AHIP
Center for Policy and Research

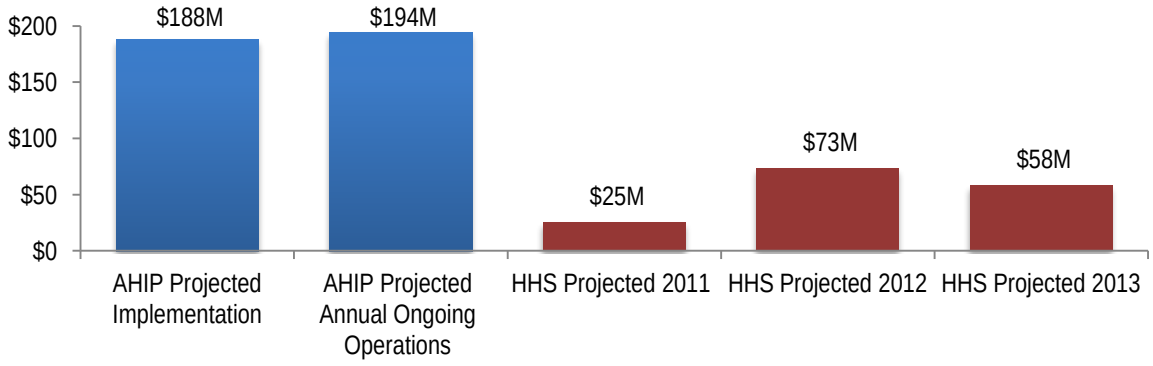
Summary of Benefits and Coverage and Uniform Glossary Proposed Rule: Implementation and Annual Ongoing Costs of Compliance

October 2011

In September 2011, AHIP conducted a survey of health insurance plans on costs of compliance with the new Summary of Benefits and Coverage (SBC) and the Uniform Glossary requirements detailed in a notice of proposed rulemaking (NPRM) issued by the Department of Health and Human Services (HHS), Department of Labor, and Department of Treasury on August 22, 2011.

The SBC and Uniform Glossary are required under the Affordable Care Act (ACA) and are intended to provide individuals and group health plan sponsors with a document that "accurately describes the benefits and coverage under the applicable plan or coverage," as well as definitions of health insurance terms. In addition, the SBC will include "coverage examples" of at least three common benefit scenarios – pregnancy, breast cancer, and diabetes.

Figure 1. AHIP Member Survey vs. HHS Estimated Issuer Cost to Comply with Summary of Benefits and Coverage and Uniform Glossary Proposed Rule



Source: AHIP Center for Policy and Research.
Notes: AHIP member survey results based on companies with 127 million enrollees and extrapolated to an estimated universe of 180 million enrollees. Estimated Costs are in 2011 Dollars. HHS estimates include both implementation and ongoing operations costs. M = millions.

The proposed rule requires health insurers to issue SBCs to individuals and employers in the shopping phase for health insurance ("shoppers"), at application, at enrollment, when a policy is issued, at renewal, or on request.

The proposed SBC template was developed by the National Association of Insurance Commissioners (NAIC), in conjunction with a working group of representatives of consumer advocacy groups, health insurers, health care professionals, and other stakeholders.[1]

Standardized, easy-to-understand information about health coverage allows consumers to make informed decisions and use their benefits in an optimal way. Health plans increasingly provide user-friendly online tools and clear materials to make sure that consumers understand the benefits and costs of their health insurance policies.

However, the deadline for the switch from health plans' current benefit materials to the proposed SBC is rapidly approaching, and the final rules are not yet published. The transition from health plans' current benefit descriptions to the new system could be difficult and costly to implement in such a narrow time frame. Likewise, some elements of the SBC, such as providing premium information on the benefit description or providing paper copies of documents, could add to the cost.

The AHIP survey indicates that the implementation and ongoing costs of the SBC requirement could be considerably higher than those estimated by HHS in the NPRM. The open-ended part of the survey allowed responding health plans to suggest other key issues that could affect costs:

- The March 23, 2012 implementation date
- Requirement to include premium information on initial SBC
- The number and complexity of coverage examples required
- Renewal process and timeframe to send SBC(s).
- The number of variations of SBCs to be delivered to each applicant or enrollee
- Duplication of materials already delivered to group health plan enrollees
- Paper delivery of SBCs to most group enrollees
- Requirement to provide SBCs to business "shoppers"
- Insufficient flexibility in the SBC template for explanation of benefit and rating tiers, especially for newly developing and innovative products

Health plans are only beginning to develop implementation strategies and estimate implementation and ongoing operations costs for the SBC rule. Furthermore, it is possible that the proposed rule will be modified and clarified when the final rule is published. Thus, the cost estimates in this survey should be regarded as preliminary.

SURVEY RESULTS

Survey results were compiled in two formats: *quantitative* estimates of implementation and annual ongoing operations costs, and *qualitative* or open-ended responses regarding operational changes and key implementation issues noted by health plans. The survey results were based on responses from health plans with about 127 million enrollees. The implementation and ongoing cost results were extrapolated to an estimated universe of 180 million

[1] *Summary of Coverage: What this Plan Covers & What it Costs.* (2012, August 22). Retrieved from U.S. Department of Health and Human Services: http://www.healthcare.gov/news/factsheets/2011/08/labels08172011b.pdf

Table 1. AHIP Survey Results and Extrapolated Results – Estimated Implementation and Annual Ongoing Operations Costs Related to Summary of Benefits and Coverage and the Uniform Glossary

Company Size	Enrollment	Total Implementation Costs	Total Annual Ongoing Operations Cost
		Survey Results	
Large (more than 5 million enrollees)	89,743,947	$87,809,000	$109,618,000
Medium (1 million to 5 million enrollees)	33,119,824	$37,431,000	$22,559,000
Small (fewer than 1 million enrollees)	4,437,027	$7,990,000	$5,266,000
All Companies in Survey	127,300,798	$133,229,000	$137,443,000
		Results Extrapolated to 180 Million Covered Lives	
Large (more than 5 million enrollees)	126,895,595	$124,159,000	$154,998,000
Medium (1 million to 5 million enrollees)	46,830,565	$52,927,000	$31,898,000
Small (fewer than 1 million enrollees)	6,273,840	$11,297,000	$7,445,000
All Companies in Survey	180,000,000	$188,383,000	$194,341,000

*Includes 4 plans reporting that they are unable to estimate costs for implementation by March 23, 2012.
Source: AHIP Center for Policy and Research.
Notes: AHIP member survey results based on companies with 127 million enrollees and extrapolated to an estimated universe of 180 million enrollees. Enrollment figures include fully-insured and self-funded covered lives provided by the 36 survey responding companies. Numbers may not sum to totals due to rounding.

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 Companies*	$94,457,000*	$72,609,000*	23%

Source: AHIP Center for Policy and Research.
Note: Survey assumed a hypothetical 18-month implementation period, assuming final rules were published in December 2011.
*Cost figures based only on companies responding with both estimated implementation costs at deadline and estimated implementation costs with an 18-month extension.

enrollees with private health insurance for comparison with the estimates provided in the proposed rule.

Figure 1 compares estimated health plan costs to comply with the SBC and the Uniform Glossary projected by HHS with the estimated costs identified in AHIP's member survey. HHS projected total costs (implementation and ongoing) for the years 2011, 2012, and 2013, while AHIP's survey estimated separate costs for implementation and annual ongoing operations. Estimated costs for both the HHS and AHIP survey are in 2011 dollars.

Table 1 shows total enrollment, estimated implementation costs, and annual ongoing operations costs for responding companies in the survey. The table shows the survey results as well as an extrapolation of the survey results to 180 million covered lives, a roughly estimated number of commercially-insured enrollees.

Large plans, which we defined as those with more than 5 million enrollees, reported estimated implementation costs of almost $88 million and annual ongoing operations costs of about $110 million. Medium-sized plans, defined as those with between 1 million and 5 million enrollees, reported $37 million in estimated implementation costs and almost $23 million in estimated annual ongoing operations costs. Smaller plans with fewer than 1 million enrollees reported estimates of almost $8 million in implementation costs and over $5 million in annual ongoing operations costs.

Table 2 shows estimated implementation cost savings with an 18-month extension of the implementation timeline, from the estimated publication date of the final rules to the date of implementation. Technically, to give responding plans a specific time frame, the costs were estimated based on the assumption that the final rule would be published in late December, 2011. Thus, the hypothetical implementation period would be the ensuing 18 month period. It is important to note that the total implementation cost at deadline takes into account *only* responding plans that estimated implementation costs at the deadline and with an 18-month extension. For plans responding with both cost figures, there was an estimated 23 percent savings on implementation costs with an 18-month implementation period.

Table 3 details the percentage of estimated annual ongoing operations cost that is attributed to the hiring of additional staff. For all responding companies in the survey, about 17 percent of annual ongoing operations costs are estimated to be attributed to the hiring of additional staff.

Table 3. Estimated Annual Ongoing Operations Cost Attributed to Hiring of Additional Staff

	Total Ongoing Operations Cost	Costs Attributed to Hiring Additional Staff	Staffing Costs as a Percent of Ongoing Cost
All Plans in Survey	$137,443,000	$23,801,000	17%

Source: AHIP Center for Policy and Research.

MAJOR ISSUES FROM HEALTH PLAN RESPONSES

The following sections provide summaries and selected quotations from the open-ended responses to the survey. The Appendix to this report provides additional direct quotations.

March 23, 2012 implementation date. Implementation costs are significant, and preliminary strategies and process developments are subject to change as final guidance is provided, increasing the complexity of compliance by March 23, 2012.

> *"In order to meet 3/23 [2012] effective date, we are having to rely on a large percent of contracting resources. A longer timeframe would allow employees who are currently working on HCR projects with an earlier effective date (i.e. 1/1/12) to become available and lower the development cost."*

Requirement to include premium information on initial SBC. Requiring the inclusion of premium information on SBC during the "shopping" phase will significantly increase complexity and costs for health insurers and cause confusion for consumers, especially in group markets. Premiums cannot be accurately provided without collection of detailed information from a shopper prior to application for coverage and could frequently change as the shopper considers options.

> *"The requirement to provide premium information in the SBCs distributed to applicants and enrollees of an employer group will have a cost impact. Carrier would be able to provide the gross premium information. However, carrier does not have access to records of employer group contributions toward their employees' premiums."*

Number and complexity of coverage examples required. The number of possible coverage examples, taking into account benefit, and plan designs will be very large, creating complexity for carriers and causing consumer confusion and increased cost.

> *"Requiring more than 3 benefit scenarios, and possibly as many as 6, potentially provided for all benefit packages offered, to be populated and incorporated into a template document…only serves to further increase the costs and complexity of producing the SBC, which is intended to be a 'Summary' of Benefits and Coverage."*

> *"We expect over 157,000 versions of the document to be developed initially and increasing as new plan designs are developed."*

Renewal process and timeframe to send SBC(s). The proposed rule requirement that health insurers must send SBCs to enrollees at least 30 days prior to renewal has the potential to significantly affect business practices regarding renewals.

> *"[The] automatic renewals [requirement to] deliver the SBC 30 days prior to the effective date is not in line with our current business practices. This requirement would cause a major change in our renewal process. In the case of automatic renewals, it would seem more appropriate that the SBC be sent within 30 days of the effective date, along with other coverage documents, rather than prior to the effective date."*

Number of variations of SBCs to be delivered to each applicant or enrollee. Throughout the shopping, application, and enrollment phases, the number of SBCs provided to applicants and enrollees may

cause increased confusion and complexity. By not allowing a single SBC to include different benefit levels and premium tiers for one person, two person and family coverage, multiple SBCs will need to be generated, thus significantly increasing the workload and development costs for carriers and potentially inundating consumers.

> *"Requiring issuers to provide SBCs to shoppers… [and] provide specific "coverage date" information, and provide multiple iterations for each product based upon coverage tier elected significantly increases compliance costs."*

Duplication of materials already delivered to group enrollees. Group plan enrollees receive summary plan documents (SPDs) and the challenge will be to minimize duplication of materials already sent to enrollees.

> *"The revised format and the specific delivery requirements for the SBC create complexity because they duplicate and completely revise an existing document and process."*

Paper delivery of SBCs to most group enrollees. Printing, mailing, and other costs related to delivering SBCs on paper may cause carriers to have to change their fulfillment processes, and will be a significant annual ongoing cost.

> *"By requiring that we provide the SBCs in paper would require us to completely redesign our fulfillment processes and costs."*

SBCs for employers and group sponsors. Allowing employers to request SBCs during "shopping" phase along with individuals significantly increases cost burden.

> *"Creating the SBC Pre-Sale for Employer Groups will increase complexity, given the high level of variations that have to be taken to account when creating the SBC."*

Insufficient flexibility in SBC template for explanation of benefit tiers. The inability for carriers to include additional more specific information, such as benefit tiers for certain plan designs, will cause confusion for consumers.

> *"HHS should consider allowing plans the option to modify the headings of the SBC template to reflect the appropriate tiered network benefits. We also recommend a field that would allow plans to include more specific information about the benefit plan. Currently we include disclaimers that outline the specific rules of the plan. The current SBC template does not include enough space to make these specifications clear to the members, which can cause confusion."*

ACKNOWLEDGEMENTS

The data for this report were compiled by Dan LaVallee of AHIP's Center for Policy and Research. For more information, please contact Jeff Lemieux, Senior Vice President, at 202.778.3200 or visit www.ahipresearch.org.

APPENDIX – Open-Ended Company Responses

The following are direct quotations from the open-ended responses to AHIP's SBC survey. The responses of multiple companies may be included in each section. The quotations were edited to eliminate redundancy, for clarity, and to de-identify the responding company.

March 23, 2012 Implementation Date

The SBC cost estimates were conservatively estimated by using only incremental costs to produce the plan design and Summary Plan Document (SPD) solutions in place today. Moreover, issuers must now invest resources (financial and personnel) to meet the effective date based upon a proposed rule that is likely to change before made final. In addition, further investment will be required to support state-specific mandated formats. Ongoing development costs will be incurred to support changes in mandates, product designs, etc.

These costs represent preliminary estimates to design, test, and implement capabilities to produce the SBC, Coverage Examples, and Uniform Glossary. The March 2012 costs reflect a 50 percent premium due to the short delivery timeframe. These estimates are subject to change as new guidance is provided regarding the final format and content of the SBC.

In order to meet 3/23 [2012] effective date, we are having to rely on a large percentage of contracting resources. A longer timeframe would allow employees who are currently working on HCR projects with an earlier effective date (i.e. 1/1/12) to become available and lower the development cost.

If we had an extension we would save on the administrative and operational costs and most likely reduce implementation costs by having the opportunity to implement more comprehensive and efficient delivery processes. Presumably, we would also have the advantage of final guidance which would allow us to pursue implementation with a greater measure of certainty that resources would not be wasted.

This project is going to require significant development effort. Solutions will need to be created that either duplicate the efforts for various systems and data mapping or a solution that presents a single source for data to feed to. Putting such a short time frame on the implementation forces health plans to choose the quickest solution (as opposed to the most appropriate), increasing the cost and inefficiency.

While we expect the financial impact to meet the March 23, 2012 deadline to be significant, our primary concern is the ability to fulfill the deadline requirement through outsourcing. The vast majority of the skills and tools needed can't be outsourced due to the complexity of the systems, lack of experience an outsourced resource would have of our with current work flow processes and IT architecture, in addition to the lack of final regulations to build a solution upon. Recent experience with the HCR Portal demonstrated the risk and additional costs that must be absorbed by pursuing a solution based on the preliminary regulations. Substantial rework was required on our HCR Portal solution to account for the variance in the final regulations.

Cost estimate assumes minimal automation due to the brief implementation timeline. Minimal automation would result in a large number of employees being hired to execute manual processes. Cost estimate assume[s] a greater level of automation (and therefore, increased initial development costs). This estimate also assumes fewer FTEs will need to be hired to complete manual tasks.

The shortened timeframe of the March 2012 deadline does affect the testing window and puts additional pressure on limited resources. [Our] estimate includes business analysis, project definition, systems development and online availability via public website.

Such a short implementation time frame means costs will be significantly greater due to:

- *Cost of additional staff resources, over and above what we would have allocated to this project if the implementation deadline were not 6 months away;*
- *Cost of temporaries to back fill for staff who will be needed on this project full time to make the deadline;*
- *Cost of inevitable rework because we have to begin implementation now before we have final requirements which will likely be changed from the NPRM;*
- *Cost of rushing a vendor to implement in a compressed time frame and having to populate 1500 SBC templates.*

If given extension, it will allow for proper/better planning of budgeting/allocation of resource[s]. Some costs may be deferred by working with vendors that have a responsibility to comply with the mandate as a market wide implementation, not specific to one entity; however, we will still be responsible for remediation of custom functionality.

To meet a 3/23/12 effective date, we will need to handle certain processes manually; therefore, staff will need to be hired until we can automate the processes.

Ongoing costs will depend on the implementation timeline and the amount of automation that can be developed.

We have not completely determined impact on all operational areas since clarification of regulations is still forthcoming through various government entity comment periods, and legal interpretations. It's imperative we get final rules and guidance, without which we cannot determine the necessary operational and system requirements. Under current assumptions, there is risk that the implementation date of 03/23/12 may not be met otherwise.

The complexity and cost of implementation is drastically increased with the requirement to provide this information down to the plan level. The strain of programming and development resources involved in creating the SBC could potentially be mitigated if this information were provided only down to the product level.

We will see rework as we need to begin to build now for a March 23, 2012 date and expect there will be changes once [the final rules] are released. The compressed timeframe will force less system and process testing, limited ability to effectively communicate with employers and brokers in advance of the changes, create confusion in the marketplace with employers and members in the initial launch period. The 03/23 date requires starting process/systems work to commence prior to [the final rules]. Additional adjustments defined in the [final rules] will create post effective date changes to our processes and systems further creating marketplace confusion.

Limited timeframe to implement, given the delay in final regulations, we are faced with an exceptionally short period of time to implement the SBC which has very complex IT requirements. An extension of the implementation date would alleviate unnecessary strain and expenditure of resources.

This single ACA provision represents significant administrative cost and should be more fully considered in light of on-going pressure for health plans to reduce these costs.

The volume of plans will make the implementation complex. That in combination with the need to essentially create individualized SBCs based on information to determine premium, makes this next to impossible. We, along with the rest of the industry, urge the need for additional time for sufficient development and testing.

Overall costs increase the longer carriers have to wait for final guidance as carriers are developing solutions based on assumptions that may not be correct and ultimately require re-work. The investments required to meet the timeline are not necessarily foundational to the long term solution. There are temporary manual solutions being developed in order to meet the compliance date, and may be revised upon release of the final regulation.

Requirement to Include Premium Information on Initial SBC

The requirements around providing "premiums" and "pharmacy" will significantly increase the complexity and cost of implementing this NPRM. It is not part of our standard business process to provide premium information at any of the "trigger" points laid out in the NPRM. We will have to completely redesign our quoting processes. Also, a decision was made by the plan to provide documentation online. Requiring that we provide the SBCs in paper would require us to completely redesign our fulfillment processes and costs.

The NPRM retains the NAIC direction to issuers regarding premium information relating to the group markets (issuers will answer "Please contact your employer for your share of the premium amount.") However, the request for comments in the NPRM on whether premium or cost information should be included in the SBC and how, raises concerns that issuers may be required under final rules to obtain this information from employers and include specific cost sharing information in the SBC. Premium and cost sharing information is particularly sensitive information for employers that issuers do not currently know. Managing significant volumes of new information across thousands of individuals would further add to the cost of implementation.

Having the Premium information on the SBC for both Group and Non-Group adds significant complexity as the SBC has to be customized. It requires data from our underwriting system to interface with our claims system to determine an employee's premium (i.e. share paid by employees, not employers). The level of specificity, including premium amount and exact benefit design, required to be included in summary of benefits and coverage (SBC) will result in the need to maintain an immense number of SBC versions.

The requirement to provide premium information in the SBCs distributed to applicants and enrollees of an employer group will have a cost impact. Carrier would be able to provide the gross premium information. However, carrier does not have access to records of employer group contributions toward their employees' premiums.

Number and Complexity of Coverage Examples Required

It will require major technical enhancements, as well as additional staffing, to provide coverage examples alone. Technical costs will be higher due to the short window of time given to implement, as will man hours for project implementation management.

Annual ongoing operations costs include printing, mailing and staffing costs for the SBC and Coverage Examples.

The requirement to produce the Coverage Examples has an obvious significant impact on the cost and complexity of producing the SBC. While the specific information necessary to simulate benefits covered under the plan or policy remains unavailable from HHS it is impossible to determine ease or difficulty of use and any associated unexpected costs or complexities. Nonetheless, populating the coverage examples will provide its own set of challenges. Requiring more than 3 benefit scenarios, and possibly as many as 6, potentially provided for all benefit packages offered, to be populated and incorporated into a template document that already challenges the provisions of Sec. 2715 (a)(1) and (a)(3)(A) of the Patient Protection and Affordable Care Act (uniform definitions are included in the 4-page limit) only serves to further increase the costs and complexity of producing the SBC, which is intended to be a 'Summary' of Benefits and Coverage

The creation of coverage examples that require simulating claims processing is burdensome. The suggestion in the NPRM for creating a portal for this purpose is something we support. If this is not feasible, a simpler approach, such as the use of uniform illustrative examples, should be used.

Coverage facts labels and other graphics increase the complexity of developing and printing/electronically publishing SBCs.

Coverage fact labels are of questionable benefit to consumers because they are potentially misleading due to wide variation between individuals' treatment costs for common conditions (for example, because of treatment complications).

Based on consumer demand, we offer a variety of plan designs, with various premiums, network structures, etc., in the marketplace. Unless comparisons are made between like plan designs, the comparison will not be meaningful and may be misleading.

The NPRM (Supplementary Information, Section I: Proposal pp 52477-78) states that HHS will update the national average payment data annually and that plans will need to modify the Coverage Examples and reprint SBCs for use 90 days after the update. The NPRM goes on to say that "these updates alone will not be considered a material modification under paragraph (b) of the 2011 proposed regulations." This means SBCs could reflect different payment data from health plan to health plan. This would render the comparisons invalid. Since the intent is to provide a comparison tool, then all plans should be required to make changes on the same cycle; otherwise the Coverage Examples are not comparable and a great deal of time, effort and cost will have been expended for a tool that is invalid.

The timing of HHS' release of national average payment data is critical. Certain times of the year, the fall for example, are extremely busy with renewals and open enrollments. HHS needs to avoid these critical times since printing is completed well in advance.

Renewal Process and Timeframe to Send SBC

The requirement to provide the SBC within 7 days of a request for information about the health coverage by a group health plan has a significant impact on the Large Group Proposal process, particularly in the case of an extensive RFP where employer groups seek information from multiple carriers to compare against current plans. Generally, information is gathered and returned to the Group within a specific time period of time and may include numerous benefit and rate options from which the Group can narrow down their selection(s). If the intent of the rule is to incorporate the SBC into the initial proposal process, the cost increase and complexity associated with the change in current process will be substantial.

The timeframes for delivery of SBC's after receipt of a request are not feasible in a group process. Seven days may be feasible in an individual, prepackaged plan market, but in a group setting, with complex and flexible benefit packages (approximately 70,000 currently) it can be as much as 60 days to respond to complex RFP's. In general, the delivery times and methods (electronic) need specific analysis given the current practices in the market which are driven by plan sponsor and producer needs.

60 day notice of material modification: many small and large groups request last minute benefit change or do not confirm renewal of coverage until a few days before the plan effective date or even request retrospective changes. It will be very difficult for our plan and our groups to comply with the 60 day requirement.

Automatic renewals require delivery of the SBC 30 days prior to the effective date – This requirement is not in line with our current business practices.

The requirement that applicants must receive SBCs by effective date of the contract can be problematic in instances where there is a retroactive effective date, or in cases where the request is received just days prior to the effective date (less than 7 days before the effective date).

Number of Variations of SBCs to be Delivered to Each Applicant or Enrollee and SBCs for Employers and Group Sponsors

The requirement to provide the SBC to group health plans or sponsors when they are shopping around will substantially increase the cost and complexity of compliance. Frequently, as many as 10-12 different plan options can be presented to employers or their brokers. Currently, those options are reflected in a one page spreadsheet. If SBCs are required, they will have to be continually modified to reflect all the different options being presented. In the group market, less than 10% of groups quoted will ultimately end up buying one of our plans. Therefore, a

significant cost will be incurred in providing multiple SBCs that contain low level information that most group purchasers will not find useful and which will not result in a sale. Once a plan is selected and a contract is entered into, it makes sense to provide the SBCs to employees at enrollment. The template content is geared toward a lay person, not to brokers and group purchasers.

"A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application or request for information about the health coverage as soon as practicable following the request, but in no event later than seven days following the request. If an SBC is provided upon request for information about health coverage and the plan (or its sponsor) subsequently applies for health coverage, a second SBC must be provided under this paragraph (a)(1)(i)(A) only if the information required to be in the SBC has changed." With respect to sentence 2, the 'Draft Instruction Guide for Group Policies' pg 3, bullet 2 (NPRM pg 52495) requires that "For final forms (provided to employees after selection), insurers should only include information for the relevant plan." Enrollees are capable of making this distinction providing the levels of cost sharing are appropriately labeled as to their applicability within each category. This requirement further adds to the increased cost and administrative burden, and the complexity of providing the SBC. This requirement appears to be in conflict with the intent of §(a)(1)(i)(A).

Preparing the documents for shoppers within the required timelines will be very time-consuming, expensive and difficult for our plan to implement.

The unique aspect of employer group coverage and coordinating all of this with employer groups adds an enormous amount of complexity to this requirement.

To require that issuers and employer groups follow the 2002 Department of Labor ("DOL") electronic distribution safe harbor is particularly burdensome in the current environment where most individuals have access to electronic information systems outside of work. To require compliance with the DOL safe harbor is likely result in paper delivery of at least initial and perhaps subsequent SBCs to group Participants and Beneficiaries, significantly increasing associated costs. Issuers do not currently know the universe of Participants or Beneficiaries nor do they know which Participants have electronic access to documents at any location where they can reasonably be expected to perform their duties and for whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Without this information, issuers are required to deem all Participants as not having such access; therefore, must build processes to obtain affirmative consent from all. A March 23, 2012 applicability date does not allow enough time for issuers to build and test such processes, educate plan sponsors on what information must be provided, and incorporate Participant and Beneficiary information into such processes.

Requiring issuers to provide SBCs to shoppers (meaning individuals who have not submitted an application) for any product they might be curious about, provide specific "coverage date" information, and provide multiple iterations for each product based upon coverage tier elected significantly increases compliance costs. Issuers do not acquire or maintain information on individuals who do not submit an application for coverage; therefore, requiring delivery of SBCs in the proposed from to "shoppers" creates the need to build an entirely new process for acquiring and maintaining such information. Furthermore, it is unlikely that many issuers will be able to track what version of which SBCs was delivered on what date to a shopper; therefore, issuers will likely be forced to resort to reissue new SBCs at the points in time identified in the NPRM under a presumption that something in most recently delivered SBC has changed.

Requiring the issuance of a new SBC iteration specific to the coverage tier elected by an individual creates the potential of multiple SBCs to an individual each time an individual adds or removes a dependent (e.g., self , self plus one, self plus two, self plus 3, family).

Currently we support almost 9,000 active benefit summaries for our existing business. To implement the mandate as currently defined would increase our volume by over 5-fold. Our existing summaries are "static" meaning the same summary is provided pre-sale and post-sale to all groups/members with the same benefit. The noted items above will cause the creation of "custom" summaries by member/group just so the items noted (policy period and coverage type, and deductible) are correctly listed when all the other data elements will be constant. This greatly increases our implementation costs and impacts our record retention abilities.

Creating the SBC Pre-Sale for Employer Groups will increase complexity, given the high level of variations that have to be taken to account when creating the SBC.

One requirement that will significantly increase the complexity and cost will be the requirement to track and provide updated versions of the SBC during the shopper/application/initial enrollment phases. This will require development of a cross-departmental distribution management solution.

The intent of the SBC is to "help individuals better understand their health coverage options so that they may make informed coverage selections". However, the instructions indicate that the SBC is to be issued pre-sale (prior to initial & annual enrollment/renewal, etc) and post-sale ("when an insurer issues a policy or delivers a certificate form" p 2 Instruction Guide). Requiring the SBC to function as both a "pre-sale" and "post-sale" document, i.e., providing the SBC twice annually will significantly increase cost and complexity.

The requirements regarding the timing of sending SBCs, particularly to shoppers, increase ongoing costs to produce and send. In addition, as proposed, we will need a method to track what versions were sent when, identify changes and send updated versions.

If we have to continue to provide for shoppers, then the safe harbor to publish on healthcare.gov does minimize some concerns. However, there is no way to track what version of an SBC a shopper receives, and as such we recommend not having to resend to shoppers if there are any changes. As with any purchase in any industry, while people are still just shopping, everything is still subject to change.

The requirement to send to multiple addresses is extremely complex. Today we do not collect additional addresses for dependents on the plan, but instead send plan materials to the subscriber. This would also be burdensome for employers. We recommend that the final rule be altered to only require SBCs be sent to the individual making the purchasing decision- the subscriber.

Paper Delivery of SBCs to Most Group Enrollees and Duplication of Materials Already Delivered to Group Enrollees

Also, the percentage of digital fulfillment versus print is difficult to predict unless we know how prominently the print alternative must be advertised. When consumers are given a choice they tend to choose print. Consider how difficult it has been to get consumers to move to online billing. Postage is around $2.50 per envelope.

Response is annual cost of printing and mailing SBCs and notices of material mod for shoppers, at open enrollment, and/or at renewal. Electronic delivery would be less ($0.00233 per e-mail) but is difficult to estimate due to uncertainty over which consumers or enrollees could or would elect electronic delivery.

The revised format and the specific delivery requirements for the SBC create complexity because they duplicate and completely revise an existing document and process.

Insufficient Flexibility in SBC Template for Explanation of Benefit Tiers

Currently, the guidelines do not allow us to add anything to the SBC. We believe that means we are prohibited from adding barcodes. Without barcodes, it is impractical to use automatic mail inserters. This will mean we have to develop a manual insertion strategy. If would also be helpful if we could print the prospect's name and address on the back page of the SBC. This would allow us to insert the SBC without creating a separate sheet to simply carry that information. Also, the guidelines do not explicitly cover binding options or simply state that insurance companies are free to bind in the most suitable way or not bind at all. Another point, we would like to add information such as creation date or a tracking number. The

federal government is encouraging a move to digital records, but the guidelines make digital tracking and record keeping difficult.

The SBC chart is not flexible enough to accommodate products with various levels of benefits/tiers. The only distinction the chart allows is Participating and Non-Participating Providers. However, there are some wellness plans that dictate what benefit the member receives based on program compliance (completing a health risk assessment etc.). The chart does not allow for this type of distinction which may lead to the issuance of a second SBC once final benefits are determined. We also have tiered provider plans specific to our hospital groups.

Currently we include disclaimers that outline the specific rules of the plan (e.g.: embedded deductible, HSA rules, etc.). The current SBC template does not include enough space to make these specifications clear to the members, which can cause confusion.