



October 21, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: CMS-9982-P

Submitted by email to: www.regulations.gov

Thank you for the opportunity to comment on the proposed rulemaking for the Summary of Benefits and Coverage and the Uniform Glossary under the Affordable Care Act.

In general, we appreciate the effort of the administration to create tools for health care literacy, as intended by this summary. Specifically, we have several very brief issues for your consideration, which are outlined below.

- 1. Inclusion of ERISA multi-employer plans:** No mention of the multiemployer plans is made in the statute regarding the inclusion of our plans in a working group, though the NAIC is specifically included in the requirements. As you are probably aware, the NAIC is unfamiliar with the issues facing multiemployer plans, and is unable to address our concerns. While we understand that the NAIC is comprised of the state insurance commissioners, which oversee state-licensed insurance, many national, regional and local self-funded entities provide exceptional health care coverage that is more comprehensive and less costly than that provided through state-licensed entities. These entities do not appear to be included in the consumer or working groups established. We hope to call the attention of the administration to this issue as it arises repeatedly in the Affordable Care Act. If the self funded plans are exempt from the provisions of the ACA, this is understandable. But if they are not, it raises substantial ongoing difficulties for these plans to have to maneuver around NAIC led models that do not understand or address our structure. The administration can create a much more workable national health care system by including, rather than excluding, self funded plans in the development of requirements that will impact these plans. To not do so continues to put these extremely effective and consumer-oriented plans at risk. The ERISA-based health care system is largely nonprofit, has a track record of 40 years of viability, and is dedicated entirely to the welfare of its membership.
- 2. Combining with the SMM:** The more specific the requirements of the notice, the greater the issues of non-inclusion. We suggest that the Summary of Material Modifications that are required by self funded plans under federal regulations be able to include or contain the proposed SBC material, which would allow funds to consolidate mailings and substantially reduce the impact of additional mailing costs. We would also

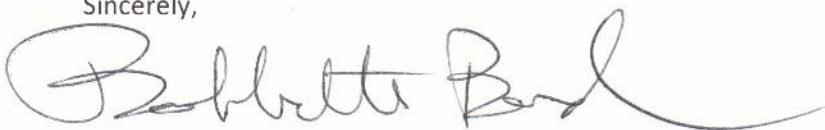
like clarification that the SBC will only be required to be redistributed (after initial distribution) when there are changes to the benefits.

3. **Notification upon enrollment:** Many self insured plans are not aware of all eligible enrollees until they enroll in the plan. Many plans also do not have annual enrollments. Therefore, we suggest that the SBC should be distributed upon plan enrollment rather than upon plan eligibility for multiemployer plans. Otherwise, we will be required to distribute an SBC before we are aware of the address to which it should be sent. This should not pose a disadvantage to plan participants, since they are not able to select an alternative plan of benefits through an annual enrollment process. We would like clarification that the actual enrollment date is an acceptable alternative to distribution no later than the first date the participant is eligible to enroll.
4. **Coverage Template (page 5):** Our communications team was confused about the purpose of page 5, as well as the content. Our Fund has substantial experience with outreach to low income minority populations with significant literacy issues.
 - a. On the right are three examples of coverage which include costs and on the left is a disclaimer stating that the examples are not to be used to estimate costs. This page of the template seems contradictory, and therefore confusing. If the intent of this page is to provide information that can be compared across plans, the left-hand text should be worked to state that it is only for that purpose.
 - b. The sample care costs should be clearly identified as not true examples.
 - c. The costs should explain that a doctor or hospital can charge whatever amount they want to if they are not in the patients plan – this page will suggest to patients that the most they will have to pay is the sample care costs regardless of where they receive their care.
 - d. For plans with benefits that are different for the eligible employee than they are for the dependent, this chart provides further confusion. For example, pregnancy is covered for the eligible employee in many plans, but not for dependent children.

We suggest this form be further reviewed and redesigned to eliminate the significant confusion that may result from its inclusion in plan materials for participants that do not have a choice of health care plans.

Thank you for your significant efforts to improve patient communications and literacy. We look forward to a final product.

Sincerely,

A handwritten signature in black ink, appearing to read "Bobbette Bond". The signature is fluid and cursive, with a large initial "B" and a long, sweeping tail.

Bobbette Bond
Executive Director, Nevada Health Care Policy Group