



October 21, 2011

The Honorable Timothy Geithner
Secretary
U.S. Department of Treasury
Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224
Attention: REG-140038-10

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave., NW
Washington, DC 20210
Attention: RIN 1210-AB52

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20101
Attention: CMS-9982-P

Submitted via the Federal Regulations Web Portal, <http://www.regulations.gov>

Re: Summary of Benefits and Coverage and the Uniform Glossary

Dear Secretary Geithner, Solis and Sebelius:

Aetna welcomes the opportunity to respond to the Department of Treasury, Department of Labor and Department of Health and Human Services (the "Agencies"), Proposed Rule – Summary of Benefits and Coverage and the Uniform Glossary. 76 Fed. Reg. 52442 (Aug. 22, 2011) (the "Proposed Rule" or "NPRM").

Aetna is one of the nation's leading diversified health care benefits companies and offers a broad range of health insurance products and related services including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and

medical management capabilities. We are dedicated to helping people achieve health and financial security by providing easy access to safe, cost-effective, high-quality health care and protecting their finances against health-related risks. Aetna plays a particularly important role in the large group insurance market where we currently offer over 69,000 different group health benefit plan options. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. One way we work to improve the quality of health care is by providing our clients, whether they are individual members or employers, with a significant choice of coverage options and the tools to enable them to choose the coverage option that best suits their health insurance needs.

The summary of benefits and coverage ("SBC") requirement of section 2715 of the Public Health Service Act ("PHSA") is intended to provide consumers with a simple tool to compare the benefit plan options in which they are eligible for. Aetna understands that the health insurance market can provide a wide variety of options for consumers and therefore we recognize the importance of providing coverage information in an accessible and informative way. We note, however, that the Proposed Rule merely duplicates existing materials provided by issuers and group health plans and will likely mislead individuals through inaccurate data provided in the coverage examples.

The Proposed Rule's requirements will also harm consumers by increasing the costs of health insurance because the requirements for SBCs are extremely expensive to implement, especially when the materials will generally have to be delivered in hard copy. We estimate that implementation costs will exceed \$45 million over 4 years. This includes IT development, incremental staffing, printing, process updates and coverage examples.

Moreover, we think that at most SBCs will only enhance the ability to comparatively shop in the individual and small group insurance markets. Participants in the large group insurance market (which includes employers that either self-insure or purchase insurance) are already fully equipped to compare and purchase policies.

In the Proposed Rule, the Agencies have adopted the NAIC SBC Form template (the "Form") in its entirety rather than using the Form as a starting point and then making necessary simplifications and improvements. This Form is demanding and expensive because it specifies the content, symbols, formatting, bolding, colors and shading – which must be precisely reproduced.

The inflexible nature of the Form does not take into account the other materials that issuers and employers already provide, such as open enrollment materials and summary plan descriptions ("SPDs"), and therefore is largely duplicative.

The issue of duplication is further exacerbated by the delivery requirements. Issuers must provide additional Forms at various points during the purchasing process (i.e., upon request, upon application, upon acceptance, upon modification and upon renewal) and

separate SBCs must be provided to employees for every single benefit option they are initially eligible for.

Aetna recommends that the Agencies modify the Proposed Rule significantly, and we would appreciate the opportunity to work with the Agencies to implement the spirit of the law to facilitate transparency to consumers in an effective, efficient way that is affordable to employers. We suggest the following critical revisions:

- (1) Provide exemption or safe harbor for large employers (both insured and self-funded)
- (2) Simplify the coverage examples;
- (3) Immediately announce a delay of the implementation date;
- (4) Safe harbor for small group coverage
- (5) Exclude non-traditional products such as student health plans, limited benefit plans and expatriate plans: and
- (6) Additional modifications to the form and process to improve value for consumers

These issues, together with our other recommendations, are outlined in detail below.

I. Provide Exemption or Safe Harbor for the Large Group Market

The Proposed Rule does not take into account the unique nature of either self-insured employer plans or insurance coverage offered in the large group market. Importantly, the large group market operates in a similar manner to the self-insured market in that employers generally bear the risk of claims experience (through experience rated coverage).

In addition, larger employers are sophisticated purchasers and routinely customize their benefit options to meet the needs of their workforce which has resulted in a market with hundreds of thousands of unique group health plans, over 69,000 of which are offered by Aetna. The employers who participate in the large group market are generally equipped with human resources departments and consultants who are responsible for preparing and distributing educational materials and generally assisting their employees with enrollment decisions.

Imposing a standardized 4 page Form (which, under the Proposed Rule, has been expanded to 8 pages) for the myriad of the plan designs offered in the large group market would be a tremendous and costly task that would not add additional value beyond the disclosure and comparison tools already available to employers and employees. We believe that both large employers and their employees will find SBCs confusing and wasteful additional paperwork.

The NAIC has already indicated that special rules may be appropriate for self-insured plans. In its December 17, 2010 letter to Secretary Sebelius, the co-chairs of the NAIC

Working Group stated, "There may be additional changes required to the forms and instructions for large self-funded employer plans . . . , but those changes have not yet been formulated in the attached documents." Large group insured plans similarly require relief.

Recommendations:

Because of these unique characteristics, we recommend that the Agencies exempt the large group insurance market from the SBC requirements entirely. Large group market coverage was exempted by statute from key aspects of the ACA, including community rating and standards relating to actuarial value and essential health benefits. PHSA §§ 2701, 2701(a).

In the event that the Agencies decline to grant a complete exemption for such plans, we recommend that the Agencies, at a minimum, provide the large group market with a safe harbor that builds upon existing large group enrollment materials and SPDs. We urge the Agencies to adopt a flexible safe harbor by providing that if a large group health plan, at or before the time of enrollment, provides enrollment materials or a current SPD, that includes the Form's required content, regardless of format, then such large group health plan will be deemed to have satisfied the Proposed Rule.

If the Agencies are unwilling to provide a safe harbor that allows this flexibility, at the very least, the safe harbor should allow the delivery of SBC information in a single contiguous and prominent section in enrollment materials or the SPD, or separately, that includes the required content. This section could be conformed to both the 8 page limitation and 12 point Times New Roman font, but the requirements that specify symbols, formatting, bolding, colors and exact shading must be eliminated. Such requirements would increase the cost of health coverage without providing sufficient additional value beyond materials already available.

II. Simplify Coverage Examples

Section 2715 of the PHSA only requires the provision of two coverage examples – one for pregnancy and one for a serious or chronic disease. The statute provides limited requirements, specifically:

a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines.

The Proposed Rule, however, requires three coverage examples – pregnancy, diabetes and breast cancer – which may be extended to up to six coverage examples. The Proposed Rule additionally requires that issuers update coverage examples within ninety days of HHS publishing updated information relating to the prescribed examples.

Moreover, the NPRM's proposed customization of the coverage facts label to the specific cost sharing of the individual does not appear to be required by the statute. The statute speaks of "examples" which implies more generic information as opposed to information customized to an individual.

The generic cost examples may make sense because even under the highly specialized and complex NPRM coverage facts proposal, individuals would still be receiving information that is not reflective of their own specific circumstances.

For instance, the breast cancer example includes more than 400 services that would have to be individually priced and the course of treatment extends over three years. The treatment of breast cancer is dependent on the individual case, so of course this averaged example would not necessarily reflect the actual course of treatment that any single individual receives.

HHS would need to supply the necessary assumptions for the course of treatment as well as the pricing. As a result, individuals in distinct regions (e.g. New York City vs. Montana) will receive the same cost information.

The Agencies recognized issues with the breast cancer example in the Preamble to the Proposed Rule where it was noted that the data would be outmoded quickly. 76 Fed. Reg. at 52444, n.5. The data would need to be updated on an annual basis. This would present severe challenges for payers and consumers. Unless all payers update their data on the same day, consumers would receive very different "coverage facts" from different payers because some would be using 2013 data while others were using 2014 data.

Finally, Aetna conservatively estimates that it will cost in excess of \$7.5 million to implement just the coverage examples. The costs largely focus on developing a complicated automated algorithm that can dynamically process data to produce the coverage examples for thousands of different benefit plan options using HHS specified data. Given that the NPRM is both costly, but still is not specific to an individual, we believe there are other alternatives that would be just as beneficial to the consumer but be administratively more efficient to implement.

Recommendations:

Ideally, the Agencies would provide a safe harbor deeming issuers in compliance where the issuer makes available transparency and comparative tools to their *enrolled members* that meet certain basic criteria. Another approach would be for the Agencies to develop standalone *non-customized* coverage examples for consumers. These examples would provide for several typical cost sharing situations (e.g. \$1,000 PPO deductible with 20 percent cost sharing). HHS would product these coverage examples and make them available through a web-link. They would not reflect the actual benefit designs of a consumer, nor would they vary by employer or insurer.

If the Agencies do not adopt either of the above approaches, we recommend that they streamline the Proposed Rule to make the examples more useful for consumers and less expensive to provide.

- a) *The Agencies should only require two coverage examples* – one for pregnancy and one for a single chronic disease. We strongly recommend that the chronic disease be common and a less complex disease, such as asthma. In no event should six examples be required. Moreover, the breast cancer coverage example should be eliminated in both the group and the individual market. Unlike a routine pregnancy, the course of treatment and the cost of treatment for a patient with a complex and widely variable disease such as breast cancer is unique to each patient. As such, the current breast cancer example could be confusing to consumers – especially ones that actually have or had breast cancer.
- b) *Allow issuers to provide coverage examples through a standardized and electronic means supported by HHS and delivered by the issuer.* Issuers, such as Aetna could include an online form on their normal website where enrollees could enter specific health plan data information (e.g., deductible, out of pocket maximums, coinsurance). When the enrollee hits “submit”, the form would be transferred electronically to an HHS portal that would process the data and return an HHS created coverage facts label in real time to the consumer’s computer. The HHS portal would maintain the database that would supply the utilization, cost and other relevant assumptions regarding claims payment (e.g., assumptions surrounding medical policy and medical necessity determinations). The coverage facts label would clearly be labeled as “government certified” but consumers would never feel that they have left the issuer's website and the transaction would be in real time and take just a few seconds (similar to the time it takes to verify a credit card for an online purchase).

This approach would be far less costly, and it would ensure that the examples are consistently calculated across different issuers, thereby promoting the goal of the Proposed Rule to improve the ability of purchasers to compare plans. If enrollees do not have access to the internet, they should be able to request a hard copy of such information by calling Aetna and having Aetna access the HHS portal and print and mail a copy to the consumer.

This approach also avoids other logistical challenges. For instance, HHS will need to update the payment and other data on an annual basis. Every issuer would need to update their coverage facts process on the same day in order for consumers to have apples to apples comparisons under the original NPRM proposal. That is not a viable approach.

- c) *Allow for Adequate Revisions-* Even if the coverage examples are simplified, Aetna needs at least 6 months to update the coverage examples from the time in which HHS updates and prescribes new information (rather than 90 days).

III. Immediately Announce Delay of the Implementation Date

The ACA requires that the Agencies develop standards for the SBC "[n]ot later than 12 months after the date of enactment of the [ACA]." PHSA § 2715(a). The ACA further provides that issuers shall deliver SBCs "not later than 24 months after the date of enactment of the [ACA]." PHSA § 2715(d)(1). This structure clearly indicates that when Congress established the March 23, 2012 effective date, it assumed that issuers and employers would have a 12 month period from the issuance of the regulations to implement SBCs.

The Proposed Rule includes an applicability date of March 23, 2012, although the Agencies seek comments on the ability of issuers to comply with this date. The Proposed Rule includes the original effective date despite the fact that it was issued 5 months after the date a final rule was to be issued. Assuming the Agencies act quickly after the sixty day comment period, at best a final rule will not be issued until the end of 2011, which is 9 to 10 months behind the schedule mandated by Congress. If the Agencies maintain the original effective date, then issuers and employers will have only 3 months to comply with the final rule, clearly at odds with Congressional intent.

Significant lead time is necessary to fully implement the Form and satisfy its delivery requirements, especially if the Agencies maintain the current format and content requirements of the Form (including coverage examples) and do not allow for more flexible delivery requirements (i.e. electronic delivery in more circumstances).

Some of the many reasons why implementation is onerous is that it will require group health plans and issuers to: (1) overhaul their IT systems to source data; (2) develop new technologies to archive plan specific documents; (3) develop new technologies to facilitate electronic presentation and delivery; (4) hire vendors to assist with general implementation and delivery requirements; (5) make significant changes to business processes; and (6) perform extensive organizational training.

This effective date is particularly onerous for the large group insurance market. As noted above, Aetna would be required to provide customized Forms for 69,000 plan designs virtually overnight. Moreover, unlike the individual market, the use of the HHS web portal would not provide any relief for the disclosure requirements with respect to "shoppers" since there are no large group products on the portal and the portal is ill equipped to handle the large quantity of highly customized large group plans.

Recommendations:

We urge that the Agencies provide an effective date of at least 12 months after the date in which the final rule is issued. To maximize efficient implementation, an effective date of 18 months after the final rule would be ideal.

In addition, the effective date should be phased in to allow for delayed implementation in the self-insured and large group markets and the coverage examples. Specifically, Aetna recommends that:

- The Agencies should immediately announce their intent to delay the effective date of the Proposed Rule so that issuers and employers do not commit resources to comply with a rule that is still in Proposed Form and is subject to potentially significant revisions.
- With respect to the individual and small group markets, the final rule should require that the Form be delivered with respect to plan or policy years beginning at least one year after the applicability date of the final rule (and ideally 18 months). The Uniform Glossary would be available at this time as well. Moreover, the Form should only be required to be delivered for enrollment periods and applications that occur after that plan or policy year commences (e.g., it should not apply to special enrollment events that occur prior to an enrollment period but after the one year effective date).
- With respect to the large group market and self-insured plans, we recommend a later effective date of plan or policy years beginning 18 months after the applicability date of the final rule. The Uniform Glossary would be available at this time as well. As with the individual and small group markets, the requirements will only apply to enrollment periods after that plan or policy year commences.
- For all markets, the coverage examples should be effective for plan or policy years beginning 24 months after the applicability of the final rule.

IV. Safe Harbor for Small Group Coverage:

Many small employers today struggle to offer health insurance coverage to their employees. As a result, offer rates are somewhat lower in the small group market –71 percent for employers size 10-24, and 48 percent for employers size 3-9.¹ To facilitate the purchase of coverage in the small group market, the federal government established PlanFinder – a web portal that requires the posting of all small group health plans available in the small group market.

The establishment of this portal required significant effort on the part of insurers who were required to extract and communicate extensive amounts of information. In addition, the federal government is using this portal to facilitate compliance with the ACA rate review provisions.

One key role of the PlanFinder is that it provides benefit information around the various small group health plans. Given that the PlanFinder already includes benefit information

that has been conformed to federal standards; we recommend that the Departments deem small group coverage that appears on PlanFinder as in compliance with the NPRM. This would be consistent with the statute's provision that the summary of benefit forms could be delivered in either electronic or paper form. This would avoid the small group insurance industry "redoing" another system change in order to facilitate yet another governmental summary benefit standard. Aetna offers approximately 2,000 benefit designs in the small group market. Every state includes its own set of benefit mandates for this marketplace as well as other differences that may need to be reflected in benefit design. Applying a new summary of benefit form to this market would be an additional cost that largely duplicates the effort for the PlanFinder program.

The NPRM alludes to using PlanFinder for the individual market:

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.

While this recognition is helpful, we believe it should go further and provide a complete safe harbor for individual market coverage and small group market coverage

Recommendations:

We recommend that the Departments deem small group health coverage posted on the PlanFinder portal as in compliance with the NPRM.

V. Exempt Non-Traditional Health Plans

A. Limited Benefit Plans Must Be Exempt

Aetna is a leading provider of group limited benefit plans (also called mini-med plans). Aetna provides group limited benefit plans exclusively to employer groups and such coverage typically covers part-time, seasonal and lower paid employees. Aetna enrolls over 400,000 individuals annually in group limited benefit plans through over 1,000 employer plan sponsors.

Current HHS regulations phase out annual dollar limits for group health plans by 2014. However, HHS has established a special waiver program for group limited benefit plans that allows such plans to continue to provide important coverage until 2014. One of the conditions for obtaining a waiver is that a prominent disclosure concerning the group limited benefit coverage must be provided to employers and individuals. This annual notice must detail the annual dollar limits that apply to covered benefits, and must also

include an HHS-mandated statement describing the approximate cost of one day in the hospital (\$1853) and the approximate number of days of hospital coverage that would be covered by the group limited benefit plan. *See* CCHIO Supplemental Guidance 2011-1D (June 17, 2011), at 7. In conjunction with the waiver program, HHS provided relief under the medical loss ratio ("MLR") rule for group limited benefit plans, recognizing the higher relative costs of administering group limited benefit plans relative to traditional group health coverage.

Requiring SBCs for group limited benefit plans that have obtained an HHS waiver is unnecessary. Benefit information is already provided to employers and enrollees, along with a special disclosure of the annual dollar limits on coverage, which is required under the waiver program. Requiring SBCs for group limited benefit plans will further drive up the already higher administrative costs of such plans. As such, it would undermine the relief provided under the waiver program and MLR rule.

Moreover, group limited benefit plans will be eliminated by 2014, so imposing additional compliance costs on such plans for such a short window of time (likely in 2013) would be of little value and could have the unintended effect of encouraging group limited benefit plan carriers to exit this business and encourage employers to drop their plans prior to 2014, before Exchange coverage and tax subsidies are available to assist the population currently served by limited benefit plans.

Recommendation:

We ask that the Agencies exclude mini-med plans entirely from the final rule.

B. Student Health Insurance Must Be Exempt

Aetna is a leading provider of student health insurance plans. Aetna provides student plans to over 160 public and private universities and colleges, and covers approximately 508,000 undergraduate and graduate students, many of whom do not have access to coverage through their parents, or, if that coverage is available, it is nonetheless unaffordable.

Since the ACA's adoption there has been uncertainty regarding whether student coverage is subject to the PHSA (and therefore the ACA). Student coverage does not constitute group coverage since it is not offered by an employer to employees. It also may be excluded from the requirements of individual coverage since student health coverage has typically been structured as short term limited duration coverage. Moreover, Congress expressed a clear intent in the ACA to preserve student coverage. ACA § 1560(c). HHS has interpreted this provision to mean that "if particular requirements in the [ACA] would, as a practical matter, have the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under Federal, State or local law, such requirements would be inapplicable..." 76 Fed. Reg. at 7771.

HHS has issued a Proposed Rule regarding student health insurance providing relief from certain provision for student plans (e.g., the guaranteed issue and renewal rules, transition periods for the annual limits requirement, and recognizing that student health center fees are not cost-sharing requirements for preventive services). In the preamble to that Proposed Rule, HHS indicated that it was considering relief from other aspects of the ACA, including the application of the annual limits rules and the MLR rule. MLR relief is needed for student plans to account for the higher administrative costs associated with frequent open enrollment periods that accommodate the academic calendar, customized policies, and above average manual billing and accounting practices that come from college health clinics. 76 Fed. Reg. at 7773.

If SBCs are required for student plans, the already higher costs of offering such coverage will be exacerbated. The requirements of the regulation regarding delivery will be particularly burdensome on student plans. In this regard, student plans generally provide more frequent enrollment periods than traditional group health plans (usually 2 times per year).

Moreover, some of the SBC content requirements will be particularly misleading for student plans. For example, student plans often have referral requirements that require that students first seek care at the university health services clinic, which would be difficult to reflect on the SBC.

Premium is also difficult to standardize and reflect for student plans since many colleges and universities add certain administrative fees to plan premium for the services they provide, which is reflected in published premium rates and ultimately retained by or returned back to the schools.

Finally, student plans are highly customized for each university or college. Most schools require special design elements for specific student segments, and any brochures and other materials must be tailored to that school and student population. Aetna administered nearly 600 unique plan designs for its 180 partner institutions in 2010 alone. Distilling these unique plans into a standardized disclosure is very problematic (much like the large group market).

Ensuring access to the SBC and the ability for an individual to certify that they viewed it at the point of sale also is impossible for many schools that require students to maintain insurance coverage as a non-academic term of institutional enrollment. In these instances, students are not voluntarily enrolling in school-sponsored insurance plans, but rather, are default enrolled by the institution when failing to provide evidence of existing coverage. Students, then, fall in and out of such requirements during the fall and spring term registration periods (e.g. students going from part- to full-time status).

Of the approximately 508,000 students Aetna currently covers, about 80 percent are subject to student coverage requirements and, as previously indicated, are automatically enrolled by their schools. As opposed to the approximate 20 percent who enroll

themselves, those subject to student coverage requirements simply lack the touch points necessary to solicit confirmation of having received the SBC.

Recommendations:

We recommend that the Agencies exempt student health plans from the Proposed Rule. However, at a minimum, the Agencies should exempt student health plans until they issue a final rule that tailors SBC requirements to student health plans as required by ACA § 1560(c).

C. Expatriate Plans Must Be Exempt

Aetna is the leading provider of expatriate plans which accommodate expatriates who live and work abroad. Aetna offers 12,000 expatriate policies that cover 400,000 participants. Based on the SBC requirements and the NAIC Form in which the Agencies have adopted, it is clear that when NAIC initiated the SBC form it did not have expatriate plans in mind.

- 1) The Form takes into account two tiers of pricing structures – in and out of network. However, in an expatriate plan there are at least three pricing structures – in and out of network and out of country, with potentially others.
- 2) The coverage facts label is ill suited for expatriate plans, because just as costs vary across states, costs vary even more significantly across country lines and even between regions within certain foreign countries.
- 3) The Form fails to take into account unique services that expatriate plans may cover in whole or in part, such as medical evacuations and repatriation.
- 4) Expatriate plans are generally designed to work with the health coverage systems in foreign countries and therefore may not include things like deductibles, co-insurance, and co-payments which are largely unique to the US health system and as a result it may be impossible for plans to supply this information on the Form.
- 5) The SBC rules fail to take into account that foreign countries may have their own coverage and disclosure requirements, i.e. certain countries will only grant work visas if health coverage plans provide certain types of coverage and certain countries may require specific language in plan documents. We are very concerned that if expatriate health plans are required to distribute SBCs in their current form it could mislead participants and potentially violate foreign health insurance laws.

Recommendations:

Because the SBC rules cater to domestic health coverage and the design of expatriate plans varies significantly with such plans, we recommend that the Agencies exempt expatriate plans from SBC requirements.

VI. Modify the Form and Process to Improve Value

A. The Frequency and Timing of Form Distribution Requirements is Duplicative and Burdensome

The Proposed Rule establishes a complex set of SBC delivery rules that must be streamlined in order for the final rule to be workable.

- *Issuer to Employer (Group Health Plan):* The Proposed Rule requires an issuer to provide a plan sponsor (generally the employer) of a group health plan a Form: (1) within 7 days of when the employer requests information; (2) at the time the employer applies for group coverage; and (3) when coverage changes after coverage has been applied for; and (4) upon renewal (generally 30 days before the effective date if changes are made and no new application is required).
- *Issuer/Employer to Employees (Enrollees) in Group Market:* Similarly, the Proposed Rule requires an issuer or plan sponsor to provide a Form to (potential) enrollees in the group coverage: (1) when the individual applies for coverage or is eligible to enroll; (2) upon a change in coverage after enrollment; (3) within 7 days of a special enrollment; (4) upon renewal; and (5) within 7 days of a request.
- *Issuer to Policyholder in Individual Market:* Finally, the Proposed Rule requires an issuer to provide a Form to an individual policyholder: (1) within 7 days of the individual request information; (2) when the individual applies for coverage; (3) upon a change in coverage after application; and (4) upon renewal.

We are concerned that the delivery rules fail to account for the negotiating and underwriting processes that are integral to the issuance of health insurance coverage. In addition, the Proposed Rule prevents logistical problems because (1) SBCs must be delivered within 7 days of a request or special enrollment, or (2) before coverage is effective if a change in coverage occurs after the SBC is initially issued.

It is not uncommon for an issuer and an employer to go through several rounds of negotiations after an application (and possibly after the open enrollment period) is made before they agree to a final policy. This is equally true for issuing coverage to individuals in the individual market. Due to this negotiation process, a policy may not be finalized until a few days just before, or even just after, the coverage goes into effect. This would give issuers no time to draft and distribute the SBC by the first date of coverage and could delay the effective date of the coverage offered if retrospective issuance is not allowed.

We emphasize this practice of negotiation goes on in both the group and individual market because it appears that the NPRM did not fully contemplate the processes that go into creating a group health policy when drafting the Proposed Rule. For instance, the Preamble to the Proposed Rule inaccurately states that it is "often the case only for individual market coverage" for the information in the SBC to change "between the time of application, when the coverage is issued and when a policy is issued." 76 Fed. Reg. 52444.

In addition, the delivery rules are unnecessarily burdensome because a separate SBC must be delivered for every plan option regardless of an individual's interest. It appears that each different level of cost sharing and each coverage tier (e.g., self, self plus spouse, family) are treated as separate options that cannot be combined.

This means that a simple PPO plan with two cost sharing levels and three family coverage tiers would have 6 independent SBCs. The number of SBCs for a complex plan (traditional PPO, indemnity, HMO) would increase exponentially. This is a particularly burdensome requirement for the group market because separate SBCs must be issued to an individual for every single benefit option in which such individual is initially eligible to enroll in.

The purpose of the SBC is to facilitate the process of purchasing health insurance by giving individuals and group health plans the ability to quickly distinguish between the plans that they are eligible for. However, we believe that the SBC will not serve this purpose because the Proposed Rule requires issuers to provide the SBC at so many points in time. Instead, each additional SBC provided, will likely result in diminishing returns because (potential) enrollees/policyholders will have to sort through multiple versions of virtually identical data sets in an attempt to determine which plan best suits their needs.

The Proposed Rule appears to make issuers and plan sponsors jointly liable for delivering SBCs to employees with respect to group coverage. One party is not relieved from liability even if the other party agrees to deliver the SBCs.

Finally we note that the NPRM requires issuers and plan sponsors to send SBCs to all participants and beneficiaries. The Agencies clarified that while it is sufficient to provide a single SBC if all the individuals reside at the same address, if any one of the beneficiaries has a different address, an SBC must be sent to such beneficiary's last known address. This rule is additionally burdensome because generally issuers and group health plans do not collect this information from their beneficiaries and would have to develop the infrastructure to do so.

Recommendations:

We believe that the Agencies must significantly streamline the SBC delivery requirements so they will not impede the process in which issuers and employers (or individuals) work together to finalize policies. It is important to note that these

modifications do not solve the underlying problems of requiring the NPRM SBCs in the large group market. An exemption or safe harbor for the large group market would still be required to avoid significant implementation costs and administrative hassles for employers. Our specific comments are as follows.

- 1) *Eliminate the requirement to deliver SBCs "on request" to persons who do not already have coverage ("shoppers") in any market-* We note that PHSA section 2715 does not require this type of disclosure to persons that have no relationship with the issuer; instead it focuses solely on applicants, enrollment and reenrollment. And we also note the Web Portal rule only helps in the individual market; it does not provide any relief with regards to small group coverage or large group coverage. Of course, issuers would be happy to provide SBCs on request to individuals that are in fact enrolled in coverage. However, in the event that the Agencies decline to eliminate on request delivery for shoppers, we recommend that at a minimum the Agencies deem both individual and small group health plans to have satisfied this requirement if they meet Web Portal requirements.
- 2) *Allow usage of a single SBC for group plans-* For group plans a single SBC should be developed that reflects all coverage tiers and all cost sharing options where the underlying coverage is otherwise the same (e.g., PPO, indemnity, HMO). This would greatly reduce the number of SBCs that must be delivered.
- 3) *Clarify that issuers do not have to deliver SBCs for every benefit option-* Issuers should not have to deliver a separate SBC for every benefit option an individual is initially eligible for in the group market because this could require issuers and employers to deliver dozens of SBCs at one time. Instead, issuers or employers should be able to deliver the SBC of one standard plan design (e.g., PPO) that shows the various levels of cost sharing and coverage tiers and indicate that SBCs for other available options are available on request.
- 4) *Adjust for Adequate Processing Time-* In the event of a change after application or enrollment, the issuer should have 30 days to deliver the SBC. If the SBC must be issued prior to the date of coverage, then coverage will be routinely delayed where issuers and employers (and individuals) are negotiating coverage terms.
- 5) *Clarify terms-* The final rule needs to supply a definition of what it means to apply for coverage (triggering an SBC). In this regard, we suggest defining the "completion of an application" as the point of time in which the issuer has sufficient information to perform underwriting and issue a binding premium quote.
- 6) *Allow issuers reasonable periods to process requests-* The final rule must give issuers more than 7 days to provide SBCs in the event of a special enrollment or a request for an SBC by an individual. We agree that the SBC should be provided

at application or enrollment, but subsequent SBCs should be delivered within a longer and more reasonable period. Otherwise, small delays in providing an SBC could trigger monetary penalties under the PHSA. We recommend that the Proposed Rule allow issuers 30 days to mirror the ERISA SPD rules. ERISA § 104(b)(4); § 502(c)(1).

- 7) *Prohibit joint liability*- We recommend that the final rule be revised so that issuers and plan sponsors are not jointly liable for delivering SBCs to employees with respect to group coverage if one party agrees to provide the SBC. Issuers routinely rely on employers to deliver certificates of coverage and SPDs, and frequently employers want to be the exclusive source of information delivered to their employees. In such circumstances, the issuer should not be exposed to penalties if SBCs are not delivered appropriately.
- 8) *Avoid duplication*- We recommend that the Agencies eliminate the requirement that issuers and plan sponsors automatically send SBCs to beneficiaries who reside at a different address than the participant. Instead they should only have to send an SBC to a beneficiary's separate address if it the participant or the beneficiary makes such a request.

B. Simplification of Form Content

The Form generally includes the information required under the statute. However, the NAIC expanded the content requirements of the statute to require the Form include premium information. The Proposed Rule states that "[t]he NAIC instructions provide that the premium generally is the premium as charged by the issuer...or the cost of coverage in the case of self-insured plans." 76 Fed. Reg. 52446. For individual policies the premium information must be in the Form itself. For group policies, the instructions provide that the employer may provide the premium information separately.

The premium requirement is problematic for a number of reasons. Most importantly, in the individual market, the premium information will be misleading and often change. The premium information provided to "shoppers" on the web portal will just include base premium rates that will change during medical underwriting. Moreover, when an individual actually applies for coverage, they often change the coverage they elect when they receive a premium quote. These changes alone could require the delivery of new SBCs since new SBCs must be delivered in the event of changes after application (see 4 above).

Similar issues occur when groups negotiate for coverage. Typically, the actual premium is not set until the negotiation process ends, which may be just days before or even days after coverage is in effect. Importantly, the requirement to disclose premium is completely duplicative and not required by the statute itself. In the group market and individual market, the policyholder is always promptly informed of the premium once

underwriting is complete and coverage is offered. Importantly, employers establish the premium that each individual employee will pay, and issuers do not typically have this information. In addition, employees that participate in group health plans are always told the cost of coverage of the competing plan options at or before the time of enrollment. Indeed, state law generally requires the consent of an individual before payroll withholdings may take place.

Premiums are also subject to variation based on employer designed wellness programs. These programs provide important incentives for employees to adopt healthier lifestyles.

Extraterritorial benefits present another significant issue with the content requirements of the Form. Specifically, when the issuer provides an SBC to employees in group coverage, it is not clear whether the SBC must include all of the mandated benefits of the various states in which the employees may reside. Some groups have employees residing in several states. The SBC should be issued to comply with the benefit requirements of the state in which the policy is issued. Certificates of coverage are provided to individuals that appropriately reflect the benefit mandates of the states they reside in, but this is a time consuming process that can be implemented only after census information is collected and coverage is put in place. To require Forms to include extraterritorial benefits in an SBC at the time of application or enrollment of a group would be virtually impossible.

An additional problem with the Form is that by placing the burden on the issuer to provide all of the necessary information to complete the Form, it does not take into account the increasing trend among issuers of large group health plans to "carve-out" certain types of coverage from their plans, i.e. pharmacy, mental health or vision and purchase this coverage else where.

This is problematic because the NPRM requires issuers to provide information in the SBC that is privy to the carve-out vendors and not the issuer. Furthermore, requiring issuers to supply information relating to these carve-out arrangements would be logistically inefficient.

Finally we call attention to the requirement that issuers and group health plans disclose the "policy period" on the Form. This is a problem in the individual market where issuers commonly provide "evergreen contracts." Evergreen contracts are unique because they do not have an explicit policy end date but rather allow the purchaser terminate their contract at will.

Recommendations:

- 1) *Eliminate premium/cost of coverage requirement from the Form.*
- 2) *Exclude extraterritorial benefits from the Form-* To address any concerns, the Agencies could include in its disclaimer that the SBC is not the actual policy and

does not include all coverage details found in the actual policy *such as extraterritorial benefits*.

- 3) *Require vendors to provide data-* we recommend that the Agencies require the carve-out vendors and not the issuers to provide the necessary SBC information on carve-out arrangements via a separate document that corresponds to the SBC, instead of requiring the issuer to provide the carve-out arrangement information in the actual SBC. We further recommend that the Agencies add disclaimer language in the SBC that informs purchasers that if they have questions about this benefit, they should contact their plan sponsor.
- 4) *Exempt individual health plans from providing "policy period" information.*

C. Translation of SBCs

The Proposed Rule requires that issuers and employers make available SBCs in a culturally and linguistically appropriate manner consistent with the language requirements of the new claims and appeals regulation. This could result in inconsistent translations by different issuers that contract with different translation services, thereby eliminating one of the purposes of the SBC – providing comparative coverage descriptions. Moreover, the pagination, size and other format requirements are even more onerous for other languages. For example, our experience is that the text of documents translated into Spanish is generally 30 percent longer.

Recommendation:

- 1) *Consistent translation-* The Agencies should either supply templates of translated Forms or provide a translation service free of charge to ensure that the SBCs are translated consistently among different issuers and group health plans.
- 2) *Flexible standards-* Relief from the page limits and format requirements must be provided for translated documents.

D. Delivery of SBCs Electronically

Like the other requirements within the Proposed Rule, the electronic delivery rules impose different requirements depending on whether it is the issuer delivering to the plan sponsor, the issuer/plan sponsor delivering to employees participating in group coverage, or the issuer in the individual market.

We support the electronic delivery rules from the issuer to the group health plan because we believe that it takes into account that most group health plans will have access to the internet and therefore it incorporates the right amount of flexibility for such transactions.

The electronic delivery rules that apply where an issuer or employer provide the SBC to employees enrolled in group coverage subject to ERISA is significantly less flexible. Indeed, the Proposed Rule appears even less flexible than the DOL regulations on which they are based. The DOL rules on electronic disclosure provide that an SPD must be furnished using "measures reasonably calculated to ensure actual receipt." 29 C.F.R. § 2520.104b-1b.

However, the Proposed Regulation's preamble indicates that the SBC must be delivered in accordance with the safe harbor provided under that regulation. 76 Fed. Reg. at 52499. The DOL safe harbor allows delivery to (1) an employee who has access to electronic documents at his or her workstation without their consent (they can opt out), or (2) an individual who has provided affirmative consent. 29 C.F.R. § 2520.104-1(c)(2)(i), (ii). By mandating compliance with the safe harbor, the Proposed Rule is significantly less flexible because the DOL rules explicitly provide that the safe harbor is not the exclusive means to satisfy electronic delivery requirements.

Additionally, the electronic delivery rules for the individual market are inflexible because the NPRM has limited the conditions in which an individual health insurance issuer can presumptively deliver the Form electronically to specific enumerated circumstances; that is, when the (potential) individual policyholder requests information/application electronically, submits an application electronically, or specifically requests that he or she be sent information/application electronically. Unless these circumstances are met, the issuer must provide the Form in paper copy.

The Proposed Rule's electronic delivery requirements are outmoded and overly restrictively with respect to SBCs that are delivered to individuals. As evident by the DOL's RFI Regarding Electronic Disclosure by Employee Benefit Plans, DOL has also recognized this and is willing to explore whether and how to expand or modify ERISA electronic delivery standards. 76 Fed. Reg. 19285.

Therefore, the Agencies should depart from the DOL framework for delivery of ERISA documents to plan participants that were adopted 10 years ago. Since that time the access to email and the internet has exploded across all age and demographic groups (including income and ethnicity) through the use of smart phones, tablet computers, lap tops and other sources.

And, there are obvious advantages to electronic delivery:

- *Cost:* It is less costly for issuers and employers to deliver documents electronically.
- *Speed:* It is faster and results in a permanent electronic record that is more accessible over time than paper records, which may never be opened and can be easily misplaced or destroyed. Speed and accessibility are particularly relevant when multiple SBCs may have to be delivered to individuals.

- *Easier to use*: Electronic delivery facilitates the goal of the Proposed Rule, which is to educate consumers regarding health coverage options and to give them an additional comparison tool. Not only will the Form in electronic version look identical to its paper version, but it will be easier to navigate with the search-and-find function in electronic media

Recommendations:

The Agencies should revise the Proposed Rule to make the electronic disclosure requirements more flexible so that issuers and employers can more easily use this method of delivery. Specifically, the Proposed Rule should be revised to permit electronic delivery to individuals (in both the group market and individual market) consistent with the standards set for the delivery of SBCs by issuers to employers. That is, so long as written or electronic notice is provided to the individual, the SBCs may be put on a specific internet site the individual is directed to.

Of course, the issuer or employer would be required to provide paper copies if the individual requested them. This assures effective delivery, while vastly reducing the costs of delivering what are already duplicating and misleading Forms and coverage examples.

E. Add Flexibility to the Summary of Material Modifications Requirements

Section 2715 requires that issuers provide notice of a material modification with respect to the information provided in the SBC 60 days in advance of the effective date of the change (regardless of whether the changes are favorable or unfavorable).

The Proposed Rule does not, however, apply this rule to changes that occur upon renewal, which are subject to a 30 day advance notice before the effective date of the change.

Aetna appreciates that consumers should generally be provided advance notice of changes to the terms of their coverage. However, it is not unusual for a policy to change after coverage goes into effect and in some circumstances the 60 day advance notice rule will be unworkable or unfavorable to consumers.

For example, it will be very difficult to issue advance notices to comply with changes in state benefit mandates that may have a very short effective date. In addition, sometimes employers wish to retroactively amend their coverage to *improve* benefits offered to employees.

Neither circumstance would be permitted under the Proposed Rule. Obviously, it would hurt employees if their employer could not retroactively improve the benefits and cost sharing described in the SBC and could only do so prospectively.

Recommendations:

We recommend that relief be provided from the 60 day advance notice rule where the issuer must make changes to comply with state or federal law that would impact SBCs.

In addition, we recommend that in the event an issuer or plan sponsor wishes to amend coverage to improve benefits or lower cost sharing such changes should be excluded from the requirement that they provide sixty days advance notice.

F. Additional Recommendations Relating to Format and Content of the Form

In addition to the myriad concerns discussed above, there are several technical issues with the format and content requirements of the NAIC Form. Our specific technical comments are as follows:

- We recommend eliminating the "Other Covered Services" box because listing benefits as bulleted items prevents us from accurately describing cost sharing and any limitations or descriptions to our members.
- We recommend covered items simply be listed in the Common Medical Event table so we can better describe cost sharing and any limitations or descriptions, rather than do so within the box, as the NAIC instructions require.
- The listing "major benefit categories" where the deductible is waived within the Question and Answer table (in addition to on each benefit in the Common Medical Event table) is redundant and likely to be confusing to consumers, as most will not understand which actual specific benefits make up a "major benefit category." This is also problematic for the following reasons: (1) it increases the length of the Question and Answer table; (2) it is challenging technically to gather and categorize all the benefits where a deductible may or may not apply; and (3) issuers will require guidance to ensure they have the same understanding of what constitutes a major benefit category. As a result, we recommend that issuers be allowed to include language indicating a waiver of the deductible on a benefit by benefit basis in the Common Medical Event table.
- With respect to the benefit rows in the Common Medical Event table that combine multiple service types, we recommend following the Colorado Health Plan Description Form example of allowing sub-lettering for each related service. For example:

Preventive Care

- a. Routine child exams
- b. Mammograms
- c. etc.

This would allow issuers to give members more specific information about their benefits in a clearer manner.

* * *

Aetna is pleased to have the opportunity to provide comments regarding the Proposed Rule for Summary of Benefits and Coverage and the Uniform Glossary. Thank you for considering our comments. Should you have any questions, please feel free to contact me.

Sincerely,



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¹ Kaiser Family Foundation, 2011 Annual Employer Health Benefits Survey, p. 32.