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

Attn: CMS-9982-P

RE: Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Notice of Proposed Rulemaking regarding the Summary of Benefits and Coverage and Uniform Glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act ("NPRM"), which was published in the Federal Register on August 22, 2011.[1] The NPRM is issued as required by Section 2715 of the Public Health Service Act, added by Section 1001 as amended by 10101(b) of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act ("PPACA"), which directs the Secretary to develop standards for use by a group health plan and a health insurance issuer in compiling and providing a summary of benefits and coverage (SBC) that accurately describes the benefits and coverage under the applicable plan or coverage. As with other regulations under these Acts, the NPRM was published jointly by the Department of the Treasury, the Department of Labor and the Department of Health and Human Services (the "Departments").[2]

[1] Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking, 76 Fed. Reg. 52,442-52,475 (August 22, 2011) (to be codified at 45 C.F.R. pts. 147; 29 CFR pt. 2590; and 26 CFR pts. 54 and 602) [hereinafter referred to as "NPRM"].

[2] Pursuant to the request in the IFRs, the Chamber is submitting these comments to one of the Departments - The Department of Health and Human Services, with the understanding that these comments will be shared with the Department of Labor and the Department of Treasury, as well.

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance – is represented. Also, the Chamber has substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

OVERVIEW

The Chamber and our member companies want quality health care to be readily available at an affordable price, a central goal of PPACA. The Chamber has also long advocated for transparency of price, quality and information. We agree that access to meaningful information about the price and quality of health care services and coverage will lead to meaningful reform and cost containment. Our comments include general recommendations with regard to fulfilling the intent of the statute and specific comments in response to questions posed by the Departments.

A. GENERAL RECOMMENDATIONS

We urge the Departments to be mindful of statutory language as they promulgate regulations. If the Departments believe that there are severe unintended consequences that would result from a strict reading of the statute, we urge the Department to carefully consider regulations which would advance the goal of the statute and avoid unintended, costly and duplicative results.

In evaluating these general recommendations, we ask the Departments to remember that Congress and the administration chose to build on the current employer-based system when drafting and enacting this law. Therefore, we urge the Departments to similarly build on current successful practices, systems and processes in implementing the law in order to avoid unnecessary, costly duplication. Most importantly, we urge the Departments to understand that employers are a main source of coverage for millions of Americans. Yet, employers already are struggling with the high cost of employee benefits.[3] It is critical that the Departments not exacerbate these cost challenges by imposing additional complex administrative costs onto employers or our administrators.

[3] See Kaiser Family Foundation Employer Health Benefits: 2011 Summary of Findings, http://ehbs.kff.org/pdf/8226.pdf "Over ten year period (2001-2011), average family premiums rose by 113 percent."

1. Promulgate Regulations According to the Statute

With regard to the timing of required compliance and the areas that the standards should govern, we urge the Departments to carefully consider the statutory language.

Timing

The text of Section 2715 begins with a requirement that standards be developed no later than 12 months after the law is enacted and subsequent deadlines follow. Later, *based on this first deadline*, the statute affords issuers, plans and sponsors a 12 month period after the establishment of standards to comply with the new documentation requirements.[4] We urge the Departments to afford issuers, plans and sponsors at least ***an 18 month period*** to comply following the issuance of final standards via a final rule. In addition to not penalizing issuers, plans and sponsors because the Departments failed to meet their statutorily prescribed deadline, we urge the Departments to permit a more realistic time frame for their compliance.

Assuming the proposed rule stands as is, it will require insurers, TPAs, and group plans to completely redesign their systems for producing benefit information and require that information to be provided at multiple times over the course of a typical plan year (including enrollment). The requirement to design a SBC for each specific benefit option (HMO, PPO, PSO, HSA/HRA), premium category (self, family, parent+child) and carve-out (behavioral health and pharmacy) will result in each enrollee potentially getting 10 – 15 SBCs depending on which options they are considering. Additional work will be needed to produce Coverage Examples (CEs). So 18 months is a more realistic estimate of what will be needed.

However, the NPRM appears to continue to require insurers and plans to comply with the provision by the March 23, 2012 deadline, when still no final rule as to what compliance entails has been issued. If a final rule were issued November 23, 2011 (which would be difficult given the Departments charge of responding to all filed comments when issuing a final rule), plans would have 4 months to comply with a very complicated requirement. This compressed timeline is inadequate for plans and issuers to make the complicated system and program changes necessary to implement these regulatory requirements. We recommend that compliance not be required until 18 months after the issuance of a final rule and we urge the Departments to announce this compliance modification immediately to provide plans and issuers certainty.

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[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).
"§2715(a) IN GENERAL.- Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage."
"§2715(d) REQUIREMENT TO PROVIDE. – Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a).

Standards As To What – Not Standards As To Whom, By Who, When, and How.

The statute is clear as to who provides the summary of benefits and coverage and uniform glossary (UG)[5], to whom[6], when[7] and how[8]. It seems strange that the NPRM states, "[t]hese regulations…will govern who provides an SBC, who receives an SBC, when the SBC will be provided and how it will be provided," when the statute already does this.

The statute at §2715(d)(1) and (3) clearly states who provides the summary of benefits and coverage: "a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States) or in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan)."

The statute at §2715(d)(1) clearly states to whom an SBC must be provided: "to an applicant, an enrollee, a policyholder or certificate holder."

The statute at §2715(d)(1) clearly states when an SBC must be provided: "prior to any enrollment restriction, at the time of application, prior to the time of enrollment, or reenrollment (as applicable) and at the time of issuance of the policy or delivery of the certificate."

The statute at §2715(d)(2) clearly states how an SBC must be provided: "in paper or electronic form."

Instead of the "who," "to whom," "when" and "how," the statute specifies that the Secretary is to issue standards to the "what." The standards the Secretary is to issue are to be "use[d]…in compiling and providing applicants…a summary of benefits and coverage explanations" - the elements and the method of compiling the SBC. While the NPRM does address the "what," or the content elements based on NAIC's recommendations, the NPRM overreaches by relegislating the who, to whom, when, and how that the statute defines.

RECOMMENDATION: Delay implementation or provide a non-enforcement period for at least 18 months following the release of the final regulations. Unless there are less costly and less burdensome alternatives, follow the statutorily prescribed who, to whom, when and how.

2. Avoid Unnecessary, Costly Duplication

If the Departments conclude that a strict reading of the statutory specifications as to the who, to whom, when and how will result in costly unintended consequences, we would support

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[5] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001 (amending Public Health Service Act §2715(d)(3).

[6] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001 (amending Public Health Service Act §2715(d)(1).

[7] Ibid

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001 (amending Public Health Service Act §2715(d)(2).

regulations that assuage this result. One such area where we urge the Departments to consider promulgating regulations to facilitate effective and proper implementation is with regard to large group plans.

Employers, health insurance issuers and other groups sponsoring group health plans already provide Summary Plan Descriptions (SPD) as required by the Employee Retirement Income and Security Act (ERISA), as well as benefit summaries that are customized to provide information in the format preferred by their employee population. Other highly-customized tools and information are also provided to employees and individuals when they enroll during open enrollment periods or otherwise. Among our chief concerns, we fear that the Deparments fail to appreciate the value of the current information that employers provide, but also the enormity of the cost to comply with this new duplicative notice requirement.

Additionally, there are other less onerous ways to facilitate easy comparisons for individuals and small employers shopping for coverage. The federal government and other health care stakeholders have expended significant resources in establishing the HHS web portal which will provide extensive information on benefit design and other aspects of coverage. The NPRM alludes to this process saying:

> Finally, consistent with the standards for electronic disclosure, these proposed regulations seek to reduce the burden of providing an SBC to individuals shopping for coverage. Specifically, these proposed regulations provide that a health insurance issuer that complies with the requirements set forth at 45 CFR 159.120 (75 FR 24470) for reporting to the Federal health care reform insurance Web portal would be deemed to comply with the requirement to provide the SBC to an individual requesting information about coverage prior to submitting an application. Any SBC furnished at the time of application or subsequently, however, would be required to be provided in a form and manner consistent with the rules described above.[9]

While the NPRM's recognition is helpful, it must go further and provide a complete safe harbor for individual market coverage and small group market coverage provided that the plans are participating in the web portal.

Unnecessary

We appreciate the repeated references in the NPRM to the goals of minimizing cost, duplication and burdens on employers and insurers. However, we remain concerned that the Departments fail to properly appreciate and account for the substantial investment that issuers and group health plan sponsors have already made to successfully ensure that individuals understand the terms of their coverage. The final regulations should build on these existing processes and methods and leverage them as much as possible. However, the proposed regulations do not. Instead, the NPRM requires issuers (and ultimately employers and purchasers) to devote significantly more financial resources to accomplish something that by and large is already being

[9] NPRM, 76 Fed. Reg. at 52,449.

achieved. As currently proposed, the rules require the provision of an unrealistically rigid SBC that will too often be redundant and will have the unintended consequence of confusing or overwhelming consumers rather than making them better informed.

Costly

The Departments also do not appear to comprehend the enormity of the cost to create and provide this new summary of benefit and coverage and uniform glossary. Given the near infinite need for additional financial resources to expand coverage and enrich benefits, we urge the Departments to recognize that there is a finite amount of money and resources that employers can spend, particularly now as employers are struggling to recover from the recent recession. Requiring this duplicative documentation will force employers to use their limited financial resources to pay to reformat materials that already exist, instead of allowing employers to use those resources to pay for more comprehensive benefits for their employees. As proposed, this NPRM requires a significant investment of employers' limited resources and does not provide additional value to employees.

Further, this mandate will also have very real ramifications on premiums. Unnecessary administrative costs drive up the cost of coverage and make it unaffordable, which harms both employees and employers. With the cost of health care already rising at 9 percent per year,[10] it is imperative that the federal government not further threaten affordable, quality employer-based coverage by imposing unnecessary administrative costs and burdens on the employer community. Unfortunately, we believe the NPRM will do just that by unnecessarily increasing cost and adding complexity for employers without providing any corresponding benefit to employees.

RECOMMENDATIONS: Provide a safe harbor for large employer group health plans that provide this information through the summary plan description in conformance with ERISA requirements and other summary materials. Create a safe harbor for individual market coverage and small group market coverage listed on the federal government Plan Finder portal. Coverage listed on the portal should be deemed to be in compliance with all aspects of the Summary of Benefit form. Individuals could access this information at anytime using the Plan Finder website. In addition, enrolled members could request hard copy printouts of the portal information from their health plan up to three times per year.

B. COMMENTS ON ECONOMIC IMPACT AND PAPERWORK BRUDEN

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13563, issued by President Obama this year, especially emphasizes the importance of quantifying both costs and benefits of regulatory alternatives considered. In the proposed rule, the Departments have failed to adequately comply with these Executive Orders (EOs).

[10] *Employer Health Benefits – 2011 Annual Survey.* The Kaiser Family Foundation and Health Research and Educational Trust. 2010. Pg 10.

Two categories of errors or omissions describe the failures of the Departments:

1. Under benefits, the Departments fail to adequately estimate the monetary benefits of the selected proposal and of non-selected alternatives; and
2. Under costs, the Departments fail to document and present a credible empirical basis for compliance labor time burdens used in cost calculations.

In each of these categories, the Departments fail to adequately analyze the economic impacts of the proposed regulation; this is discussed in detail below.

1. Benefits: No basis for assertion that benefits outweigh costs

The Departments identify the benefits of the proposed rule qualitatively in terms of reduced transactions costs to health insurance consumers. While the idea that a uniform template for comparing the premiums, out-of-pocket costs, and benefits of competing health insurance plans would reduce the consumer's time, effort and errors in asssessing health insurance costs, the Departments have made no attempt to estimate the monetary value of these benefits.

The Departments could have readily developed quantitative estimates of the savings in time that a typical consumer would achieve by conducting an experiment in which different randomly selected groups of consumers were asked to choose the least costly (or best value by some other criteria) plan from among a selected group of plans. The treatment group would have been provided with information using the proposed standard information template and a control group of subjects would have been asked to choose based on review of existing plan information documents. Both the time to make choice and the accuracy of choices by members of each group could be measured.

This experiment would have provided a statistical test of the hypotheses that the standardized template results in reduced consumer choice time investment and in greater choice efficiency (accuracy with respect to a defined choice criterion). If the findings confirmed that the standardized template resulted in reduced consumer time to make choices, than the time difference could have been multiplied by a measure of average consumer time-value (such as average hourly wage) to obtain a monetized estimate of the benefit per consumer. This parameter multiplied by the estimated number of affected consumers who make health insurance choices each year would provide one component of the annual benefit for the proposed rule. The other component of benefit, the putative value of increased choice efficiency, could also be estimated from the experiment results by comparing, for example, the average plan cost chosen by members of the treatment group to the average plan cost chosen by members of the control group. Instead of simple cost, the efficiency benefit also could have applied a value criteria reflecting optimization of plan benefits relative to cost.

The experimental approach could have been expanded to test several different versions of a standardized template. By doing this, the Departments could have demonstrated that the proposed template is in fact more effective and efficient than alternatives that could have been proposed.

Without the results of monetized benefit estimates which the Departments could have readily obtained, there is no empirical basis for the Department's assertion that the benefits of the proposed rule exceed its considerable costs. Nor have the Departments shown that the specific template proposed is effective in comparison to other templates that could have been proposed or even in comparison to no template at all.

The Departments should withdraw the current proposal and conduct experiments to test the hypothesis that a standard template will provide the claimed benefits of reduced consumer transaction time and increased efficiency of choice, that the monetized benefits, if any, of the proposed standard template exceed those of alternatives, and that the monetized benefits of the proposal exceed the reasonably estimated costs of implementation and compliance. In many regulatory analysis contexts the estimation of benefits in monetary terms is quite challenging to agency resources and capabilities. In this case, the task of estimating monetized benefits is remarkably direct and feasible, and the Departments' failure to pursue this opportunity is both unfortunate and perplexing.

2. Costs

The Departments have estimated the costs of the proposed rule as being comprised of two major components: (1) the initial costs of modifying information technology (IT) systems and work processes to comply with the proposal, and (2) the annual on-going costs of production and review of Summaries of Benefits and Costs (SBCs) and Coverage Examples (CEs) to update material to reflect changes in plan costs, benefits and characteristics, and to distribute the Glossary and SBC's (including CEs) to persons who request them. In most cases, the cost components are computed by the Departments for the typical insurer or third party administrator (TPA) as the sum across an array of labor categories of the multiplicative product of an hourly labor rate and an estimated number of hours of labor to accomplish a given compliance task.

While the hourly labor costs applied by the Departments seem to be appropriately based on Bureau of Labor Statistics (BLS) survey data, the time estimates for most tasks are flawed in two critical respects: (1) the Departments have not provided an empirical basis for the time parameters used, and (2) in many cases the time parameters assumed are too small to be credible. In those cases where a supposed source for the time estimate is provided, inspection of the source reveals that it is a prior regulatory impact analysis or Paperwork Reduction Act Information Collection Request (ICR) document in which the cited time estimates are only arbitrary assumptions without empirical basis.

Credible, empirical sources of data on which to base time parameters in the cost calculation were available to the Departments, but they have arbitrarily chosen not to use these better data sources:

1. The Departments could have conducted sample surveys of insurers and TPAs potentially affected by the proposed rule to obtain their experience-based estimates of the time parameters required to accomplish defined compliance activities;

2. The Departments could have conducted follow-up surveys of prior ICRs which involve similar tasks to those required for compliance with the proposed rule.

3. The Departments could have conducted experiments in which government employees are assigned to conduct simulations of the activities required for compliance with the proposed rule in which their time and effectiveness in accomplishing the tasks are recorded.

The Departments have claimed that the proposed rule is not an economically significant rule under E.O. 12688, nor a major rule under the Congressional Review Act ($100 million annual cost threshold), and not a major rule under the Unfunded Mandates Act (approximately $136 million annual cost threshold in 2011). The validity of this claim is questionable given how close the Departments' published cost estimates are to the relevant thresholds and given the sensitivity of the cost computations to changes in the assumed labor time parameters to reflect more credible or empirically-based time estimates. At the very least, the Departments should modify their cost estimates to include an uncertainty analysis which examines how the computed cost varies when key parameters change within a reasonable expectation range. Such an analysis is required by OMB guidelines for economically significant rule proposals.

The following items detail examples of omissions, questionable assumptions or errors which cumulatively point to the likelihood that the annual costs of the proposed rule will exceed the thresholds for economically significant and major rules under the relevant Executive Orders and statutes.

1. Table 4 (p. 52457) of the proposed rule Preamble lists the estimated cost of compliance for 2012 as $73 million. These are described as labor and non-labor "maintenance" costs – costs associated with reviewing updating, producing and distributing the glossary, the SBCs and CEs. Table 3 (same page) shows one-time costs for modifying and developing IT systems and work flow processes and for first time development of SBCs and CEs as $25 million, but these costs are ascribed to 2011. Since it is already late in 2011, it is likely that these initial, one-time costs will also be incurred in 2012, bringing the total for that year to $98 million – almost equal to the economically significant/major rule threshold even without considering other reasonable adjustments to the cost computations of the Departments.

2. The Departments have based their estimates of the numbers of persons who will request glossaries and SBCs/CEs as a percentage of the total number of persons currently enrolled in individual or employer-sponsored group health insurance plans. The Departments have ignored a primary intent of the health law to reduce the number of uninsured individuals. The basis used by the Departments to estimate the demand for glossaries and SBCs/CEs is too low and should be raised to include an estimate of demand for these materials from currently uninsured individuals who will be seeking (or at least contemplating) insurance coverage in 2012, 2013 and future years. This adjustment will likely raise the compliance cost for 2012 and later years to a total in

excess of the economically significant/major rule thresholds.

3. The Departments estimate that it will require a total of 960 labor hours for large insurers or TPAs to implement one-time changes in IT systems and work flow processes to accommodate the proposed changes, but no empirical basis is provided for this estimate. The estimate amounts to less than 6 months of effort by one full-time-equivalent employee. Give the complexities of decision-making, reviews and process implementation typical of large organizations, this is an incredibly low and naïve time estimate. The Departments should look to their own experiences in implementing similar IT and work flow changes. If the time requirement were merely doubled, the one-time cost component would increase from $25 million to $50 million, and the Departments have provided no analysis, empirical data or reasonable basis for denying that the plausible cost could be many times higher. The estimate provided by the Departments is arbitrary and capricious and appears designed to mislead the public and policy-makers regarding the true economic significance of the costs of the proposed rule.

4. The Departments estimate that "each issuer/TPA would need 3 hours to produce and 1 hour to review, SBCs" annually. This estimate also is arbitrary and without any empirical basis. The estimates of 3 hours to produce and 1 hour to review the SBC are incredibly low and naïve given the importance of the documents in terms of both legal liability and marketing impact. The detailed calculations shown in Table 6 of the Preamble indicate that the Departments estimate that producing the information to include in the SBC would require only 90 minutes of effort by an insurance underwriter or similar financial professional in the benefits/sales area (compensated at $41.94 per hour). It would be a simple exercise for the Departments to assign staff members from their own actuarial units to simulate the production of SBC data from available insurance plan data and reports and to report realistic time estimates for this critical compliance task. Similarly, the estimate embedded in Table 6 of only one-half hour each for attorney and financial management reviews of the draft SBC are incredibly low and naïve. If any insurer or TPA were to actually publish an SBC based on such limited effort and review, the exposure to legal liability from error would be potentially catastrophic.

5. A major element of the compliance costs estimated by the Departments is the cost of distributing the SBCs in response to public requests. The total costs are quite sensitive to the number of annual requests that each insurer/TPA will receive and to the distribution of responses between printed/mailed responses and electronic responses. The Departments' estimates of the number of responses and of the proportion of responses that will entail the more expensive printed/mailed alternative are arbitrary, without a sound empirical basis, and seem designed to under-estimate the actual likely cost of the proposed regulation. At the very least, the Departments should report costs based on ranges of likely numbers of requests and modes of responses. Preferably, the Departments should conduct a pilot test of the proposed requirement to obtain realistic empirical information. Alternatively, the Departments should conduct a survey of insurers/TPAs to obtain their experience-based estimates of these critical parameters.

The extensive flaws in the economic impact analysis of the proposed rule produced by the Department's support the conclusion that the current proposal is arbitrary and capricious and has not been developed with due regard for the requirements of the relevant Executive Orders and statutes. The claim that the proposed rule is not economically significant or major is not supported by credible facts, and review of the naïve calculations made by the Departments reveals reasonable cause to conclude that the costs will likely far exceed the relevant thresholds. Similarly, the failure of the Departments to present any monetized estimate of benefits, when it was quite feasible to have done so, puts in question the claim that the benefits of the proposed regulation will exceed its costs.

RECOMMENDATIONS: To correct these flaws, the Departments should immediately withdraw the current proposal, undertake the experiments, surveys and other research described in these comments before publishing a revised proposal more reasonable in terms of costs and benefits.

C. SPECIFIC RECOMMENDATIONS

1. Arbitrary Mid-Month Effective Date

The statute provides that the SBC must be provided "prior to any enrollment restriction" on or after March 23, 2012 without regard to plan year. The proposed rules provide no clarification of the effective date. As a result, insurers and all group health plans must be prepared to provide an SBC on March 23, 2012, without regard to plan year. This will also create an additional burden on employers. Producing the SBCs twice, once for new enrollees and again at renewal during the first year of implementation dramatically increases the work effort and expense required to comply.

RECOMMENDATION: Clarify that the requirement to provide the SBC applies based on the plan's first plan year on or after the delayed effective date or non-enforcement period.

2. Improper Regulatory Changes

As discussed above, we appreciate the role of the Departments in promulgating regulations to facilitate the implementation of the statute and understand that there are instances where regulations must slightly deviate from a strict reading of the statute to assuage conflicts, improve effectiveness, facilitate compliance and ameliorate unnecessary costs and burdens. However, unlike the modifications recommended above there are several statutory modifications made by the NPRM that will complicate implementation and increase the cost and burden of compliance. We urge the Departments to promulgate a final rule that does not extend the "how" and the "when" prescribed in the statute.

Improper Modification to Statutory "How"

We urge the Department to follow more closely the statute's requirement that allows entities to be deemed compliant if SBC is provided in paper or electronic form. The statute does not indicate that SBCs must ever be provided in paper format, much less that it be provided in paper

format “free of charge.” The NPRM further fails to limit the “free of charge” provision of this material.

RECOMMENDATION: Given that there is considerable, unnecessary expense associated with providing paper documentation, we recommend that if the Departments insist on requiring paper SBCs, that issuers, plans or plan sponsors only be required to provide paper SBCs in response to an express request and only once a year, in addition to the statutory required times when it must be provided.

Improper Modification to Statutory “When”

The NRPM places a new requirement that plans or issuers must provide an SBC or UG within 7 days of a request. This burdensome short time period is not contained in the statute and in many instances – depending on the time of year and other administrative or system changes scheduled to occur – may be overly burdensome.

RECOMMENDATION: We recommend that the final rule require plans to provide SBCs as soon as practicable upon request.

3. Proper Modifications

There are several modifications that the NPRM proposes which the Chamber supports. Specifically, we appreciate the proposal to allow a single SBC to be provided when multiple participants and/or beneficiaries reside at the same address. We agree with the recommendation that plans and issuers only need to automatically provide a new SBC with respect to the benefit package in which the participant/beneficiary is enrolled, with regard to renewal when a plan offers multiple benefit packages. Finally, we agree with the interpretation that notice is only required for a material modification that affects the information on the SBC and occurs other than in connection with renewal or reissuance of coverage. We believe that notice need not come in the form of a new SBC.

RECOMMENDATIONS: We recommend that the Departments include these proper modifications in the final rule.

4. Coverage Facts Label Requirement

We are concerned that the current construction of the coverage facts label is unnecessarily complex and will lead to additional costs for employers and our employees – including both the self-funded and the insured plans. In addition, these examples would need to be updated every year with HHS data. It would be unlikely that all employers and insurers could assure that their labels were updated on the same day – leading to employees and consumers obtaining very different data from different employers and insurers.

The statute requires an issuer or group health plan to provide only two coverage examples (CEs): one for pregnancy and one for a chronic disease. The NPRM, however, requires up to six CEs including pregnancy, diabetes and breast cancer. These CEs do not serve the goal of HHS to

"illustrate benefits provided under the plan or coverage for common benefits and scenarios" because the CEs rely on skewed/complicated/ assumptions provided by HHS based on industry wide averages.

These assumptions include: course of treatment, length of treatment and the cost of treatment. We note that averages will never accurately illustrate an individual's cost sharing because illnesses, particularly complex diseases - such as breast cancer - are unique to each patient. Furthermore, the cost of treatment varies significantly based on geographic region, the provider and the health plan. Generally, we want to provide our purchasers with accurate information and not mislead them in any way. However we are particularly concerned with CEs because they will not only mislead purchasers, but they will mislead our sick purchasers because these are the individuals that will look to the CEs and rely on the cost sharing estimates. The more inaccurate the cost sharing estimates are, the greater the detriment to this vulnerable population.

RECOMMENDATION: We recommend deleting the Coverage Examples (CE) requirements, simplifying the CE requirements or creating alternative mechanisms to implement the CE requirement. Therefore, we ask that HHS either delete the CEs altogether or limit CEs to the statutorily mandated number – two – one for pregnancy and one for chronic disease, and have them be generic in nature. Next we recommend that HHS choose a chronic disease that is generally less complicated and more common, and that HHS not use breast cancer. We further think that when HHS establishes the parameters of CEs, it should limit the simulation to a course of treatment that lasts no longer than one year. This will control the potential for variables that will inevitably occur during the course of treatment over the long term and will thereby promote greater accuracy in the CEs. Finally we ask that HHS incorporate bold warning language (and possibly even graphics that indicate caution) in a prominent location on the CE coverage label to limit the extent in which individuals will rely on the estimated cost sharing data.

Finally, we recommend that HHS, TPAs and insurers work together to find an alternative mechanism to provide consumers with CEs so that the programming costs and resources and other complexities with compiling these by products are reduced. Many plans already uses cost estimator tools that can serve as an alternative to the CEs as proposed. For example, the cost estimator tool currently made available to members insured under the Federal Employees Health Benefit Plan supplies a range of the total medical cost estimates in nearly every U.S. zip code. While the tool currently provides ranges for 59 common, elective medical procedures at hospitals and other care centers, its capabilities will be expanded significantly in upcoming months.

5. Expatriate Health Plans

We appreciate the acknowledgment in the Preamble to the proposed regulation regarding the unique characteristics of expatriate and international health plans. As relates to Section 2715, coverage information that is particularly important to expatriates (e.g., medical evacuation and repatriation benefits and country-appropriate care) is not even contemplated in the SBC and there is no space allocated for this information. The forms are U.S. centric and have no applicability outside of the United States.

RECOMMENDATIONS: In recognition of those unique characteristics, we urge that expatriate health plans be exempt from these and all requirements of the Affordable Care Act as was intended under the law.

CONCLUSION

The U.S. Chamber of Commerce urges the Departments to work carefully and cooperatively with employers and to leverage and solicit input from employers based on their experience in providing plan specific information to consumers. We caution the Departments against promulgating regulations that impose unnecessary expenses onto employer-sponsored health coverage.

Sincerely,

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