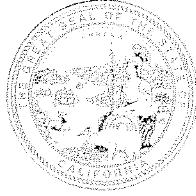

DAVE JONES
Insurance Commissioner

October 21, 2011

Medicare & Medicaid Services
Department of Health and Human Services
Re. File Codes CMS-9982-P, CMS-9982-NC
PO Box 8016
Baltimore, MD 21244-1850

Via electronic submission https://www.regulations.gov

SUBJECT:
- Proposed Rules on Summary of Benefits and Coverage and Uniform Glossary, CMS-9982-P
- Proposed Rules on Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Services Act, CMS-9982-NC

Dear Sir/Madam:

The California Department of Insurance (CDI), in consultation with the California Department of Managed Health Care (DMHC), and the California Health Benefit Exchange, has reviewed the proposed regulations, form templates and documents for the Summary of Benefits and Coverage (SBC) and the Glossary of Health Insurance and Medical Terms (Uniform Glossary). We acknowledge the effort underlying the proposed SBC and Uniform Glossary to date, and the goal of uniformity in disclosure and plan comparison forms. However, we find the proposed SBC regulations, form templates, and Uniform Glossary potentially problematic in helping consumers to understand health insurance coverage and to aid them in comparing health insurance coverage and prices. This cover letter reflects agreement amongst the three California state agencies named above on the issues outlined here and the comments that follow each letter reflect each agency's additional concerns relative to the issues and questions.

We are concerned that the information required by the form templates and Uniform Glossary may not provide consumers with the most complete and helpful information to facilitate plan comparison and understand their coverage. Significantly, the terminology in both the SBC and the Uniform Glossary may be different from the actual controlling language in a contract or policy, confusing consumers about their coverage when the policy and contract terms are brought to bear once they access services. Understanding that standard definitions are required by the ACA, these definitions should be as clear as possible, so that consumers will comprehend the concepts and be better equipped to understand the definitions contained in their policies or contracts, if different.

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Terms like "practitioner," "habilitation," and "urgent care" may need additional clarification in the SBC through parenthetical examples to be meaningful to consumers (e.g., habilitation further referenced as physical, speech and occupational therapy). Consumers would be further assisted in comparing coverage options if additional related categories of service were included, such as emergency room physician services, in order to provide a more complete view of the cost components in a hospital emergency room visit.

In addition, much of the terminology proposed does not track with the coverage categories and terminology generally used in managed care plans, or with related state law, and may be confusing to some consumers. For example, HMOs generally provide no coverage for out-of-network providers except in emergency care situations, but the Uniform Glossary implies that there will be some coverage out-of-network in all cases. Overall, many of the definitions seem to relate only to preferred provider organizations (PPOs). We recommend that all definitions be scrutinized and edited to make sure that they reflect how each term relates to both HMOs and PPOs.

Certain comments, described in greater detail in the chart below, are of particular importance to CDI:

1. All definitions must specify how they apply differently to PPO type policies and to HMO type policies
2. All insurers must describe how dependents (including children), who live away from the service area are covered, and where the consumer can get more information about that
3. All insurers must be required to provide a periodic detailed accounting for PPO type policies.

The following chart reflects the California Department of Insurance's comments to specific sections of the regulations and guidance.

The Department staff and I are happy to consult with you on these comments and to work with you on making the regulations and guidance better and clearer for consumers and insurers alike. If you wish to contact the Department of Insurance about these issues, you may contact me or Janice Rocco, Deputy Commission for Health Policy and Reform at (916) 492-3500.

Sincerely,

DAVE JONES
Insurance Commissioner

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REGULATIONS 45 CFR §147.200	
Uniform definitions of standard insurance terms 45 CFR §147.200(a)(2)(A) and uniform glossary (45 CFR §147.200(c).	(a)(2)(A) should use the term "Uniform glossary" for consistency.
45 CFR §147.200(c)(4) Uniform definitions/Uniform glossary	The current regulation requires insurers to provide the Uniform Glossary either electronically or on paper upon request. However, the Appendices refer to an electronic link through which the consumer can access the Glossary electronically. The Appendices should also contain an option for the consumer to request the Glossary in paper format.
45 CFR §147.200(a)(1)(i)(B) Notification of change in coverage to group master policyholder	Why does the regulation use the term "offer"? If "offer" means a time when the issuer offers to *change* the policy, then the notification must be sent as of the date of the "offer", not as of the date of applicability of the change in coverage. Sending the notification on the date of coverage is too late. However, if the term "offer" means a declaration that the terms of policy have changed, then the term "offer" is inappropriate and should not be used.
45 CFR §147.200(a)(1)(ii)(C) Notification of change in coverage to group actual insureds/participants	Notification of changes to coverage on date of coverage is too late.
45 CFR §147.200 (a)(1)(ii)(E)	Vague. When is new SBC sent - when the policyholder signs up

Notification of renewal of Group policy to participants.	to renew, or when renewal is effective? The SBC should be sent before renewal is effective.
45 CFR §147.200 (a)(1)(ii)(E)(1) Notification of renewal of Group policy to participants.	What does "materials" mean? Does that term mean application?
45 CFR §147.200 (a)(1)(iv)((B) Notification of change in coverage to individual policyholders	On first day of coverage, when individual insured has signed an insurance contract for insurance, the individual insured should get the actual policy. The SBC should be delivered earlier than the first day of coverage.
45 CFR §147.200 (a)(2)(i)(H)	PLEASE ADD a statement that the SBC is only a summary and that the actual policy should be consulted to see the governing policy provisions. See Appendix A2 p 1 of 6 - the language at the top does not comply with this directive.
45 CFR §147.200 (b)	Notice of Modifications. How does this work with Group(a)(1)(i)(B); Participants in Group(a)(1)(ii)(C), Individual (a)(1)(iv)B)?
GUIDANCE per 45 CFR §147	
45 CFR §147 Overall	You should consider whether Exchanges should be required to use the SBC forms for their "apples-to-apples" comparisons, to avoid further confusion.
45 CFR §147 Appendix A-2 PPO page 1 of 6	(a) PLEASE ADD "What is the coverage area for this plan?" ["coverage area" should also be defined in the Glossary] (b) PLEASE ADD – "How is my spouse/child covered if s/he lives outside the coverage area?"

	The insurers should be directed to give a specific response, e.g., "If your spouse or child lives outside your service area, s/he must travel to the service area to receive covered services, or, s/he is covered the same way that you are with different in/out of network charges and coverage." Or, "HMOs do not cover services by out-of-network medical providers except in cases of emergency services. Accordingly, if your spouse/child lives outside of the service area, s/he is covered for emergency services only when outside the service area, but covered for all services if/when s/he returns to the service area for treatment." Insurers should also be required to refer to materials, websites, and/or provide links to additional information regarding network provider locations, and what services are covered, etc. (c) See above re regulations 45 CFR §147.200(a)(2)(i)(H). Forms should contain statement that SBC is only a summary and that the actual policy should be consulted to see the governing policy provisions. PLEASE ADD – If there is disagreement between the SBC and the policy, the policy language controls. See Appendix A2 p 1 of 6. The language at the top does not comply with this directive. (d) The Glossary should also be offered on paper. (e) "What is the premium?" "…or your application may be denied." Clarify that this language can be used in years 2012-2014 only. (f) Does the "overall" deductible include the pharmacy deductible? If yes, then the overall deductible is actually

	$2,800/$7,800. Please clarify. (g) Pharmacy deductible – Is this per person or per family? (h) "Is there an out of pocket limit on my expenses?" The required answer is confusing. Clarify whether $2500/person and $7,500/family includes the $300 pharmacy deductible or not. (i) "What is not included in the out-of-pocket limit". Why are prescription drugs listed? Prescription drugs are an EHB. Is this language just for use in years 2012-2014? (j) "Is there an overall annual limit". What does "overall annual limit" mean – EHBs plus non EHBs? The answer in the form refers to p.2 description on limits on "what the insurer will pay for specific covered services, such as office visits." However, p.2 of the form does not show what the *insurer* will pay, but rather shows what the *insured* will pay. After 2014, insurers are required to impose *no* annual limit for EHBs, but will have annual limits for non EHB covered benefits, and perhaps varied/different annual limits for different non EHB covered benefits.
45 CFR §147 Appendix A-2 PPO Page 2 of 6	What about tiers? In the Glossary, the Preferred Provider and Non-Preferred Provider definitions say that payment for different tiers of participating providers may be different. That should be explained on this page too.
45 CFR §147 Appendix A-2 PPO Page 3 of 6	"If you need immediate medical attention" – "Urgent Care": This should include an explanation that emergency rooms, even if it's the ER in your network, often use physicians who are not in your network, and that these physicians may balance bill. At a minimum, this should refer to balance billing definition at top of p.2 of 6.

45 CFR §147 Appendix A-2 PPO page 4 of 6	(a) Excluded Services – How will the policyholder know what is “routine”? Some PPOs have gatekeeper primary care physicians and some do not. If this PPO does not have a gatekeeper, how would policyholder know what is routine and what is not? (b) Where is the “coverage area” described? What is the coverage area for this policy? If a spouse, child or other dependent moves outside of the coverage area, sometimes s/he is no longer covered, sometimes s/he is covered for ER services only, sometimes s/he is covered same as in/out of network. PLEASE ADD an explanation that explains this issue. See above under 45 CFR §147 Appendix A-2 PPO, page 1 of 6. (c) Grievance – is this a complaint to government regulator or to insurer? If it means a complaint to a government regulator, it should say “You have the right to file a written complaint <u>with your state insurance regulator</u> to express your dissatisfaction…” The insurers should be required to provide contact information to the appropriate state regulator. (d) Or, if Grievance is meant to be the first level of complaint to the insurer regarding a denial of benefits or authorization, it should say “[a] grievance is the first level of your complaint to the insurer/plan following its denial of your benefit or treatment…” etc. (e) Appeal section should say “an appeal is a request <u>to</u> your health insurer to review a decision ~~or grievance again~~ <u>it made in response to your Grievance.”</u> (f) PLEASE ADD. For further information about Grievance/appeals, you can also contact your state insurance/HMO regulator at

	www.yourinsuranceregulator.gov, and should include 800 #s. (g) Instructions re Excluded and Covered services must be clearer. The form should use term "excluded" or "not covered," but not both. Insurers should include in this list their most significant exclusions/limitations. (h) The sections of the form Services Your Plan Does NOT Cover and Other Covered Services, should contain a more representative list of exclusions and covered services.
45 CFR §147 Appendix A-2 PPO page 5 of 6	(a) "About these coverage examples": Please change language as follows: "These examples show how this policy/plan might cover medical care in three situations. Use these examples, in general, to see how much insurance ~~protection~~ coverage you might get from this and from other different policies/plans. (b) Having a Baby – "Maternity is not covered, so you pay 100%": Maternity is an EHB. Is this language for just years 2012-2014? (c) Treating breast cancer – Here, "limits or exclusions" is for the wig only, and the wig is called a prosthetic. Wouldn't an average consumer think of a breast cancer prosthetic as reconstruction of the breast? Listing "wig" as a prosthetic device for breast cancer (and an uncovered prosthetic device) might be alarming to consumers. This needs to be changed/explained. (d) "Limit" should be clarified. Does it mean "limit" in the sense of lifetime/annual limit? Or "limit" as something short of an exclusion?

	(e) Managing Diabetes – why would medical equipment and supplies be excluded? For diabetes treatment, those should be durable medical equipment – necessary to treating the illness. And same comments as above re "limits" "exclusions" definitions.
45 CFR §147 Appendix A-2 PPO page 6 of 6	(a) "What are some assumptions" "costs". This section should say that for purposes of calculating out of pocket limit, premiums are not included." This is because for the average person, a premium is a cost. "Patient's condition was not an excluded or preexisting condition." This is confusing because: • There has been widespread publicity that there will be no exclusions after 1/1/2014. • If this will be used in years 2012- 2014 we don't want to encourage insurers to exclude Pre existing conditions. • If this will be used in years 2012-2014, it should explain that after 1/1/2014, there will be no exclusions permitted for preexisting conditions. • Insurers don't always exclude every preexisting condition. • An exclusion is not an exclusion of an entire condition, but rather an exclusion of a service – see wigs under breast cancer. (b) "Can I use Coverage Examples to Compare plans": The answer is confusing – "…check the "you pay" box. "The smaller that number, the more coverage the plan provides <u>and, the less you contribute to the coverage."</u>
Appendix B	(a) Title: Instructions should be "Draft Instruction Guide for

	SBC Template" for Group." (b) "eligible employee who enrolls ~~conducts enrollment~~ electronically…."
Appendix C-1 Individual HMO Page 1 or 4 Model for Yes answers	(a) Why does the HMO form contain 4 pages and not 6, as for the PPO? (b) Why are pages 2-4 or 2-6 not provided? (c) We assume that numbers will be filled in.
Appendix C-2 Individual HMO Page 1 of 4 Model for No answers.	(a) Why for HMO are there just 4 pages when for PPO there are 6 pages? Why is only page 1 provided? (b) Out of Pocket – needs to be clarified – out of pocket for HMO is just co-pay, so it should say, "no limit on co-pay." (c) "does plan use network providers" – Why is the answer "no"? How can an HMO not have specific providers? An HMOs providers would be all the providers in the HMO's facility, or there would be a list.. (d) "do I need a referral" Do HMOs always require a referral? Why is this answer "no"? (e) "are there services the plan doesn't cover" If this answer is "No" where is p.3 with the list of services that are not covered? (f) What is not included in out of pocket? (g) "Is there an overall annual limit on what the insurer pays" - Why is the answer "yes"? Is this language for years 2012-2014? (h) "does plan use network of providers" - why is the answer that if you use in network, plan will pay "some" or all of costs? Don't most HMOs pay the entire cost except for the co-pay? Don't HMOs pay $0 for out of network? This should be explained.

GLOSSARY	
General	(a) The glossary should be available on government websites too. (b) Additional terms should be defined, e.g., Plan types: HMO, PPO. POS, indemnity, high deductible, limitation, Coverage Area, annual limit, overall annual limit, policy, formulary. (c) All definitions should be clear as to how they apply differently to PPO type policies and HMO type policies.
Appeal	This is confusing – see comment above on appeal/grievance
Balance Billing	This definition must clarify how, if at all, balance billing applies to both PPOs and to HMOs.
Co-Insurance	This definition should explain clearly whether co-insurance incepts only after the deductible has been met and whether co-insurance is part of out of pocket limit. As written, the definition is unclear.
Complications of Pregnancy	Why is this mentioned? Maternity benefits are an EHB. It is confusing to include this definition. Since ambulatory care (morning sickness) and hospitalization (preeclampsia) and maternity, are all covered as EHBs, why include this definition, if complications of pregnancy are all covered?
Deductible	The definition should be clear as to what expenses count towards the deductible – for example, do both co-insurance and co-pays count toward the deductible? Also, what is the period of the deductible? The definition needs to say that a new deductible applies every year, or every policy period, and the forms (Appendices) should be modified to state that the deductible starts

	again for each policy period, or calendar year.
Durable Medical Equipment	This includes blood testing strips for diabetes, but the example in Appendix for PPO *excludes* medical equipment for diabetes.
Hospice	Does hospice also cover people who are dying of old age, or just people dying of a disease?
Medically necessary	There is concern that this definition may restrict care for disabled persons or place other unintended limitations.
Network	Please add an explanation of how the networks relate to coverage area/service area?
Out of pocket limit	The definition needs to be clearer as to what is and is not included.
Plan	What about individual insurance policy? "Plan" is a confusing term, as ERISA employee benefit plans are referred to as plans, to differentiate from the health policies and other employee benefits contained therein. Also, health coverage provided by an HMO is called a plan.
Preauthorization	Please clarify how this would be different for a PPO type policy or for an HMO type policy? The definition needs to be clear as to the difference (if there is any) between pre-authorizations and referrals? Please add an explanation of other terms used to mean the same thing. The last sentence is confusing: If the service is pre-authorized by the primary care physician, then it isn't it covered by HMO?

	What does this mean in PPO context?
Preferred/Participating	If this refers to the tiered system, then it should say what it means. Please clarify among all of the documents whether the terms preferred and non preferred, participating and non-participating, in network and out of network, etc. are the same or different, and how so in the PPO and HMO context.
Premium	The amount that must be paid for your health insurance. This should explain that there may also be additional charges, co-pays, co-insurance.
Prescription drug coverage	Unclear. Does this mean as a separate policy or as a coverage within a health insurance policy/plan?
Primary care physician	PLEASE ADD that a woman may choose an OBGYN to be her primary physician and that parents may choose a pediatrician to be their child's primary physician. PLEASE ADD in some cases the primary physician is a gatekeeper, and that you need the primary's permission to see other doctors.
How You and Your Insurer Share Costs – Example	
This, for the first time, explains that coinsurance doesn't start to be charged until deductible has been paid.	