiered network HMO plan which offers three distinct physician networks, all with different premium contributions, copayments and other benefit features. Enrollees are allowed to select primary care providers from any of the tiered networks and are then subject to the benefits associated with that tier, based on summary information provided in their schedule of benefits. We are concerned that the proposed SBC template would not allow for a summary of the coverage information in a way that would be understandable or sufficient to describe the benefits and cost sharing.

United also offers the Diabetes Health Plan, a value-based insurance design offered by employers to their diabetic or pre-diabetic employee populations. The plan helps enrollees with diabetes improve their health and avoid complications associated with diabetes by offering a benefit design that incents the use of important health care services and medications. This benefit design, which varies cost sharing for certain services related to diabetes treatment and select physicians who deliver those services, would also prove extremely difficult to summarize in the proposed SBC template in a manner understandable to consumers.

These products are only two of the many benefit designs currently offered to employer groups, labor organizations and individuals, which vary significantly from conventional PPO or HMO products and are the product of customer demand for high quality, affordable health care. It is critically important that the SBC requirement does not stifle this innovation in product design or hamper consumers' understanding of how their coverage works.

Recommendation: We strongly urge the Departments to evaluate the myriad benefit designs offered in today's market and ensure that the Final Rule adopts a SBC template that is sufficiently flexible to summarize these benefit and coverage features. An inflexible SBC template could curb product innovation due to concerns over enforcement actions related to SBC content. The Departments would have sufficient time to consider this issue and potential SBC template revisions during the 12 to 18-month non-enforcement period recommended earlier.

3. The Departments should use the Plan Finder website to provide plan information to consumers “shopping” for coverage, consistent with the language in the Act.

HHS has developed the Plan Finder (www.healthcare.gov) website as a tool for individual consumers and small employers to review coverage options in their area. The Plan Finder tool is currently expanding the data available about coverage options in order to provide consumers and small employers with benefit and premium information for the plans they are considering. Using the Plan Finder website as a method to provide plan comparison information to “casual shoppers” (i.e., prior to application or enrollment) best utilizes this new government resource and allows plans and issuers to focus on SBC distribution once consumers have applied for coverage.

When considering distribution to individuals and small groups selecting coverage, it is important to recognize that the role of brokers, other producers and other coverage selection resources typically means that plans and issuers do not have any information about the individuals or small groups applying for coverage prior to receiving an application from an individual or prior to a small group’s enrollment in the plan. Using Plan Finder as a mechanism for individuals and small groups to obtain plan comparison information prior to application addresses this issue.

This approach is supported by the language in the Act, which requires plans and issuers to provide the SBC “to applicants, enrollees, and policyholders or certificate holders,” and not to casual shoppers who have not yet applied for coverage. The Act also requires the SBC to be provided for the first time “to an applicant at the time of application and to an enrollee prior to the time of enrollment or reenrollment,” not upon request for information about the health coverage. We believe the Departments should observe the statutory intent by eliminating any requirement to provide the SBC to individuals or groups requesting information prior to applying for coverage.

The NPRM also provides that an insurer offering individual health insurance coverage that complies with the requirements set forth at 45 CFR § 159.120 (relating to the federal health reform Web portal) is deemed to comply with the requirement to provide the SBC to an individual requesting information prior to applying for coverage. If the Departments do not eliminate the requirement to distribute the SBC to individuals or groups prior to application, we strongly recommend that the Departments extend the deemed compliance referenced above to plans and issuers offering small group health insurance coverage, since this data is also being collected for display on the Plan Finder website. This deemed compliance would apply to all SBC distribution requirements for individual and small groups prior to application in the plan. With regard to SBC distribution to large or self-funded groups, we recommend that the Departments study this issue further as outlined in item #10 below.

Recommendation: We recommend that the Final Rule eliminate any requirement to provide the SBC to individuals or small groups requesting information prior to applying for coverage, consistent with the language in the Act. If the Departments retain the requirement to provide the SBC prior to applying for coverage, we request that the Final Rule provide that insurer compliance with the Plan Finder data submission requirements will be deemed to comply with all pre-application SBC distribution requirements for both individuals and small groups.

Utilization of the Plan Finder website for requests for plan information prior to the time of application/enrollment is an appropriate use of this consumer education tool.

4. The Departments should streamline SBC production by simplifying the proposed SBC template and enabling one SBC form for distribution.

The NPRM notes that the proposed SBC template includes several data elements that are not required by the Act, and also requests comments on the SBC format and template generally. Elements in the proposed SBC template that are not required by the statute include: premium, policy period, plan type, type of coverage, grievance and appeals information, provider network information (through an internet website), prescription drug formulary information (through an internet website) and an internet address for obtaining the Uniform Glossary.

Several of these data elements (e.g., policy period, type of coverage, grievance and appeals information) are not essential to evaluating coverage and benefits when making insurance decisions. Removing these elements from the proposed SBC template would simplify production and help reduce administrative costs, because plans and issuers would be able to produce SBCs for products, rather than specific to each individual or employer group policy. Eliminating these elements would also enable plans and issuers to reduce consumer confusion by delivering only one SBC, rather than an initial version (prior to enrollment) and a final version (upon effective date of coverage). In addition, specific to individual policies, providing a policy period seems to suggest benefits are provided for a limited time, which is not the case for policies that continue to remain in force as long as premium is paid timely. Multiple versions would be required only if benefit or cost sharing information were changed.

Similarly, grievance and appeals information is not essential to making plan selections but instead adds complexity and cost to SBC production. Consumers are much more likely to look for appeals information when they require assistance with a claim or complaint, and plans and issuers already are required to include contact phone numbers and/or websites on Explanations of Benefits and other notices of adverse determination.

We also request that the Departments permit plans and issuers to include multiple levels of cost sharing in the SBC (e.g., deductibles shown for individual coverage, individual plus one and individual plus family or listing “per person” deductibles with any limits to the number of family members who must meet their deductible). Many single applicants in the individual market will be expecting to add family members to their plan in the future. As a result, it is important they understand at the time they are selecting a plan and at the time of adding dependents what the benefits of the policy are when additional family members are covered. While the NAIC Working Group’s Instructions suggested that a final SBC (upon effective date of coverage) reference cost sharing information specific to the individual’s or participant’s coverage election, we are concerned that this would require SBC production tailored to a consumer’s specific coverage election. Combining multiple levels of cost sharing could be displayed in an easily understandable format and would provide all the information needed by the consumer considering adding additional family members. In addition, this modification would greatly reduce administrative costs.

On one platform representing approximately 80 percent of UnitedHealthcare's fully-insured small and mid-sized group business, we estimate that the breadth of cost sharing choices for both medical and pharmacy benefits will result in 1.9 million different SBCs, reflecting the various permutations of medical and pharmacy benefit combinations that individuals and plans may select. Requiring each SBC to reflect an individual's coverage level (e.g., individual, individual plus spouse, individual plus family, children only) would increase the required number of SBCs produced by four-fold. Requiring generation of state-specific SBCs indicating individual State Offices of Consumer Assistance would further increase the required number of SBCs produced by 50 times. Unless the SBC format is modified to address these issues, one company could be required to produce up to 380 million SBCs for distribution to just one segment of its fully-insured commercial business.

Recommendation: The Departments should develop a SBC template that incorporates data elements that outline the cost sharing and coverage benefits of a policy, but eliminates data elements that are not required by the Act and add complexity to SBC production. The Final Rule should:

- Eliminate the following elements from the SBC: policy period, type of coverage, grievance and appeals information; and
- Allow plans and issuers to include multiple levels of cost sharing in the SBC. Having multiple coverage levels shown on the SBC would enable consumers to make an informed choice about the coverage level that best suits their family's needs when coverage is available through multiple employers. The consumer could evaluate the options of having each spouse enroll as employee only, or selecting family coverage in one of the available plans.

5. Premium information is not required by the Act and should be removed from the proposed SBC format.

As discussed above, the Act does not require inclusion of premium information in the SBC. The NPRM and Solicitation of Comments request comments on whether the SBC should include premium/cost information and, if so, whether it should reflect actual costs net of employer contribution and costs for different tiers of coverage. Comments are also requested on methods for providing premium information in a way that is understandable and useful to individuals and plans.

While we recognize that premium information is a factor in making coverage decisions, inserting premium amounts in the SBC raises numerous challenges:

- Prior to submission of a complete application, plans and issuers can only provide estimated premiums, which will vary significantly from the final premium, based on several factors, including age, gender, zip code, family size, tobacco use, medical history and other elements.
- In the group market, employers frequently subsidize premiums by amounts that are not known to issuers. Providing total premium on the SBC without considering employer contributions would be misleading for those making coverage decisions. The relevant number in selecting coverage is the employee contribution amount, which is determined and communicated by the employer and is not available to the insurer to include in the SBC. Based on our experience to date obtaining employer data for the purpose of medical

loss ratio reporting and rebate disbursement, we believe it is not feasible to require plans and issuers to obtain premium contribution information from employers to populate SBCs.

- In 2014, premium calculations for the SBC would be further complicated by the application of premium subsidies available to eligible individuals who purchase coverage in the Exchanges.

We request that the Departments remove premium information from the SBC, in order to ensure that inclusion of this data is not misleading to consumers. Individuals and small groups selecting coverage through the Plan Finder will have access to information allowing general rate comparisons. In addition, employees selecting coverage through their employer already receive relevant premium and employee contribution information directly from their employer, as part of their open enrollment materials.

Recommendation: We recommend that the Departments remove premium information from the SBC template. If the Departments determine that premium information should be included, we recommend that (1) plans and issuers be permitted to refer individuals to separate plan communications already in place that provide premium information (e.g., premium quotes, billing statements, premium notices), and (2) plans and issuers be permitted to refer participants to their employers for precise premium and employee contribution information, consistent with the recommendation of the NAIC Consumer Information Working Group (Working Group).

6. The Departments should establish a safe harbor permitting SBC distribution by employers, labor organizations and producers, consistent with current business practices.

The NPRM requires SBC distribution at multiple times prior to enrollment in a plan.

- In the group market: (1) to groups upon requesting information; (2) to groups upon application; (3) to participants and beneficiaries during open enrollment; and (4) to participants and beneficiaries upon requesting information.
- In the individual market: (1) to individuals upon requesting information; and (2) to individuals upon application.

In many cases in the individual and group market, producers provide assistance to those shopping for insurance coverage, including identifying plan options, obtaining or providing premium quotes, submitting applications and facilitating group enrollment. Within the group health plan market, the employer or labor organization selects the plan(s) to offer employees and provides employees with information about their coverage options. It is appropriate that the SBC distribution rules build on existing business practices and allow both producers and employers to maintain their role in the coverage selection and enrollment process. In fact, issuers typically do not have any contact with consumers considering insurance coverage until they actually submit an application or are enrolled in the plan.

Recommendation: The Departments should establish safe harbors that build on business practices and allow issuers to coordinate with employers, labor organizations, group health plans and producers to distribute SBCs consistent with the following parameters:

- Permit issuers to rely upon group health plans (GHP) for delivery of SBCs in all pre-enrollment situations (e.g., initial group open enrollment, special enrollees and newly eligible members, renewal open enrollment). Issuers would provide SBCs to employers and labor organizations for all purchased coverage options with sufficient time to allow the GHP to provide timely delivery to members.
- Following enrollment in the plan, plans and issuers would deliver SBCs to all enrolled members in accordance with anti-duplication rules, prior to coverage effective date or within a reasonable period of time if enrollment is received less than seven days before effective date.
- Permit issuers to rely upon producers for delivery of SBCs in pre-enrollment situations, where the producer is involved with an individual's or group's plan selection. Issuers would ensure producer access to accurate SBCs for the coverage options they are offering.

7. The Departments should establish rules that encourage electronic SBC delivery, consistent with the distribution of other important documents to individuals.

The NPRM applies the existing DOL electronic safe harbor requirements to SBC delivery. This safe harbor, which was originally proposed in 1999, requires updating given the evolution of electronic media and access, as evidenced by the recent DOL Request for Information Regarding Electronic Disclosure by Employee Benefit Plans (RFI) 76 FR 19285. The NPRM establishes a separate electronic disclosure standard for the individual market. The Departments request comments on the electronic disclosure standards for both individuals and groups.

We are greatly concerned that applying the existing DOL electronic safe harbor requirements would establish hurdles to electronic delivery that are inconsistent with requirements for distribution of other important documents (e.g., pension and tax documents). A less restrictive electronic distribution rule would be in the interest of the plans and benefit consumers, who could receive information more quickly, as well as reduce use of paper and administrative costs. In fact, United's experience with online access to documents indicates that customer demand continues to grow, with a 10 percent increase in electronic utilization over the past two years despite the relatively restrictive standards of the DOL electronic safe harbor requirements.

Following issuance of a hard copy notice (e.g., a postcard) or email if available, plans and issuers should be allowed to distribute SBCs electronically, via a continuous access secure website, with paper copies provided upon request of the individual participant or employer. This approach would be consistent with the guidelines used for purposes of furnishing pension benefit statements. We believe that this approach to SBC delivery would meet the disclosure standards contained in ERISA and be in the best interests of consumers and plans.

Alternatively, we suggest that the Departments establish an additional safe harbor allowing for the electronic distribution of SBCs by group health plan issuers that have obtained a certificate of compliance from their employer customers. Under this approach, the employer would certify to the plan or issuer that it had complied with either the workplace access or affirmative consent requirements of the electronic disclosure rule. Those rules could be

modernized by including within a new safe harbor employees that have used either an email address or a continuous access website for plan communications during the 12-month period preceding the issuance of the SBC.

Use of an employer certification process would recognize that the employer, and not the issuer, is in the best position to determine an employee's ability to access electronic communications. Creation of a safe harbor would facilitate the electronic distribution of SBCs by issuers that provide coverage in the group market, thereby reducing the cost of coverage. We are convinced that expanded electronic delivery options are in the best interests of plans and their participants, especially since a plan participant who fails to receive a SBC electronically can contact the issuer to obtain a hard copy immediately.

Improvements should also be made to the individual market provisions. While we appreciate that the electronic distribution requirements for individual coverage are slightly less restrictive than in the group market, in response to the Departments' request for comments, we recommend a paper "opt in" standard that permits insurers to distribute the SBC electronically unless a paper copy is requested. We also recommend eliminating the requirement to acknowledge receipt of the SBC, which we believe is unnecessary and not standard practice for the distribution of other similar plan coverage materials. An acknowledgement is not necessary because in the event that an individual fails to obtain the SBC electronically, they may call the issuer's customer care toll-free number and obtain a hard copy.

As UnitedHealth Group noted in its response to the RFI on electronic disclosure, various sources, including the U.S. Health Care Efficiency Index, identify approximately \$30 billion in savings opportunities through the increased adoption of electronic administrative transactions and the related efficiencies. The Office of Personnel Management (OPM) recently noted that the use of electronic communications in place of mailing health insurance brochures saved, with that singular action, \$5 million in premium expenses. By contrast, our preliminary analysis indicates that the NPRM's restrictive electronic distribution requirements could increase our SBC distribution costs by at least \$15 million due to greater paper production, handling and postage.

Recommendation: The Departments should provide less restrictive rules for electronic delivery, allowing plans and issuers to provide participants with initial hard copy notice of the electronic availability of documents via a mailed postcard or other hard copy vehicle, or email if available, with directions on how to view the electronic SBC version or contact the issuer for a paper copy. Alternatively, we recommend the Departments consider a safe harbor allowing electronic distribution by issuers that have obtained an employer certificate of compliance with electronic distribution requirements. Finally, we recommend that the electronic distribution requirements for the individual market permit a paper "opt in" standard and eliminate the requirement to acknowledge SBC receipt.

8. The Departments should consider alternative means to provide Coverage Example information, including consideration of other technologies and existing plan cost estimator tools.

The NPRM incorporates the Coverage Example as part of the SBC and proposes a model that would use a hypothetical treatment scenario and associated hypothetical costs of service to generate cost sharing illustrations. The Departments indicate that this information could be used by consumers to compare their share of the costs of care under different plan or coverage options to make informed purchasing decisions. Both the NPRM and the Solicitation of Comments invite comments on the coverage examples, including the need for phase-in of the coverage examples, whether additional benefit scenarios would be helpful, the benefits and costs associated with developing multiple coverage examples, how multiple coverage examples would promote or hinder the ability to understand and compare terms of coverage, and alternative distribution of the coverage examples.

Phase-in of Coverage Examples and Alternative Approaches: We strongly encourage the Departments to delay implementation of the Coverage Examples for 12 to 18 months and convene a stakeholder working group to study alternative approaches to providing useful cost information to consumers. Implementation of the Coverage Example requirement, based on the study's recommendation, should occur no sooner than 12 to 18 months following issuance of the Departments' final requirements.

More Robust Tools Exist in the Market: The Coverage Examples will be produced based on information provided by HHS, including all medical services that HHS indicates should be delivered under their scenarios, associated costs and specific assumptions about the coverage scenario (e.g., accumulation toward deductible, network selection, drug selection). As a result, the Coverage Examples will not indicate differences in cost sharing due to variation in the insurer's contracted rates with physicians and hospitals, cost differentials due to geographic variation, variation in policies used to reimburse providers and insurer programs to help consumers manage their medical condition and treatment. For example, the Coverage Examples will not reflect potentially significant differences in cost sharing due to a physician's or hospital's participation in an Accountable Care Organization, Patient-Centered Medical Home or other initiatives that reimburse for services using bundled payments, risk arrangements or other non-claims based policies. The Coverage Examples also will not reflect costs specific to the consumer, including the actual services recommended by their physician, treatments for other medical conditions that may impact their cost sharing, and their selection of physicians, hospitals and other care providers.

While we appreciate that the proposed Coverage Example format includes disclaimer statements addressing the issues outlined above, we continue to have concerns about whether consumers will understand what the Coverage Examples do and do not represent. We recommend that the Departments consider whether and how consumers – or enrollees who have made their coverage decisions – may instead benefit from using plans' and issuers' cost estimator tools, which are fairly widespread in today's market. These robust tools provide more comprehensive information on a range of medical scenarios and allow consumers to get an accurate range of costs associated with treatment they are considering.

Additional Benefit Scenarios: Given the complexity of the Coverage Example and its implementation, we strongly recommend that the Departments refrain from creating additional benefit scenarios at this time. If the Departments pursue additional scenarios in the longer term, we recommend using simpler medical scenarios, which may be more relevant to a greater number of consumers and pose less risk in leading consumers to expect certain

services to treat a condition. We recommend using simple, less complex medical conditions that may be defined with limited variability. Alternatively, we recommend that any medical conditions illustrated use a normative scenario, with the list of services being limited to those that are most commonly used for treatment, according to recognized clinical resources.

Recommendations: Given the clear need for further consideration of issues related to the Coverage Example, including the model, method of distribution, benefit scenarios and implementation, we urge the Departments to consider the following recommendations:

- Delay implementation of the Coverage Examples for 12 to 18 months and convene a stakeholder working group to consider alternative approaches to providing cost information to consumers;
- Consider use of insurer cost estimator tools in lieu of Coverage Examples, based on the consumer value of obtaining more accurate cost ranges and access to more information on medical treatments and scenarios; and
- If the Departments retain the proposed Coverage Example template, permit insurers to add language to the Coverage Example referring enrollees to plan treatment cost estimator tools. These plan cost estimator tools will allow enrollees to obtain actual estimates to inform health care decision-making.

9. The Departments should consider how the SBC requirements will work with coverage comparison and educational tools already provided in the large group and self-funded market segments.

The large group and self-funded group markets typically develop and distribute sophisticated enrollment and educational materials to employees during plan selection and upon enrollment. The custom plan designs offered in this market segment make production of the SBC materials duplicative, administratively burdensome and costly to implement. In addition, this market segment frequently offers coverage through multiple benefit options, with certain benefits (e.g., pharmacy, mental health and substance abuse) carved out and administered separately from medical benefits. These carveout situations add further complexity to SBC and Coverage Example production, since none of the service providers to the group health plan (e.g., insurer or TPA) would have all the information necessary to produce the document.

During its deliberations, the NAIC Working Group recognized these challenges and urged the Departments to recognize the different characteristics of the large group and ASO market and consider whether and how the SBC requirement should be implemented for these consumers.

We specifically recommend obtaining input on the SBC requirements from large employer groups and self-funded group health plans. These groups spend considerable time evaluating their benefit options and developing effective ways to communicate coverage options and information to their employees. Many employers have developed attractive, concise and informative benefit summary comparisons for their employees' use during open enrollment. We recommend reviewing the form and content of these summaries which have been used successfully for many years to consider whether the prescribed SBC format would benefit these participants and beneficiaries. While we recognize that these existing documents may

not provide for plan-to-plan comparisons across different employers, they do ensure that employees receive understandable information necessary to make plan coverage decisions. To additionally require delivery of the SBC would confuse consumers with duplicative information and incur additional, unnecessary costs.

The NPRM also invites comments on whether the SBC may be incorporated into the Summary Plan Document (SPD) provided to participants. We do not recommend combining these documents, since the diversity of benefits provided in the self-funded market segments and level of detail required to produce SPD updates would not allow for coordinating production of these documents.

Recommendation: The Departments should evaluate the need for SBCs in the large group and self-funded market segments and weigh this against the complexity of producing SBCs for myriad custom plans designs and potential carveout situations. We recommend that the Departments establish a 12 to 18-month non-enforcement period (as described in our earlier comments) and conduct a study to evaluate the large group/ASO market segment and make recommendations on the implementation of Section 2715 in this market segment. The study should include:

- Consultation with plans and issuers, employers, benefit consultants and consumers;
- Assessment of health care coverage education and open enrollment materials currently provided to employees;
- Assessment of large group/ASO employee understanding of coverage education and open enrollment materials currently in use; and
- Evaluation of SBC format and feasibility of summarizing large group/ASO plan benefit offerings, including complex benefit designs, benefit carveout arrangements and other variations.

10. The Departments should confirm that certain plan changes are not subject to the 60-Day Advance Notice of a Material Modification.

The NPRM provides that the 60-day advance notice of a material modification is limited to material plan changes that affect the SBC and excludes plan renewals and reissuance. We strongly support the Departments' approach to implementing this provision and the recognition of current plan sales, negotiation and selection timeframes. The NPRM also invites comments on any circumstances where the 60-day advance notice might be difficult.

We request clarification that plans and employers are permitted to make changes retroactively to fix clerical errors that occurred during the sales process or implementation, without triggering the 60-day advance notice requirement. We also ask the Departments to consider circumstances where an employer makes benefit plan changes after the effective date of coverage, due to ongoing negotiations, and whether these changes can be considered to be in connection with the renewal or reissuance of coverage if made within a reasonable period of time and retroactive to the effective date.

We also recommend that the Departments clarify that the 60-day advance notice requirement does not apply to new state-mandated benefits. Existing state law would apply specific to providing any required notices. At a minimum, we recommend that the Departments

acknowledge that, in many circumstances, plans and issuers may not be able to provide 60-day advance notice of state benefit mandates if new state laws are passed with near-immediate effective dates.

Recommendations: We recommend that the Departments consider the following issues related to the 60-day advance notice requirement:

- Confirm that plans and employers are permitted to make retroactive changes within 60 days of the effective date of coverage to correct clerical errors that occurred during the sales or implementation process, without triggering the 60-day advance notice requirement;
- Confirm that employers may make benefit plan changes retroactive to the effective date of coverage, as part of ongoing renewal or reissuance of coverage, without triggering the 60-day advance notice requirement, if made within 60 days of the effective date; and
- Confirm that the 60-day advance notice requirement does not apply to new state-mandated benefits but to the extent notice requirements do exist, the 60-day timeframe may be waived or shortened in the event of a new state mandated benefit enacted with insufficient time to provide the 60 days' notice.

11. The Departments should ensure that SBC distribution allows for ongoing coverage selection and negotiation processes and does not limit employer group coverage choices.

In automatic renewal situations, the NPRM requires plans and issuers to provide the SBC to participants and beneficiaries no later than 30 days prior to the first day of coverage under the new plan year. We are concerned that delivering the SBC to participants and beneficiaries at this point in the process would result in confusion, since many employers make plan selections and decisions less than 30 days prior to their renewal effective date. For example, a group's participants and beneficiaries could receive the SBC describing their coverage for the next year and eligible for auto-renewal, but the employer could instead select a plan with very different benefits and cost sharing or even drop coverage altogether. Such a scenario would result in confusion for participants and difficulty for the employer's intended communications about plans for benefit coverage.

In order to avoid such confusion, we request that the SBC distribution requirement for automatic renewal situations be limited to the group, with the group health plan responsible for SBC distribution to participants and beneficiaries. This will mitigate the risk of participants and beneficiaries receiving multiple SBCs before the employer makes its renewal decision. In addition, if the group provides notice to issuers anytime during the 30-day window, issuers should have up to 30 days after notice of the benefit change to issue the SBC.

The NPRM also requires issuers in the individual market to provide the SBC to policyholders annually at renewal. Most individual policies do not have annual renewals, but rather are guaranteed renewable as long as premiums are paid timely. We request that this SBC distribution requirement be eliminated. Eliminating this requirement would be consistent with the Act, which requires issuers to provide the SBC at the time of application (applicable to the individual market), at the time of enrollment or re-enrollment (applicable to the employer group market), and at time of issuance.

Recommendation: The Departments should revise the SBC distribution requirement for automatic renewals to deliver to the group health plans only, in order to provide sufficient time for the group to make its renewal decision and mitigate confusion among participants and beneficiaries. We recommend that the Department require the group health plan to distribute the SBC to participants and beneficiaries to ensure receipt of documents describing the employer’s final plan selection. We also request eliminating the SBC distribution requirements for automatic renewals in the individual market.

12. The Departments should ensure that the SBC, Uniform Glossary and Coverage Examples all retain clear disclaimer language indicating that the materials are for educational purposes only and do not replace or supersede the plan’s policy documents.

In the Departments’ Solicitation of Comments, the Departments invite comments on the adequacy of the disclosure on the proposed SBC template that the SBC is not the actual policy and does not include all of the coverage details found in the actual policy. We previously submitted comments to the NAIC Working Group requesting that a strong, uniform disclaimer be included on these materials directing consumers to consult their policy or coverage documents for prevailing details on their actual insurance or plan coverage. The Working Group had extensive discussions about how these materials are intended to represent a general summary of plan coverage, and that they do not amend or otherwise control existing policy and coverage documents.

We believe it is critically important that the documents clearly indicate that the terms and conditions of the consumer’s actual contract or plan will likely vary and that all claim payments will be based on the actual terms and conditions of that document. We request that the Departments retain this disclosure language in all the documents subject to the NPRM.

Recommendation: We request that the Final Rule and final format for the SBC, including the Coverage Examples and Uniform Glossary, retain strong disclosure language indicating that the materials are intended for consumer education purposes only and do not supersede provisions or other details in the plan’s policies or certificates.

13. The Departments should evaluate the use of the SBC in benefit carveout arrangements where multiple plans and issuers manage benefits.

The NPRM does not specifically address SBC production and distribution in circumstances where multiple plans and issuers manage the essential benefits described in the SBC or incorporated into the Coverage Example. For example, it is unclear how plans and issuers would produce a SBC if a separate issuer administered pharmacy or mental health benefits. This complexity will occur frequently in the large group and self-funded market segments, where there may be significant carveout of select benefits.

The Act potentially requires each issuer, including fully-insured, carveout specialized benefit plans, to produce and distribute separate SBCs describing the benefits they administer. These separate SBCs would be confusing to consumers and would provide little or no value in making coverage selections since employees selecting plans typically do not have a choice of the carveout vendor. Similarly, some employers include funding arrangements, such as health

reimbursement accounts (HRAs) and health flexible spending accounts (health FSAs), as part of their group health plans, which are administered by a separate vendor. Requiring HRA and health FSA administrators to produce SBCs that describe this financial benefit – in a format geared toward describing health insurance coverage – would neither be informative nor helpful to selecting insurance coverage. In both scenarios, any value to consumers would be far outweighed by the confusion caused by receiving these additional materials.

Because these carveout arrangements are common in the large group and self-funded markets, we recommend that the Departments consider these issues as part of the stakeholder discussions considering the impact of the SBC requirement on these market segments, as described in our earlier comment.

Recommendations: We request that the Departments consider these carveout scenarios as part of the previously recommended study on whether and how the SBC should be distributed in the large group and self-funded market segments. As part of their review, the Departments should consider the consumer confusion that may result from receipt of numerous documents in these scenarios, as well as the minimal value these documents would provide consumers and the infeasibility and burden of requiring issuers to coordinate to produce a single SBC.

14. The Departments should maintain the Uniform Glossary on a government website, in order to ensure uniformity in the document.

The NPRM and Solicitation of Comments provide that plans and issuers will not be permitted to modify the Uniform Glossary and confirm that the Glossary is not intended to provide legal or contractual definitions that necessarily apply accurately, without modification, to every plan or coverage. We appreciate the Departments' recognition that the Glossary's terms are intended for consumer education purposes only and not meant to supersede plan policy or legal terms.

Distribution of Uniform Glossary: The NPRM also provides that the Uniform Glossary may be made available by providing a website link where the Glossary can be viewed and downloaded. This was recommended by the NAIC Working Group and incorporated into the proposed SBC format. However, the NPRM also includes language stating that the insurer must make copies of the Uniform Glossary available. Because the Uniform Glossary will not be subject to modification by plans and issuers, we recommend that the Departments confirm that the government website will be the sole resource for producing the Glossary. We also recommend that the Departments provide translated versions of the Uniform Glossary on this government website.

Glossary Terms: The Departments also invited comments on the terms in the Glossary and whether any additional terms should be added. Attached to these comments is a list of suggested revisions to definitions, many of which were previously submitted to the NAIC Working Group last fall.

Recommendations: The Departments should establish a government website to house the Uniform Glossary and additional translated versions, and plans and issuers should direct consumers to the website for the Glossary, as recommended by the NAIC Working Group. In

order to ensure consumer access to the most current versions of the Uniform Glossary, plans and issuers should not be required to provide paper copies of the Uniform Glossary and instead should direct consumers to the government website.

15. The Final Rule should clarify that states are not allowed to modify the SBC, which would facilitate uniform comparisons of benefits and coverage options.

The individual states have had meaningful input into the formation of the SBC requirement through the NAIC Working Group. By all accounts, the process was open and reflected broad participation by the states and advocacy organizations.

Given the nature of this process, we believe that it would be appropriate for the Departments to adopt a uniform SBC rule that can be consistently applied by group health plans and issuers on a nationwide basis without being subject to inconsistent state law. Congress' stated goal in enacting the SBC requirement was to give group health plan participants, as well as persons covered in the individual market, with a means of comparing coverage and benefit offerings on a consistent basis. To the extent the individual states begin enacting their own versions of SBC content or delivery legislation, this would thwart Congress' intent to provide for uniform comparisons of coverage options.

Therefore, we urge the Departments to adopt a uniform rule that will not be subject to state law provisions and that will facilitate uniform comparisons of benefits and coverage options. As an alternative, any state-permitted revisions to the SBC template should be incorporated through an addendum to the document rather than within the prescribed template.

Recommendation: The Departments should adopt a uniform rule for SBC content and distribution that preempts state law alterations or additional requirements to the content or delivery, in order to facilitate uniform comparisons of consumer benefits and coverage options. If states are permitted to impose additional requirements on the SBC template, we request that such additions be incorporated through an addendum to the document rather than within the prescribed template.

16. The Agencies should exclude expatriate plans and executive medical plans from the SBC and Uniform Glossary requirements.

The Departments request comments on whether any specific rules are necessary to accommodate expatriate plans, including whether any adjustments are needed under Section 2715.

Expatriate insurance plans are designed to cover individuals living or working overseas. As such, these plans are tailored to address the needs of enrollees living in countries across the globe. A policy written for an expatriate working in one country may look substantially different than a policy written for someone working in another country. Additionally, expatriate plans have unique characteristics including developing and maintaining providers in other countries, navigating health care services in countries all over the world, operating multi-lingual call centers year-round in multiple time zones, processing and paying claims in a variety of languages and currencies, and hiring employees who can speak multiple languages.

The highly complex nature of offering insurance coverage overseas does not fit squarely with the provisions of the Act governing coverage offered in the United States. For example, the NAIC recognized these challenges when developing guidelines for calculating the Medical Loss Ratio (MLR).

Finally, expatriate and executive level employees are among the most sophisticated employees in the workforce today. These employees are frequently provided with enhanced health benefits, subject to taxation, and are provided outside of tax qualified group health plans. In addition, these employees are uniquely situated to understand and receive the benefits they are entitled to under their compensation packages.

Recommendation: We recommend that the Final Rule exclude expatriate plans and executive medical plans from the requirements to produce and distribute the SBC and Uniform Glossary.

17. The Departments should not add additional data elements to the proposed SBC template at this time.

The Departments invite comments on whether additional data should be incorporated into the SBC template, including preexisting condition exclusions under the plan, status as a grandfathered health plan, or other information. Because consumers already have sufficient disclosure of this information through insurer-provided materials, we recommend against the Departments adding data elements to the SBC template at this time; rather, we encourage simplifying the SBC template as described earlier in our comments.

Recommendation: We recommend that the Departments refrain from adding any additional data elements to the SBC template at this time.

18. Reasonable parameters should be established for providing the SBC upon request.

The NPRM requires plans and issuers to provide the SBC upon request within seven (7) days, which poses challenges due to the complexity of the proposed SBC template and restrictive electronic distribution requirements, which will result in high volumes of paper distribution via postal service. Because the SBC describes coverage and benefit requirements and does not otherwise provide information required for urgent or emergency circumstances, we believe that a 15 business day requirement is reasonable for providing the SBC upon request.

Recommendation: The Final Rule should clarify that plans and issuers are required to provide the SBC upon request within 15 business days.

19. The Departments should clarify SBC distribution requirements for individuals with conversion and continuation of coverage policies and plans that are closed to new business.

The NPRM does not indicate clearly whether or how the SBC distribution requirements apply to individuals enrolled in conversion or continuation coverage. We request clarification from the Departments on distribution to these participants.

The NPRM also does not specify that the SBC distribution requirements (i.e., applicants at the time of application, enrollees at the time of enrollment or reenrollment, and policyholders at the time of issuance) do not apply for plans that are closed to new business. Because these plans are closed to new applicants and enrollees, there would be no need to issue the SBC at application, enrollment, reenrollment or issuance. We request confirmation that closed blocks of business are not subject to the SBC distribution requirements.

Recommendation: We request that the Final Rule clarify SBC distribution requirements for conversion or continuation coverage policies and confirm that closed blocks of business are not subject to these requirements.

20. The Instructions recommended by the NAIC should be revised to reflect the issues outlined in the aforementioned comments.

The NAIC Working Group recommended Instructions for implementing the SBC and Coverage Examples in the individual and small group market segments. Although these Instructions were transmitted by the NAIC Working Group to the Departments, Working Group discussions and communications indicate numerous issues that require further consideration or revision. In addition, the NAIC Working Group did not develop Instructions for the large group or self-funded market segment, in part due to questions about the need and applicability of the SBC for these groups and consumers.

We request that the Departments modify the Instructions for implementing the SBC and Coverage Examples, taking into account the recommendations outlined in this response, including modifications to the SBC and Coverage Example format and delivery requirements.

Recommendation: The Departments should ensure that the Instructions for implementing the SBC and Coverage Examples are modified to reflect changes in the Final Rule, based on the issues outlined above.

Additional Comments on SBC Template

Following are recommended changes to the proposed SBC template, which we believe will improve consumer understanding of the information and/or ensure that the template will accommodate variations in insurance benefit design. These recommended changes supplement our detailed comments.

Flexibility to accommodate innovative benefit designs

- As described in our detailed comments (item #2), different elements in the SBC template may require modification in order to more accurately describe innovative, non-traditional benefit designs (e.g., value-based insurance, multiple tiered networks, benefits incorporating health retirement accounts or health savings accounts, plans based on Accountable Care Organizations or medical homes). SBC template fields that will likely require modification include: Why This Matters, cost sharing descriptions, chart on pages 2 and 3 summarizing benefits.

Participating/non-participating providers

- The form should be modified if coverage is limited to participating or in-network providers only. Retaining language indicating that participating providers may cost less, if non-participating providers are not covered at all, could be confusing.

Prescription Drugs

- Categories for prescription drugs may require flexibility. Some carriers use numbered tiers (e.g. Tier 1, Tier 2) that are not generic or brand specific.

Diagnostic tests

- Provide area to clarify whether tests are covered differently depending on location of testing, including if there is separate cost sharing for tests conducted during an office visit.

Notice of “Your Grievance and Appeal Rights”

- Recommend removing this section (as described above in detailed comments). This section is not required by the statute and not necessary for consumers making plan coverage selections. Removing this element can simplify SBC production.

Deductible

- Permit insurer flexibility to vary terms depending on the timeframe applicable to plan described in the SBC. Examples may include: annual deductible, plan year deductible.
- Permit insurers to combine multiple coverage levels in deductible and other cost sharing sections.
- Recommend addressing how insurers will manage SBC formats with products with embedded deductibles.

Plan Type

- Recommend removing the “Plan Type” field at the top of each page. This is not required by the statute and would be difficult to complete accurately given the variation and innovation in benefit designs, including the growing number of options that are not conventional HMO or PPO products.

Type of Coverage (“Coverage for”)

- Recommend removing the “Coverage for” field at the top of each page. This is not required by statute and not necessary for consumers making plan coverage selections. Removing this element can simplify SBC production.

Provider Networks

- Need to address plans with multiple networks, narrow networks or other network-based products that are unlikely to be accommodated in the current SBC format.

Home health care/rehab/etc. benefits

- Recommend changing “If you have a recovery or other special health need” to “If you have a special health care need following a hospital stay or surgery.”

Self-Funded Coverage

- Recommend that SBC format be modified appropriately to address variation related to self-funded arrangements (e.g., language in “Your Right to Continue Coverage” and “Your Appeal Rights”).

Why This Matters – Yes Answers

- Recommend deleting the statement “So, a longer list of expense means you have less coverage,” as this statement may not always be accurate and may be misleading.

Why This Matters – No Answers

- Recommend deleting the statement “Because you don’t have to meet deductibles for specific services, this plan starts to cover costs sooner” as this statement may not always be accurate and may be misleading. The overall deductible plus specific services deductible for Plan A could be far less than the overall deductible alone for Plan B, if Plan A has a very low overall deductible and Plan B has a very high overall deductible.

Ancillary Benefits

- As it pertains to dental and vision benefits, the SBC template appears designed for 2014 when essential pediatric benefits are included in most medical plans (for small group and individual), but not today’s market or the large group market in 2014. We recommend evaluating how ancillary benefits will be described in the SBC template, given the current market offerings and changes anticipated in 2014.

Additional Comments on Coverage Examples

Assumptions

- Recommend modifying the last assumption to indicate that the scenario assumes that the consumer received care from the in-network provider allowing the highest level of benefits.
- Recommend adding an additional assumption indicating that the scenario assumes that all services obtained any prior authorization or referrals required by the plan.

Can I use Coverage Examples to compare plans?

- Recommend revising the following statement: “The smaller that number, the more coverage the plan provides for this specific treatment scenario assuming plans have the same financial arrangements with providers.” Without this revision, this statement may not always be accurate and may be misleading.

Additional Comments on Uniform Glossary

Following are recommended changes to the proposed Uniform Glossary which we believe will improve consumer understanding of the terms and address potential confusion resulting from terms that may conflict with common industry definitions. These comments were previously submitted to the NAIC Consumer Information Working Group in the Fall 2010.

Appeal

The definition may be confusing with the word “again,” suggest the modification below.

- Current definition: A request for your health insurer or plan to review a decision or a grievance again.
- Suggested change: A request for your health insurers or plan to review a previous decision or grievance.

Balance Billing

Balance billing may occur in certain, albeit limited, circumstances with contracted or preferred providers.

- Current definition: When a non-preferred provider bills you for the difference between the provider’s charge and the allowed amount. A preferred provider may not balance bill you.
- Suggested change: When a provider bills you for the difference between the provider’s charge and the allowed amount. Generally, a preferred provider may not balance bill you.

Co-insurance

Coinsurance is generally applied after you have met any required deductible; in addition, coinsurance may vary depending on the provider’s contracting status. It may be clearer to address varying coinsurance levels in this definition rather than defining in-network vs. out-of-network coinsurance.

- Current definition: The percentage you pay (for example, 20%) of the allowed amount for covered health care.
- Suggested change: The percentage (for example, 20%) of the allowed amount that you must pay for covered health care services. Coinsurance is generally applied after you have met any required deductible. There may be different levels of coinsurance depending on whether your provider is preferred or non-preferred.

Co-payment

It may be helpful to note that copayments are typically paid at the time consumers receive the service, rather than receiving a bill later.

- Current definition: A fixed amount (for example, \$15) you pay for covered health care, usually when you receive the service. The amount can vary by the type of health care.

- Suggested change: A fixed dollar amount (for example, \$15) you must pay for covered health care. It is usually payable at the time you receive the service. The co-payment amount can vary by the type of health care service.

Durable Medical Equipment

This definition may be more general than what plans will cover, since DME is frequently required to serve a medical purpose and considered not disposable and durable enough to withstand repeated use. In addition, insulin testing strips are frequently covered by the pharmacy benefit and not as DME.

- Current definition: Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.
- Suggested change: Medical equipment and supplies ordered by a health care provider to serve a medical purpose. These items are considered not disposable but durable enough to withstand repeated use. Types of DME include: oxygen equipment, wheelchairs or crutches.

Emergency Medical Condition

In order to be consistent with federal and state statutes regarding coverage of emergency services, we suggest additional language to adequately convey the serious nature of the condition.

- Current definition: An illness, injury or condition so serious that a reasonable person would seek care right away.
- Suggested change: An illness, injury or condition so serious that a reasonable person would seek care right away to avoid severe harm or death.

Emergency Medical Transportation

We suggest tying this definition to the defined term “emergency medical condition.”

- Current definition: Ambulance services for a medical condition that must be treated right away.
- Suggested change: Ambulance services for an emergency medical condition.

Emergency Services

We suggest revising the definition to clarify that the services are specific to those necessary to evaluate, stabilize and treat the condition.

- Current definition: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- Suggested change: Health care services that are required to evaluate, stabilize and treat an emergency medical condition

Excluded Services

A suggested change was made to reflect that excluded services may also exclude certain conditions.

- Current definition: Health care services that your health insurance or plan doesn’t pay for or cover.
- Suggested change: Health care services or conditions that your health insurance or plan doesn’t cover.

Habilitation Services

We suggest revising the definition to indicate that the services are required for daily living.

- Current definition: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.
- Suggested change: Health care services that help a person keep, learn or improve skills and functioning which are required for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Home Health Care

We suggest revising the definition to reflect the provision of services in the home.

- Current definition: Health care services a person receives at home.
- Suggested change: Health care services a person receives from a home health care agency at home.

Hospitalization

It is possible to be admitted to the hospital and then released prior to staying overnight, with the stay still considered inpatient care. We have revised the definition to reflect this possibility.

- Current definition: Care in a hospital that requires an overnight stay. An overnight stay for observation may be outpatient care.
- Suggested change: Care in a hospital that usually, but not always, requires an overnight stay. An overnight stay for observation may be outpatient care.

In-Network Co-insurance

We have suggested addressing this issue as part of the coinsurance and copayment definitions (outlined above). This may allow this term to be eliminated.

Medically Necessary

We have suggested a change to this term to reflect plan policies addressing medical necessity.

- Current definition: Health care services or supplies needed to diagnose, prevent or treat your condition and that meet accepted standards of medical practice.
- Suggested change: Health care services or supplies needed to diagnose or treat your medical condition according to generally accepted standards of medical practice and the terms described in your health insurance policy.

Network

We suggest using this definition to clarify the concept of tiered providers, which may be less confusing to consumers.

- Current definition: The facilities, providers and entities your health insurer or plan has contracted with to provide health care services.
- Suggested change: Health care facilities, providers and other entities that have contracted with your health insurer or plan to provide health care services to covered members. Check your health insurance or plan to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Non-Preferred Provider

We suggest using the network definition (above) to provide detail on the concept of non-preferred providers.

- Current definition: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.
- Suggested change: A provider who doesn't have a contract with your health insurer or plan to provide services to you. Generally you will pay more if you go to a non-preferred provider.

Out-of-Network Coinsurance

We have suggested addressing this issue as part of the coinsurance and copayment definitions (outlined above). This may allow this term to be eliminated.

Out-of-Network Co-payment

We have suggested addressing this issue as part of the coinsurance and copayment definitions (outlined above). This may allow this term to be eliminated.

Preferred Provider

See suggested changes to network definition.

- Current definition: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can go to all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.
- Suggested change: A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

We suggest revising the definition to clarify the potential shared responsibility for premium. We also note that self-funded plans may use the terms "cost of coverage" or "your coverage cost."

- Current definition: The amount of money that must be paid for your health insurance or plan. It is usually paid monthly, quarterly or yearly by you and/or your employer.
- Suggested change: The amount of money that must be paid for your health insurance or plan. It is usually paid monthly, quarterly or yearly. Premium may be paid by you, your employer, or shared between the two of you.

Prescription Drug Coverage

See suggested change to definition.

- Current definition: Health insurance or plan that helps pay for prescription drugs and medications.
- Suggested change: Health insurance or plan that helps pay for covered prescription drugs and medications.

Reconstructive Surgery

We suggest including “injury” in the definition to clarify circumstances that may require reconstructive surgery.

- Current definition: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents or medical conditions.
- Suggested change: Surgery and follow-up treatment needed to correct or improve the function of a part of the body which is the result of a birth defect, accident, injury or other medical conditions.

Rehabilitative Services

We suggest clarifying that the definition does not include maintenance care, which generally is not considered rehabilitative under most plans.

- Current definition: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
- Suggested change: Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

A licensed nurse can provide non-skilled care in a home, but under this definition, this would be considered skilled nursing care. The level of service being provided, and not just who provides the service, should be part of this definition. Comment: Needs to address what is NOT custodial (e.g. delivered for purposes of assisting with daily living, etc.).

- Current definition: Services from licensed nurses in your own home or in a nursing home. Skilled care are services from technicians and therapists in your own home or in a nursing home.
- Suggested change: Services from licensed nurses in your own home or in a nursing home. Skilled care are services from technicians and therapists in your own home or in a nursing home, and do not include care delivered for purposes of assisting with daily living (such as feeding, dressing, etc.).

UCR

This issue should be revised to define the term “Out-of-Network Payment Standards” as defined below. Plans use varying standards to reimburse out-of-network providers, ranging from "usual, customary and reasonable," to a defined payment schedule tied to in-network benefits to payments based on Medicare payment. We believe this term would more appropriately address the concept.

- Current definition (UCR): The amount paid for an identical or similar medical service in a geographic area or that providers in your area usually charge for a particular health care service. UCR is sometimes used to determine the allowed amount.
- Suggested change (Out-of-Network Payment Standards): The amount defined in your benefit plan that will be paid for covered services delivered by an out-of-network provider.

Urgent Care

We offer an alternative definition of urgent care including examples of conditions that might require urgent care treatment, which may be helpful to consumers.

- Current definition: Care for an illness, injury or condition serious enough to require prompt care but not so severe as to require emergency room care.
- Suggested change: An urgent situation that requires prompt medical attention to avoid complications and unnecessary suffering (but not so severe as to require emergency room care), such as high fever, a skin rash, or an ear infection.