APPENDIX A

Detailed Comments on Summary of Benefits and Coverage Proposed Rule

A. Time Frames for Producing the Summary of Benefits and Coverage (SBC)

1. **Short Production Times.** The proposed rule requires health insurers and health plans to produce SBCs, under several circumstances, within seven days of a request. The production of an SBC requires the matching of specific health benefit coverage provisions to specific benefit coverage selections made by individual purchasers and group plan participants. The very large number of contract variations that health insurers and health plans will have to maintain for the completion of SBCs – some AHIP members estimate the number of variations to exceed 150,000 – when combined with the need to retrieve and assemble this information on an individual basis, calls for a longer period of time to produce an SBC to assure the preparation and delivery of a complete and accurate SBC.

   Recommendation: The final rule should provide for the production of SBCs within 15 business days of the receipt of a request to produce an SBC document.

2. **Timing of Employer Coverage Choice Decisions and Amendments.** Employers are not required to make coverage selection/purchasing decisions, including amending those choices, within a specific time frame, and may do so at any time, up to and even after the policy effective date. Health insurers recognize that employers, particularly small employers, may need additional time to make coverage decisions and prefer to accommodate their employer customers in this regard. The proposed rule, however, requires the delivery of an SBC upon enrollment and, if the coverage terms subsequently change, before the first day of coverage.

   Recommendation: In cases where employers communicate coverage selection decisions, including a decision to amend a previously selected coverage options, to health insurers less than 30 days in advance of the policy or plan effective date, health insurers should be required to produce SBCs as soon as practicable, but no later than 15 business days following receipt of the employer's final coverage decision.

3. **Timing of Employer Coverage Choice Decisions and Amendments for Health Plans Maintained Pursuant to Collective Bargaining Agreements (CBAs).** Because of the nature of the negotiation process between labor and management, changes to health plans maintained pursuant to CBAs are typically made without regard to plan year. As a result, coverage terms for such plans are often finalized after the beginning of a plan year and may require retroactive implementation of coverage changes. Given that the terms of coverage, including effective dates, are dictated by the CBA, it may not be possible in all cases to provide 60-days advance notice of a material modification.

Recommendation: In cases where a health plan is maintained pursuant to a CBA, the final rule should provide that existing disclosure requirements are deemed to provide sufficient notice of, and such plans are not required to provide 60 days advance notice with respect to any coverage changes, regardless the effective date agreed to within the CBA.

4. **Delivery of Material Modifications Due to Clerical Errors.** The proposed rule provides that where benefit plan changes require delivery of an updated SBC, a material modification notice must be delivered 60 days in advance of the benefit plan change, except in instances of coverage renewals. The rule makes no exceptions for situations involving clerical errors that do not affect the actual coverage − but which may require multiple mailings of modification notices and amended SBCs − increasing the possibility for consumer confusion concerning errors that make no modifications to actual coverage.

   Recommendation: The final rule should allow issuance of amended SBCs due to clerical errors, without triggering the 60-day advance material modification notice requirement.

B. SBC Delivery Issues

1. **Delivery of SBCs to Employers.** The proposed rule requires SBC delivery as part of enrollment packages and, if there are changes to previously issued SBCs, again before the first day of coverage. The proposed rule also contemplates the SBCs will be delivered to the home address of employees and certain beneficiaries. Further, it requires health insurance plans to produce SBCs for renewing enrollees as part of re-enrollment packages and health insurance plans and employers to be jointly responsible for delivery of the SBCs.

   While hearth insurers can produce enrollment and renewal packages (and do produce the certificates of coverage), the general practice is for health insurers to bulk deliver these materials to employers, who then provide copies to their employees during open enrollment periods, which most often occur at the workplace, or by permitted mail or electronic delivery. The most effective and efficient delivery method for delivery of SBCs would be to follow these existing practices.

   Recommendation: The final rule should establish that health insurer delivery of enrollment or re-enrollment SBCs to an employer constitutes delivery to the employee participant (and any beneficiaries of the employee) for the purpose of delivery compliance under the ACA. The final rule should also allow delivery by employers to employees at the employee's workplace.

2. **Delivery of SBCs to Employer's Broker or Benefit Consultant.** The proposed rule requires health plans to produce SBCs for renewing enrollees as part of re-enrollment packages, but is silent with regard to delivery through an employer's designated broker or benefits consultant. A common practice within the group marketplace is for health insurers to bulk deliver these materials to an employer's designated broker or benefits consultant, who then provides these materials to the employer or directly to the employees in instances where the broker or consultant conducts the open enrollment on behalf of the employer. The final rule should recognize this general business practice.

   Recommendation: The final rule should establish that in instances where an employer informs a health insurer that the employer has retained the services of a broker or benefits consultant, the delivery of enrollment or re-enrollment SBCs to an employer's designated broker or benefits consultant constitutes delivery to the employee and dependent for the purpose of delivery compliance under the ACA.

3. **SBC Preparation and Delivery in Certain New Sales Situations.** Often health insurers do not obtain detailed census information, such as names and addresses, for new group enrollments, including those for new hires and special enrollments, until the submission of enrollment forms. In these circumstances, quotes are provided to employers based on general employee census information. This practice reduces the burden for employers requesting premium quotes, by eliminating the need for employers to provide employee names and addresses to the health insurer, while also eliminating the need to disclose protected personal health information to insurers – which may never be needed if the employer does not purchase the coverage. To comply with the proposed rule, health insurers and employers must amend long-standing current business practices to ensure that employers produce the detailed health plan participant census information necessary to complete the SBCs in advance of enrollment and the effective date of coverage.

   Recommendation: In instances where employers do not provide detailed health plan participant census data sufficient to produce SBCs 30 days before enrollment, the final rule should permit health insurers to produce SBCs for delivery to the employer no later than 15 business days following receipt of the detailed health plan participant census information.

C. Flexibility Issues in Completing SBCs

1. **Presentation of Non-Network Coverage Products in the Individual Insurance Market.** AHIP's members are particularly concerned that the current SBC template is primarily designed to summarize and describe a provider network-based product. This presents substantial issues with respect to the ability of the SBC template to adequately

and accurately describe other types of products, which do not use provider networks. These include products that may no longer be marketed by a health insurer, but are regularly renewed by individual consumers. The template does not contemplate these types of products and they cannot adequately be described using the predetermined fields.

Recommendation: The final rule should recognize that the SBC template does not adequately provide for the summarization and description of non-network provider coverage products and allow health plans greater flexibility to remove inapplicable, predetermined fields and use that space to provide relevant information to non-group policyholders with those products.

2. **Link to Web Sites at Fulfillment.** Health insurers offer numerous web-based tools and disclosure materials designed to assist their customers in understanding and effectively utilizing their benefits. The prescriptive instructions prevent health insurers from providing their customers with links to these materials in the SBC, thereby denying consumers with easy and timely access to these tools and materials.

   Recommendation: The final rule should allow health insurers and health plans to amend the SBC template to provide links to their proprietary tools and disclosure materials, such as cost estimators, provider selection sites, and consumer education materials, in order to provide information beyond that provided by the SBC.

3. **Inclusion of Group Coverage Enrollee Premium Information.** The National Association of Insurance Commissioners (NAIC) recognized that employers, not health insurers, establish employee premium sharing levels that are necessary for completion of the SBCs. That recognition was not fully reflected in the proposed rule. Consequently, the group insurer instructions require employers to provide employee coverage cost information, while the premium field, which will not contain enrollee (employee specific) coverage cost information, continues to be part of the SBC template.

   Recommendation: The final rule should remove the premium field from the SBC template for group coverage and provide that employers disclose group coverage enrollee cost information to their employees in some other transparent manner.

4. **Inclusion of Non-group Coverage Enrollee Premium Information.** The proposed rule requires the creation of a separate SBC for each premium tier level (individual, two person, parent and child, family, etc) when an SBC is requested by individuals shopping for coverage. This is also the case for new non-group applicants, if the SBC information has changed from the information posted on the Plan Finder at HealthCare.gov. To satisfy this requirement, SBCs for each rating tier must be created, forcing consumers to

look through up to 30 pages of SBCs to find the information they need. Even with the production of all of these SBC forms, the premium information on each SBC remains at best a representative value based upon an insurer's manual rating values – the premium will only become fixed and valid upon the completion of the underwriting process. Health insurers provide accurate premium information to consumers and policyholders at various points in time, and requiring estimates to be included in the SBC could prove misleading.

Recommendation: The final rule should remove the premium field from the non-group SBC and allow insurers to present accurate premium information separately.

5. **HHS Coverage Examples Website.** The proposed rule calls for the HHS to create a website for the posting of data to assist health plans and health insurers in creating Coverage Examples (CE). Public access to this website may lead consumers to believe that the information is indicative of HHS preferred courses of treatment for the listed health conditions and appropriate fee amounts for those medical services.

   Recommendation: The HHS CEs data website should be designed as a limited access source, available only to health plans and health insurers for the purpose of creating CEs. Alternatively, if the website is public, the final rule should require that the website be clearly marked that:

   - it contains information provided solely for completion of the CE portion of the SBC document;
   - CEs are illustrative examples created to help consumers compare health coverage plans;
   - the terms and conditions of a consumer's or employee's actual medical experience will vary from the data within the template; and
   - claim payments will be based on submitted claims and the terms and conditions of a consumer's health coverage contract or plan.

   Further, the rule should require that this statement be prominently displayed on the website in a manner similar to other disclaimers required in the SBC document.

6. **SBC Disclosure Language.** AHIP members remain very concerned about the sufficiency of the disclosure language in the SBC. To prevent consumer overreliance on the SBC and further assist consumers with decisions regarding benefits and access to services, the SBC should contain additional language explaining the purpose and limitations of the information in the SBC and providing direction for how a consumer can obtain additional information.

Recommendation: The final rule should amend the SBC template to clearly indicate that the form was adopted by HHS for use by all health insurers and health plans and that consumers should contact their health insurer, plan administrator or employer for additional information about benefits and coverage.

7. **Out-of-Pocket Limits and Non-contracting Providers.** On page one of the SBC template, the explanation for the question "Is there an out-of-pocket limit on my expenses?" states that this answer is to show the most a consumer could pay during a policy period. This answer is only partially correct, as it is only true in the case of in-network charges and payments, and is clearly incorrect for consumers who use the services of out-of-network providers.

   Recommendation: The final rule should amend the SBC document to clearly indicate this statement is only true for in-network care.

8. **Out-of-Pocket Limits and Contractual Penalties.** The SBC document does not clearly indicate that penalties imposed on individual policyholders or group enrollees for failure to comply with benefit plan provisions, such as precertification requirements, are not applied against out-of-pocket limits. Consumers need to be aware that penalties imposed for failure to comply with the requirements of their coverage may cause higher out-of-pocket costs.

   Recommendation: The final rule should amend the SBC template and insurer instructions, so that the out-of-pocket row on the first page clearly discloses to consumers that penalties imposed for failure to comply with plan provisions, such as precertification requirements, are not applied against out-of-pocket limits. Accordingly, we recommend that the sentence "This limit never includes your premium, balance-billed charges or health care your plan doesn't cover" be amended to read "This limit never includes your premium, balance-billed charges, health care your plan doesn't cover, and penalties for not complying with plan provisions (e.g., non-notification penalties)."

9. **Carved-Out Benefits.** Employers often provide medical benefits through multiple health insurance issuers or third party administrators. For example, the medical benefits may be insured/administered by one entity and the behavioral health or pharmacy benefits insured/administered by another entity. Neither entity would be aware of the benefits insured/administered by the other. We recommend that separate SBCs be allowed in these "carved-out" situations.

   Recommendation: The final rule should clarify that the SBC provided by the issuer of a group insurance policy or group health plan administrator is required to describe only

the benefits it covers. Non-covered services should be represented in the SBC as not covered, with a comment to contact your employer for information on these services. This aligns with the NAIC instructions on coverage examples, whereby costs for non-covered services are reflected in the "you pay" table.

10. **Pre-enrollment Availability of Policies and Certificates.** The proposed rule requires the inclusion of a notice at the top of the first page of the ABC template warns the reader the SBC is "not a policy" in addition to language in the footer that the reader may obtain a copy of the policy by directing them to a website and phone number. In instances where the SBC is being provided to consumers applying for new non-group coverage or enrolling in newly established group coverage, there is no existing policy to review. Even in instances of purchases of new group coverage where an employer has purchased coverage plans, it is a common business practice for health insurers to create the policy and the related coverage certificates only after the enrollment process has been completed. There again, there is no existing coverage document for a consumer in the group market to review. Under the proposed rule, insurers are not permitted to delete this misleading text.

    In both instances of the purchase of individual insurance and the enrollment in group coverage, the consumers will receive their respective insurance policy or certificate of coverage shortly following the completion of the individual insurance application process and the group enrollment process.

    Recommendation: The final rule should permit insurers to remove the language that a policy or certificate is available to consumers making application for non-group coverage or enrolling in group coverage.

D. Other Workability Issues

1. **Health Savings Account and Health Reimbursement Arrangement Funds.** The SBC document does not provide space for important information concerning funds related to Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs) needed by group enrollees to perform a cost benefit analysis in the selection of a plan of coverage at open enrollment. These accounts or funds provide consumers with an important tool to manage health care costs in conjunction with their health coverage. Failure to provide this information may lead consumers to overlook the unique advantages provided by HSAs and HRAs. In addition, incorporating HSA and HRA information within the SBC template is important for individual purchasers of HSA and HRA coverage, so they can obtain adequate disclosures related to these arrangements.

Recommendation: The final rule should amend the SBC template to allow health insurers and employers to disclose information to consumers and employees about the existence of an account or fund related to HSAs and HRAs. This will ensure consumers have the information necessary to evaluate the important implications of such accounts when applying for or enrolling in coverage.

2. **Grievance and Appeals Rights.** The SBC template on page four requires contact information for consumers to learn about their grievance and appeal rights. This information is already provided to all consumers as part of the policy or certificate delivery process and is not required by the ACA to be included on the SBC. In addition, because the instructions require identification of "the proper state health insurance customer assistance program and include their website and phone number" for handling grievances and appeals, insured group health plans for multi-state employers would need to potentially list up to 50 different state regulatory agencies on the SBC or issue separate SBCs for each jurisdiction.

   Recommendation: The final rule should remove the grievance and appeals information requirements from the SBC template, since health insurers currently provide these disclosures in other documents.

3. **Separate SBCs Required for Every Non-Group Premium Tier Option.** The instructions for the SBC template require the creation of a separate SBC for each premium tier level (individual, two person, parent and child, family, etc) for new non-group applicants. This requirement will require health insurers to issue up to five or more separate SBCs to an applicant for individual coverage and was proposed by the NAIC as the only means to provide non-group applicants with complete pricing information for available coverage plans and products. With the creation of the HHS Plan Finder tool, this rating information is now readily available to shoppers though this web-site.

   Under the proposed rule, these multiple SBCs would still need to be provided upon request, forcing consumers to look through up to 30 pages of SBCs to find the information they need. As permitted for group coverage, insurers should be allowed to present the costs for the different rating levels – single person, two person, parent and child, family, etc. – on a separate rate disclosure sheet, and insurers should be permitted to provide all of the deductible and annual out-of-pocket maximum tier information for a coverage plan on one SBC, thereby significantly reducing the burden of production and significantly increasing the consumer's ability to quickly find the information they need.

   Recommendation: The final rule should remove the premium field from the non-group SBC and allow insurers to present premium information on a separate premium

disclosure form to be delivered with an SBC. The final rule should permit insurers to provide all of the deductible and annual out-of-pocket maximum tier information for a coverage plan on one SBC form.

4. **Rate Tables.** On page four of the instructions for group coverage, under the caption, ***What is The Premium?***, the instructions require the attachment of an insurer's complete rate table for small group plans that use such methods for determining premiums.

   Recommendation: The final rule should remove any reference to a "rate table" for coverage options on the SBC and require employers to separately provide information on employee cost-sharing to the employee.

5. **Need for Additional Space to Provide Information.** The format of the SBC template cannot accommodate many benefit plan structures and related information, offered by health insurers and health plans. The inclusion of an additional row, perhaps entitled "Other Important Information" would provide the opportunity for health insurers to identity significant coverage plan provisions related to covered services, cost sharing, limitations, and exceptions. By creating this row to provide additional, coverage plan specific information, enrollees would be better informed about these additional policy provisions.

   Recommendation: The final rule should create a section in the SBC template that allows health insurers and employers to provide additional coverage and benefits information to consumers.

6. **Preventive Care.** The SBC document does not clearly set forth that preventive care is available without cost sharing for non-grandfathered plans. This is important information for currently uninsured individuals, who may be unaware of the new ACA provisions concerning no cost sharing for preventive care.

   Recommendation: The final rule should amend the SBC template and insurer instructions to disclose that certain preventive care may be obtained without cost sharing.

7. **Expatriate Health Plans.** The preamble to the proposed rule acknowledges the unique characteristics of expatriate and international health plans and invites comment on these plans. Employers with globally-mobile workforces typically sponsor a single international plan to cover their expatriate employees. Accordingly, a comparison of plans at time of enrollment, a situation that fundamental to the concept of the SBC, is non-existent with expatriate or international coverage. The utility of the SBC in this context is highly questionable.

Recommendation: The final rule should recognize the unique characteristics of expatriate and international coverage and the limitations of the SBC template to adequately address those characteristics. Accordingly, expatriate and international plans should be exempted from the requirements of the final rule.

8. HIPAA Excepted Benefits. We appreciate the clarification regarding scope and applicability in the instructions for completing the SBC contained in Appendices B-1 and B-2. Specifically, the guidance to states and health plans regarding the continued exemption for products that are classified as HIPAA "excepted benefits" is very helpful and will assist stakeholders as we work collaboratively to implement the new federal requirements.

Recommendation: The final rule should include the guidance found in the instructions in Appendices B-1 and B-2 of the proposed rule that HIPAA "excepted benefits" are exempt from the requirements of PHSA Section 2715.

9. **Stand-Alone HRAs.** The proposed rule does not provide an exception for stand-alone HRA's. However, if an SBC is required for a stand-alone HRA, all of the fill-ins for the various fields in the SBC template reflect "$0" or "No" or "None." The result will be the production of an SBC that is unnecessary and not at all useful to employees.

Recommendation: The final rule should exempt stand-alone HRAs from any requirement for the completion of an SBC.