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

Re: Summary of Benefits and Coverage and the Uniform Glossary (CMS–9982–P) Templates, Instructions, and Related Materials (CMS–9982–NC)

Submitted electronically: www.regulations.gov

Dear Sir or Madam:

America's Health Insurance Plans (AHIP) is writing to provide comments in response to the Notice of Proposed Rulemaking on the Summary of Benefits and Coverage and Uniform Glossary (the "proposed rule") and the Templates, Instructions, and Related Materials (the "related materials") published in the *Federal Register* on August 22, 2011. The proposed rule and the related materials implement provisions of the Affordable Care Act (ACA), which require health insurers and group health plans to provide information to enrollees and policy or certificate holders about their benefits and coverage.

AHIP and its members have long supported efforts to provide consumers with clear information about their health coverage options – such disclosures empower consumers to make informed decisions about their health coverage. In fact, health insurance plans today employ a wide range of user-friendly information disclosures, including coverage brochures, premium and cost-sharing comparison, and online tools, to help consumers understand the benefits and costs of their health care coverage. These materials are designed to provide individuals and businesses with clearly communicated and actionable information.

The benefits of providing a new summary of coverage document, in addition to what is already provided to consumers, must be balanced against the increased administrative burden that drives up costs to consumers and employers. For example, since most large employers customize the benefit packages they provide to their employees, some health insurance plans could be required to create tens of thousands of different versions of this new document – which would add significant administrative costs without providing meaningful help to employees.

Our comments in this letter and the attached detailed recommendations document (Appendix A) are intended to promote better and more efficient disclosure of insurance policy and health plan information to consumers.

I. Establish a Realistic and Efficient Implementation Time Frame

Recommendations: We strongly recommend that health insurers and employers be given 18 months after the issuance of a final rule to implement the SBC requirements. In addition, compliance should be required for plan or policy years on or after the effective implementation date. In considering this time frame, it is also critical that any decision permitting additional time to comply be announced as soon as possible to provide certainty moving forward and allow health insurance plans and employers sufficient time to adjust compliance efforts accordingly.

Rationale: The March 23, 2012 effective date for compliance in the proposed rule presents major challenges. The proposed rule requires an almost *complete redesign* of how information is provided to consumers today, and it will be difficult and costly to fully implement in the short time frame, which is significantly less than the compliance deadline clearly specified in Section 2715 of the Public Health Service Act (PHSA), as amended by the ACA. In developing the standards in the proposed rule, the ACA directs the Secretary of Health and Human Services (HHS) to consult with the National Association of Insurance Commissioners (NAIC). The NAIC began its work in June of 2010 and did not submit its final report to HHS until July 27, 2011, more than three months after the implementing rule should have been published. Following the late submission of the NAIC report, the proposed rule was subsequently issued on August 21, 2011. We believe an explanation of the complex circumstances HHS faced in issuing a final rule by the deadline should be made. We think that such an understanding is relevant to, and supports the basis for, delaying implementation.[1]

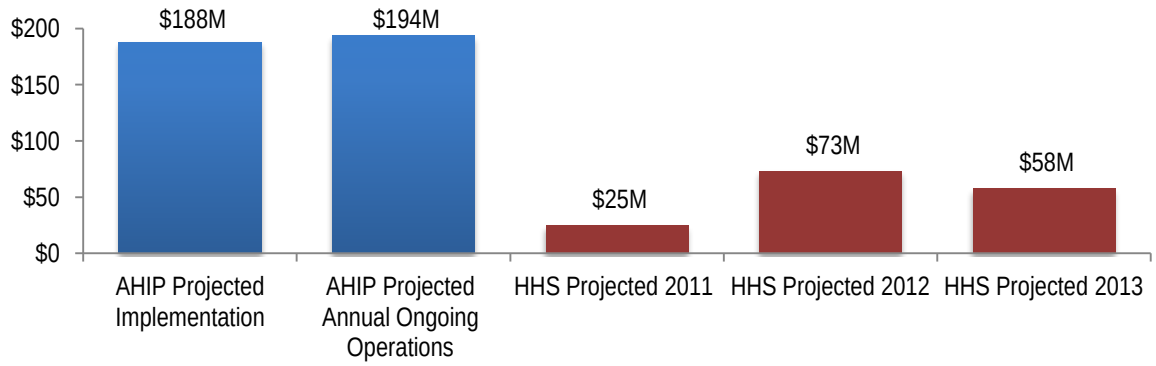
This implementation challenge is exacerbated by the fact that we the nature and scope of changes to the Summary of Benefits and Coverage (SBC) requirements that may be made in the final rule and the subsequent guidance referenced in the proposed rule remain unknown. As a result, the proposed rule does not provide health insurers or group health plans with sufficient time for compliance.

[1] The failure to meet the ACA deadline for issuing standards has been severely disruptive. Regulatory agencies have broad discretion to provide an enforcement delay or safe harbor to allow affected stakeholders enough time to implement new regulatory requirements. This approach has been followed previously with other ACA requirements, such as the rules for claims internal appeals and external review where it was recognized that strict compliance with the ACA deadlines was not possible given the delay in issuing regulations and clarifying guidance.

A. Ease Administrative Burden and Promote Efficiency. To determine the impact of the proposed rule and to inform these comments, we conducted a survey of our membership to determine the cost burden of the proposed rule and health plans, representing over two-thirds of the estimated universe of 180 million enrollees with private coverage (through individual and group insurance and self-funded plans), responded to the survey. The survey indicates that both the initial implementation costs ($188 million) and one year of ongoing operations costs ($194 million) are each higher than the three-year total cost estimate of $156 million that was included in the proposed rule. (See Figure 1. The full report is attached as Appendix B.) These higher costs reflect the expenditure of considerable resources, including extensive reliance on out-sourced services, to comply with the major changes for processes and systems to produce and distribute the SBCs.

Figure 1.

AHIP Member Survey vs. HHS Estimated Issuer Cost to Comply with Summary of Benefits and Coverage and Uniform Glossary Proposed Rule



Note: AHIP member survey results based on companies with 127 million enrollees and extrapolated to an estimated universe of 180 million enrollees.
Note: Estimated Costs are in 2011 Dollars. HHS estimates include both implementation and ongoing operations costs.

B. Allow Additional Time to Address "Workability" Challenges. In addition to the cost burden, we have identified a number of operational concerns or "workability" issues that must be addressed in a final rule. These issues are significant, and Appendix A contains a detailed description of and makes specific recommendations for these issues in four main categories:

- Time frames for producing SBCs;
- SBC delivery issues;
- Flexibility issues in completing the SBC; and
- Other workability issues.

Until these issues are resolved, it will be difficult for insurers and group health plans to fully implement all of the changes that will be necessary to provide meaningful and timely information to consumers.

C. Provide 18 Months after Issuance of Final Rule for Implementation. Given that the final regulation will be delayed significantly and will be beyond the timeframe included in the ACA, an implementation timeframe should be established that gives health insurers and employers sufficient time to make the operational and administrative changes needed to create the SBCs. Our members have indicated that 18 months following the issuance of the final rule would give them sufficient time create and distribute the new documents and, in the AHIP survey described above, they estimated significant reductions in implementation costs of 23 percent with an 18-month implementation time frame. (See Table 2.)

Table 2

AHIP Survey Results – Estimated Cost Savings with an 18-Month Implementation Timeline

	Implementation Cost at Deadline	Implementation Cost with 18-Month Extension	Percent Savings with Extension
Responding Plans*	$94,456,820*	$72,608,527*	23%

Source: AHIP Center for Policy and Research.
*Cost figures based only on plans responding with both estimated implementation costs at deadline and estimated implementation costs with an 18-month extension.

In addition, in establishing an effective date for implementation, we suggest that HHS adopt the compliance approach used for other ACA requirements, i.e., compliance is required for plan or policy years beginning on or after the effective date.[2] This approach addresses the significant operational disruptions that would occur if changes are required in the middle of a plan or policy year. Further, this time frame will allow for full consideration of open issues and resolution of operational challenges, as requested in this letter. We also note that during the implementation phase, individual consumers and small employers will have access to the federal health insurance Web portal (known as the Plan Finder at Healthcare.gov) that will allow them to shop and compare coverage.

D. Provide Immediate Guidance on the Implementation Schedule. Health insurers and employers are already expending considerable resources to meet the March 23, 2012 compliance deadline. These are costs that cannot be recovered if changes are made to the final rule. To minimize the administrative and financial burdens, it is critical that the agencies immediately provide clear guidance on the expected publication date of the final rule and when compliance will be required.

II. Allow Alternatives for Providing Information to "Shoppers"

Recommendations: Since the ACA does not require the SBCs to be provided to shoppers, AHIP recommends that the final rule not include this requirement. Instead, individuals and small businesses should be allowed to obtain information about coverage options through the federal health insurance Web portal, and the final rule should not require SBCs for large employer shoppers.

Rationale: We support the goal of providing information to consumers and employers about their coverage. Section 2715 of the PHSA requires that SBCs be provided to "(A) an applicant at the time of application; (B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and (C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate." The proposed rule, however, goes beyond the statutory provision by requiring that SBCs also be provided to consumer and business "shoppers" for coverage. In addition, the PHSA provision requires HHS to consult with the NAIC in formulating the content and format for the SBCs.

[2] Under this approach, for many employers sponsoring group coverage, this will mean an effective date of January 1, 2014, aligning the implementation of the SBC requirements with the opening of the Exchanges and implementation of other ACA requirements, such as essential benefits and certification of actuarial value.

In its deliberations, the NAIC discussed a requirement that SBCs be created for individual and employer shoppers. However, it was recognized that such disclosures were not required under the ACA and questions were raised about the document's usefulness where an individual or employer is "browsing" health coverage options. For example, it would be impossible for insurers to estimate premiums and include this information on the SBC, without a fuller understanding of the specific coverage provisions sought by the shopper with respect to a given benefit plan, as well as the demographic details regarding the individual consumer or an employer's population. As a result, the template and instructions that were recommended by the NAIC – and substantially adopted in the proposed rule – are not designed for shoppers and do not work well for individual consumers or businesses seeking coverage.

We believe that the requirement to provide SBCs to shoppers is not supported by the ACA and should not be included in the final rule. Further, if the goal is to provide information to consumers and businesses during the shopping phase, we suggest alternative approaches for the individual, small group, and large group insurance markets.

Individual Shoppers. The proposed rule provides that with respect to individual consumers, a health insurance issuer that complies with requirements for the federal health insurance Web portal will be deemed to comply with requirements to provide SBCs to individual shoppers. We strongly support this approach as it appropriately recognizes the need to streamline processes and avoid duplication of existing efforts to inform individuals about their coverage options.

Small Group Shoppers. We strongly recommend that the approach discussed above for individual consumers be extended to businesses shopping for insurance coverage in the small group market. Currently, HHS is requiring health insurers to submit information about their small group insurance market products for the Web portal and the information will be included on the Plan Finder beginning on November 15, 2011. We suggest small businesses can use the portal as a valuable resource to obtain information about all available small group insurance products.

Large Group Shoppers. As previously noted and pursuant to the statute, the SBCs were designed to provide information to individual consumers only. The template was not designed for businesses shopping for coverage, especially large employers, who typically have access to more internal and external information resources and frequently rely on brokers or health benefits consultants for assistance in designing health insurance benefits and procuring coverage. In almost all cases, large employers, or their brokers or consultants, ask health insurers to respond to a Request for Proposal (RFP) that specifies benefit design and administration standards and requires a tailored, detailed response. Requiring the insurer to provide an SBC to the employer, in addition to the RFP response or other submission is an unnecessary and costly

duplication of effort. Since the NAIC-recommended SBC template was not designed for shoppers, it does not consider the resources currently available to and used by large employers to obtain coverage.

III. Align ACA and ERISA Disclosure Obligations to Streamline Processes and Reduce Duplication

Recommendations: Group health plans and insurers providing coverage to group plans should be permitted to provide the information required under the SBC final rule by including the information in materials already provided to employees.

We also recommend that a uniform approach be established that permits health insurers and group health plans to provide coverage information electronically, if the individual has access to the internet or other electronic media such as e-mail.

Rationale: The proposed rule requires group health plans to provide SBCs to participants and beneficiaries and invites comments on ways that the ACA requirements might be coordinated with group health plan disclosures, such as summary plan descriptions (SPDs) and other materials required by other federal laws, such as the Employee Retirement Income Security Act (ERISA). The proposed rule, however, does not make any specific accommodations for currently-required ERISA disclosure materials. Additionally, the proposed rule does not recognize the extensive disclosures about cost and coverage already provided today by employers to their employees.

Consequently, the standards under the proposed rule are in many instances duplicative of information currently required by ERISA and provided by employers today, such as descriptions of benefits covered under the plan, information on network providers, processes for preauthorization or utilization review, and other information about the benefit plan.

More specifically, the SPD required under ERISA must provide the following information:

- Description or summary of benefits;
- Description of cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts;
- Any annual or lifetime caps or other limits on benefits;
- The extent to which preventive services are covered;
- Whether and under what circumstances existing and new drugs are covered;
- Whether and under what circumstances coverages are provided for medical tests, devices and procedures;

- Provisions governing the use of network providers;
- The composition of the provider network;
- Whether and under what circumstances out-of-network services are covered;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service; and
- Rights to continuation coverage (e.g., COBRA).

A chart showing the ERISA-required information for SPDs and comparing those to the requirements in the proposed rule for SBCs is attached to this letter as Appendix C. As noted above and shown in the chart, employers currently provide considerable information to their employees regarding their health care coverage. In addition, if employers offer more than one benefit plan, they typically provide enrollment packages to their employees that allow employees to compare the benefit plan options and premiums. These enrollment packages are provided in addition to the required SPDs, and employers expend considerable resources in making these materials understandable and informative and customizing them for their particular benefit plan options and employee populations.

As noted above, the proposed rule makes no specific accommodation for currently required documents and also does not acknowledge all of the materials employers currently provide to employees. Employers should have the flexibility to include the SBC information required by the ACA within currently-provided materials, in a manner consistent with the ERISA requirements for SPDs. This will allow group health plans to tailor the communication in a manner that best meets the needs of their employee populations, while achieving the overall goals of the ACA to provide more complete information to individuals about their benefits and coverage.

In addition, group health plans and insurers should be given flexibility to use electronic delivery to distribute SBCs or other disclosure materials with SBC-required information. The SBC is not an ERISA document that needs to comply with ERISA electronic delivery rules; rather the SBC is a PHSA disclosure document under an express statutory provision allowing SBCs to be delivered in "electronic form." We urge HHS to develop procedures that facilitate the electronic delivery of SBCs and other disclosure materials to consumers.

IV. Allow Greater Flexibility to Enable Issuance of Meaningful SBCs

Recommendations: We recognize that the ACA requires SBCs, however, given the workability issues with completing the template, we recommend that the final rule and template instructions should explicitly give health insurers and employers flexibility in completion of the form to allow them to provide more accurate and functional information.

Rationale: The proposed rule and related materials establish strict guidelines – based on NAIC recommendations – for the completion of SBC forms. These instructions include detailed font and format requirements, in addition to specific guidelines for the inclusion of required text that cannot be altered or deleted. This strict standard does not make practical sense and can result, under some circumstances, in the SBC providing misleading or incomplete information to consumers about their coverage.

Today, some insurers offer products which include, not just one provider network, but multiple provider networks, each with varying reimbursement levels based on a consumer's choice of a specific network for services. Although the SBC format allows for disclosures of multiple level products, such as three-tier point-of-service plans, there is no capability within the SBC template or in the instructions for an insurer or employer to provide information regarding multiple provider networks may be needed by consumers to either evaluate the product or the multi-provider network benefits.

The instructions and template also effectively prohibit the inclusion of additional statutorily-required language pertaining to required translations. The proposed rule requires SBCs to include notices in "applicable non-English languages" that translation services are available to consumers, who may have specific language needs. Notwithstanding this requirement, the SBC template provides no space to include the notice and no flexibility to rearrange the SBC to create space for the required information.

The proposed template is also inadequate in that it fails to reflect all of the benefit designs available in the market today. We are concerned that consumers and enrollees will receive insufficient information from the SBC template about innovative and creative products, such as those incorporating value-based design features and patient-centered medical homes that cannot be adequately described within the confines of the template. As an example, an AHIP member is piloting an innovative, three-tiered product – with different provider networks in each tier (including one with a patent-centered medical home) and different eligibility criteria (including participation in wellness activities) for the tiers. Enrollees would receive inadequate disclosure about this coverage if the information needed to explain the options is truncated and distorted to fit within the confines of the SBC template.

V. Provide Consumers with Meaningful Coverage Examples

Recommendations: We respectfully suggest that the coverage examples be removed from the SBC template at this time and HHS convene a work group of affected parties to further explore ways in which to provide consumers with meaningful information about benefits and cost sharing under their coverage. Such functionality might be provided through existing insurer Web sites, as part of health insurance exchange web portals available in 2014, or a new HHS-designed common tool.

Rationale: We have strong concerns that consumers could be misled by the coverage examples (CEs), as required under the proposed rule and SBC template. To complete the CEs, health insurance issuers will be required to use HHS-generated cost data for the common treatment scenarios on which all CEs will be based. These common treatment scenarios for breast cancer, normal delivery, and type-II diabetes will need to be based upon HHS assumptions for the course and cost of treatment, including the specific medical and or surgical services provided for the condition. This will not provide relevant or accurate information to consumers. In addition, HHS will need to provide a common methodology for calculating cost sharing that may not reflect the wide variation in the cost of services across the country and each health insurance issuer's or group health plan's reimbursement approaches.

AHIP and its members understand that the CEs are only presented as illustrations, but believe that there are more efficient and accurate alternatives for providing consumers with information about the benefits provided and the costs they may incur under their specific coverage. We note, for example, that many of our members today are providing consumers with cost calculators and other on-line tools to assist them with an understanding of coverage and provider options. Such on-line tools are a more effective way of providing information to individuals about the medical services that are available to them and the potential cost sharing involved. The CEs cannot provide this more accurate and actionable information.

VI. Ensure that the SBC Requirements are Workable

Recommendation: We recommend that HHS establish a technical work group with HHS staff and health plan representatives to identify solutions to these workability issues in advance of the issuance of the final rule.

Rationale: The proposed rule presents many issues with respect to the "workability" of its requirements. For example, during the NAIC process, many operational concerns were raised with respect to delivery of the SBCs and the SBC template. Because these operational issues were not taken up during the NAIC process, it was anticipated that they would be addressed in the proposed rule. Unfortunately, many of these workability issues were not addressed in the proposed rule, and Appendix A of this letter specifically identifies a number of these issues that we recommend be addressed in the final rule.

Issues are identified within four categories:

- Timeframes for producing SBCs;
- SBC delivery issues;
- Flexibility issues in completing the SBC; and
- Other workability issues.

Appendix A provides detail on issues within these four categories, with specific recommendations for identified issues.

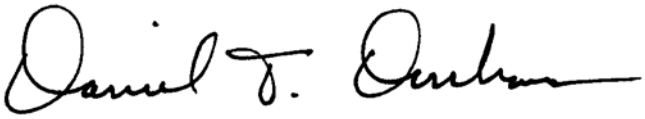
VII. Promote Uniform Approaches for the SBCs and Compliance

Recommendations: We recommend that the final rule encourage states to forego form filing requirements for the federally-required SBCs and – to promote uniformity and efficiency – not vary the rule's requirements for the SBCs. We also recommend that HHS, in conjunction with the states and other affected parties, establish standards that provide for the effective and efficient oversight of SBCs and reference these standards in the final rule.

Rationale: The proposed rule does not address the issues of state form filing requirements and market conduct examinations for compliance with the rule's requirements. While we recognize that the language within PHSA Section 2715 preempts state laws that "require a summary of benefits and coverage that provides less information to consumers" than that required through the SBCs, we believe it makes no sense to allow states to require different rules regarding SBCs, including with respect to any rules regarding the filing and approval of SBCs by state insurance departments. If both federal and state-specific SBCs are permitted, consumers would receive multiple disclosure documents providing different information in different formats and language for the same health insurance coverage. Further, since HHS will look to states to enforce compliance with the SBC requirements, we believe an approach should be adopted that promotes uniform enforcement of these uniform document requirements.

We appreciate the opportunity to provide comments on this important issue. AHIP and its members worked with the NAIC as the SBC and related materials were developed and we look forward to continuing our collaboration with HHS as it considers critical modifications before issuing the final rule.

Sincerely,



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