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Submitted Via Federal Rulemaking Portal: http://www.regulations.gov

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

Attn: CMS-9982-P

RE: Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Notice of Proposed Rulemaking regarding the Summary of Benefits and Coverage and Uniform Glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act ("NPRM"), which was published in the Federal Register on August 22, 2011.[1] The NPRM is issued as required by Section 2715 of the Public Health Service Act, added by Section 1001 as amended by 10101(b) of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act ("PPACA"), which directs the Secretary to develop standards for use by a group health plan and a health insurance issuer in compiling and providing a summary of benefits and coverage (SBC) that accurately describes the benefits and coverage under the applicable plan or coverage. As with other regulations under these Acts, the NPRM was published jointly by the Department of the Treasury, the Department of Labor and the Department of Health and Human Services (the "Departments").[2]

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[1] Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking, 76 Fed. Reg. 52,442-52,475 (August 22, 2011) (to be codified at 45 C.F.R. pts. 147; 29 CFR pt. 2590; and 26 CFR pts. 54 and 602) [hereinafter referred to as "NPRM"].

[2] Pursuant to the request in the IFRs, the Chamber is submitting these comments to one of the Departments - The Department of Health and Human Services, with the understanding that these comments will be shared with the Department of Labor and the Department of Treasury, as well.

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance – is represented. Also, the Chamber has substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

OVERVIEW

The Chamber and our member companies want quality health care to be readily available at an affordable price, a central goal of PPACA. The Chamber has also long advocated for transparency of price, quality and information. We agree that access to meaningful information about the price and quality of health care services and coverage will lead to meaningful reform and cost containment. Our comments include general recommendations with regard to fulfilling the intent of the statute and specific comments in response to questions posed by the Departments.

A. GENERAL RECOMMENDATIONS

We urge the Departments to be mindful of statutory language as they promulgate regulations. If the Departments believe that there are severe unintended consequences that would result from a strict reading of the statute, we urge the Department to carefully consider regulations which would advance the goal of the statute and avoid unintended, costly and duplicative results.

In evaluating these general recommendations, we ask the Departments to remember that Congress and the administration chose to build on the current employer-based system when drafting and enacting this law. Therefore, we urge the Departments to similarly build on current successful practices, systems and processes in implementing the law in order to avoid unnecessary, costly duplication. Most importantly, we urge the Departments to understand that employers are a main source of coverage for millions of Americans. Yet, employers already are struggling with the high cost of employee benefits.[3] It is critical that the Departments not exacerbate these cost challenges by imposing additional complex administrative costs onto employers or our administrators.

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[3] See Kaiser Family Foundation Employer Health Benefits: 2011 Summary of Findings, http://ehbs.kff.org/pdf/8226.pdf "Over ten year period (2001-2011), average family premiums rose by 113 percent."

1. Promulgate Regulations According to the Statute

With regard to the timing of required compliance and the areas that the standards should govern, we urge the Departments to carefully consider the statutory language.

Timing

The text of Section 2715 begins with a requirement that standards be developed no later than 12 months after the law is enacted and subsequent deadlines follow. Later, *based on this first deadline*, the statute affords issuers, plans and sponsors a 12 month period after the establishment of standards to comply with the new documentation requirements.[4] We urge the Departments to afford issuers, plans and sponsors at least *an 18 month period* to comply following the issuance of final standards via a final rule. In addition to not penalizing issuers, plans and sponsors because the Departments failed to meet their statutorily prescribed deadline, we urge the Departments to permit a more realistic time frame for their compliance.

Assuming the proposed rule stands as is, it will require insurers, TPAs, and group plans to completely redesign their systems for producing benefit information and require that information to be provided at multiple times over the course of a typical plan year (including enrollment). The requirement to design a SBC for each specific benefit option (HMO, PPO, PSO, HSA/HRA), premium category (self, family, parent+child) and carve-out (behavioral health and pharmacy) will result in each enrollee potentially getting 10 – 15 SBCs depending on which options they are considering. Additional work will be needed to produce Coverage Examples (CEs). So 18 months is a more realistic estimate of what will be needed.

However, the NPRM appears to continue to require insurers and plans to comply with the provision by the March 23, 2012 deadline, when still no final rule as to what compliance entails has been issued. If a final rule were issued November 23, 2011 (which would be difficult given the Departments charge of responding to all filed comments when issuing a final rule), plans would have 4 months to comply with a very complicated requirement. This compressed timeline is inadequate for plans and issuers to make the complicated system and program changes necessary to implement these regulatory requirements. We recommend that compliance not be required until 18 months after the issuance of a final rule and we urge the Departments to announce this compliance modification immediately to provide plans and issuers certainty.

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[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

"§2715(a) IN GENERAL.- Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage."

"§2715(d) REQUIREMENT TO PROVIDE. – Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a).

Standards As To What – Not Standards As To Whom, By Who, When, and How.

The statute is clear as to who provides the summary of benefits and coverage and uniform glossary (UG)[5], to whom[6], when[7] and how[8]. It seems strange that the NPRM states, "[t]hese regulations…will govern who provides an SBC, who receives an SBC, when the SBC will be provided and how it will be provided," when the statute already does this.

The statute at §2715(d)(1) and (3) clearly states who provides the summary of benefits and coverage: "a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States) or in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan)."

The statute at §2715(d)(1) clearly states to whom an SBC must be provided: "to an applicant, an enrollee, a policyholder or certificate holder."

The statute at §2715(d)(1) clearly states when an SBC must be provided: "prior to any enrollment restriction, at the time of application, prior to the time of enrollment, or reenrollment (as applicable) and at the time of issuance of the policy or delivery of the certificate."

The statute at §2715(d)(2) clearly states how an SBC must be provided: "in paper or electronic form."

Instead of the "who," "to whom," "when" and "how," the statute specifies that the Secretary is to issue standards to the "what." The standards the Secretary is to issue are to be "use[d]…in compiling and providing applicants…a summary of benefits and coverage explanations" - the elements and the method of compiling the SBC. While the NPRM does address the "what," or the content elements based on NAIC's recommendations, the NPRM overreaches by relegislating the who, to whom, when, and how that the statute defines.

RECOMMENDATION: Delay implementation or provide a non-enforcement period for at least 18 months following the release of the final regulations. Unless there are less costly and less burdensome alternatives, follow the statutorily prescribed who, to whom, when and how.

2. Avoid Unnecessary, Costly Duplication

If the Departments conclude that a strict reading of the statutory specifications as to the who, to whom, when and how will result in costly unintended consequences, we would support

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[5] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001 (amending Public Health Service Act §2715(d)(3).

[6] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001 (amending Public Health Service Act §2715(d)(1).

[7] Ibid

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001 (amending Public Health Service Act §2715(d)(2).

regulations that assuage this result. One such area where we urge the Departments to consider promulgating regulations to facilitate effective and proper implementation is with regard to large group plans.

Employers, health insurance issuers and other groups sponsoring group health plans already provide Summary Plan Descriptions (SPD) as required by the Employee Retirement Income and Security Act (ERISA), as well as benefit summaries that are customized to provide information in the format preferred by their employee population. Other highly-customized tools and information are also provided to employees and individuals when they enroll during open enrollment periods or otherwise. Among our chief concerns, we fear that the Deparments fail to appreciate the value of the current information that employers provide, but also the enormity of the cost to comply with this new duplicative notice requirement.

Additionally, there are other less onerous ways to facilitate easy comparisons for individuals and small employers shopping for coverage. The federal government and other health care stakeholders have expended significant resources in establishing the HHS web portal which will provide extensive information on benefit design and other aspects of coverage. The NPRM alludes to this process saying:

> Finally, consistent with the standards for electronic disclosure, these proposed regulations seek to reduce the burden of providing an SBC to individuals shopping for coverage. Specifically, these proposed regulations provide that a health insurance issuer that complies with the requirements set forth at 45 CFR 159.120 (75 FR 24470) for reporting to the Federal health care reform insurance Web portal would be deemed to comply with the requirement to provide the SBC to an individual requesting information about coverage prior to submitting an application. Any SBC furnished at the time of application or subsequently, however, would be required to be provided in a form and manner consistent with the rules described above.[9]

While the NPRM's recognition is helpful, it must go further and provide a complete safe harbor for individual market coverage and small group market coverage provided that the plans are participating in the web portal.

Unnecessary

We appreciate the repeated references in the NPRM to the goals of minimizing cost, duplication and burdens on employers and insurers. However, we remain concerned that the Departments fail to properly appreciate and account for the substantial investment that issuers and group health plan sponsors have already made to successfully ensure that individuals understand the terms of their coverage. The final regulations should build on these existing processes and methods and leverage them as much as possible. However, the proposed regulations do not. Instead, the NPRM requires issuers (and ultimately employers and purchasers) to devote significantly more financial resources to accomplish something that by and large is already being

[9] NPRM, 76 Fed. Reg. at 52,449.

achieved. As currently proposed, the rules require the provision of an unrealistically rigid SBC that will too often be redundant and will have the unintended consequence of confusing or overwhelming consumers rather than making them better informed.

Costly

The Departments also do not appear to comprehend the enormity of the cost to create and provide this new summary of benefit and coverage and uniform glossary. Given the near infinite need for additional financial resources to expand coverage and enrich benefits, we urge the Departments to recognize that there is a finite amount of money and resources that employers can spend, particularly now as employers are struggling to recover from the recent recession. Requiring this duplicative documentation will force employers to use their limited financial resources to pay to reformat materials that already exist, instead of allowing employers to use those resources to pay for more comprehensive benefits for their employees. As proposed, this NPRM requires a significant investment of employers' limited resources and does not provide additional value to employees.

Further, this mandate will also have very real ramifications on premiums. Unnecessary administrative costs drive up the cost of coverage and make it unaffordable, which harms both employees and employers. With the cost of health care already rising at 9 percent per year,[10] it is imperative that the federal government not further threaten affordable, quality employer-based coverage by imposing unnecessary administrative costs and burdens on the employer community. Unfortunately, we believe the NPRM will do just that by unnecessarily increasing cost and adding complexity for employers without providing any corresponding benefit to employees.

RECOMMENDATIONS: Provide a safe harbor for large employer group health plans that provide this information through the summary plan description in conformance with ERISA requirements and other summary materials. Create a safe harbor for individual market coverage and small group market coverage listed on the federal government Plan Finder portal. Coverage listed on the portal should be deemed to be in compliance with all aspects of the Summary of Benefit form. Individuals could access this information at anytime using the Plan Finder website. In addition, enrolled members could request hard copy printouts of the portal information from their health plan up to three times per year.

B. COMMENTS ON ECONOMIC IMPACT AND PAPERWORK BRUDEN

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13563, issued by President Obama this year, especially emphasizes the importance of quantifying both costs and benefits of regulatory alternatives considered. In the proposed rule, the Departments have failed to adequately comply with these Executive Orders (EOs).

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[10] *Employer Health Benefits – 2011 Annual Survey.* The Kaiser Family Foundation and Health Research and Educational Trust. 2010. Pg 10.

Two categories of errors or omissions describe the failures of the Departments:

1. Under benefits, the Departments fail to adequately estimate the monetary benefits of the selected proposal and of non-selected alternatives; and
2. Under costs, the Departments fail to document and present a credible empirical basis for compliance labor time burdens used in cost calculations.

In each of these categories, the Departments fail to adequately analyze the economic impacts of the proposed regulation; this is discussed in detail below.

1. Benefits: No basis for assertion that benefits outweigh costs

The Departments identify the benefits of the proposed rule qualitatively in terms of reduced transactions costs to health insurance consumers. While the idea that a uniform template for comparing the premiums, out-of-pocket costs, and benefits of competing health insurance plans would reduce the consumer's time, effort and errors in asssessing health insurance costs, the Departments have made no attempt to estimate the monetary value of these benefits.

The Departments could have readily developed quantitative estimates of the savings in time that a typical consumer would achieve by conducting an experiment in which different randomly selected groups of consumers were asked to choose the least costly (or best value by some other criteria) plan from among a selected group of plans. The treatment group would have been provided with information using the proposed standard information template and a control group of subjects would have been asked to choose based on review of existing plan information documents. Both the time to make choice and the accuracy of choices by members of each group could be measured.

This experiment would have provided a statistical test of the hypotheses that the standardized template results in reduced consumer choice time investment and in greater choice efficiency (accuracy with respect to a defined choice criterion). If the findings confirmed that the standardized template resulted in reduced consumer time to make choices, than the time difference could have been multiplied by a measure of average consumer time-value (such as average hourly wage) to obtain a monetized estimate of the benefit per consumer. This parameter multiplied by the estimated number of affected consumers who make health insurance choices each year would provide one component of the annual benefit for the proposed rule. The other component of benefit, the putative value of increased choice efficiency, could also be estimated from the experiment results by comparing, for example, the average plan cost chosen by members of the treatment group to the average plan cost chosen by members of the control group. Instead of simple cost, the efficiency benefit also could have applied a value criteria reflecting optimization of plan benefits relative to cost.

The experimental approach could have been expanded to test several different versions of a standardized template. By doing this, the Departments could have demonstrated that the proposed template is in fact more effective and efficient than alternatives that could have been proposed.

Without the results of monetized benefit estimates which the Departments could have readily obtained, there is no empirical basis for the Department's assertion that the benefits of the proposed rule exceed its considerable costs. Nor have the Departments shown that the specific template proposed is effective in comparison to other templates that could have been proposed or even in comparison to no template at all.

The Departments should withdraw the current proposal and conduct experiments to test the hypothesis that a standard template will provide the claimed benefits of reduced consumer transaction time and increased efficiency of choice, that the monetized benefits, if any, of the proposed standard template exceed those of alternatives, and that the monetized benefits of the proposal exceed the reasonably estimated costs of implementation and compliance. In many regulatory analysis contexts the estimation of benefits in monetary terms is quite challenging to agency resources and capabilities. In this case, the task of estimating monetized benefits is remarkably direct and feasible, and the Departments' failure to pursue this opportunity is both unfortunate and perplexing.

2. Costs

The Departments have estimated the costs of the proposed rule as being comprised of two major components: (1) the initial costs of modifying information technology (IT) systems and work processes to comply with the proposal, and (2) the annual on-going costs of production and review of Summaries of Benefits and Costs (SBCs) and Coverage Examples (CEs) to update material to reflect changes in plan costs, benefits and characteristics, and to distribute the Glossary and SBC's (including CEs) to persons who request them. In most cases, the cost components are computed by the Departments for the typical insurer or third party administrator (TPA) as the sum across an array of labor categories of the multiplicative product of an hourly labor rate and an estimated number of hours of labor to accomplish a given compliance task.

While the hourly labor costs applied by the Departments seem to be appropriately based on Bureau of Labor Statistics (BLS) survey data, the time estimates for most tasks are flawed in two critical respects: (1) the Departments have not provided an empirical basis for the time parameters used, and (2) in many cases the time parameters assumed are too small to be credible. In those cases where a supposed source for the time estimate is provided, inspection of the source reveals that it is a prior regulatory impact analysis or Paperwork Reduction Act Information Collection Request (ICR) document in which the cited time estimates are only arbitrary assumptions without empirical basis.

Credible, empirical sources of data on which to base time parameters in the cost calculation were available to the Departments, but they have arbitrarily chosen not to use these better data sources:

1. The Departments could have conducted sample surveys of insurers and TPAs potentially affected by the proposed rule to obtain their experience-based estimates of the time parameters required to accomplish defined compliance activities;

2. The Departments could have conducted follow-up surveys of prior ICRs which involve similar tasks to those required for compliance with the proposed rule.

3. The Departments could have conducted experiments in which government employees are assigned to conduct simulations of the activities required for compliance with the proposed rule in which their time and effectiveness in accomplishing the tasks are recorded.

The Departments have claimed that the proposed rule is not an economically significant rule under E.O. 12688, nor a major rule under the Congressional Review Act ($100 million annual cost threshold), and not a major rule under the Unfunded Mandates Act (approximately $136 million annual cost threshold in 2011). The validity of this claim is questionable given how close the Departments' published cost estimates are to the relevant thresholds and given the sensitivity of the cost computations to changes in the assumed labor time parameters to reflect more credible or empirically-based time estimates. At the very least, the Departments should modify their cost estimates to include an uncertainty analysis which examines how the computed cost varies when key parameters change within a reasonable expectation range. Such an analysis is required by OMB guidelines for economically significant rule proposals.

The following items detail examples of omissions, questionable assumptions or errors which cumulatively point to the likelihood that the annual costs of the proposed rule will exceed the thresholds for economically significant and major rules under the relevant Executive Orders and statutes.

1. Table 4 (p. 52457) of the proposed rule Preamble lists the estimated cost of compliance for 2012 as $73 million. These are described as labor and non-labor "maintenance" costs – costs associated with reviewing updating, producing and distributing the glossary, the SBCs and CEs. Table 3 (same page) shows one-time costs for modifying and developing IT systems and work flow processes and for first time development of SBCs and CEs as $25 million, but these costs are ascribed to 2011. Since it is already late in 2011, it is likely that these initial, one-time costs will also be incurred in 2012, bringing the total for that year to $98 million – almost equal to the economically significant/major rule threshold even without considering other reasonable adjustments to the cost computations of the Departments.

2. The Departments have based their estimates of the numbers of persons who will request glossaries and SBCs/CEs as a percentage of the total number of persons currently enrolled in individual or employer-sponsored group health insurance plans. The Departments have ignored a primary intent of the health law to reduce the number of uninsured individuals. The basis used by the Departments to estimate the demand for glossaries and SBCs/CEs is too low and should be raised to include an estimate of demand for these materials from currently uninsured individuals who will be seeking (or at least contemplating) insurance coverage in 2012, 2013 and future years. This adjustment will likely raise the compliance cost for 2012 and later years to a total in

excess of the economically significant/major rule thresholds.

3. The Departments estimate that it will require a total of 960 labor hours for large insurers or TPAs to implement one-time changes in IT systems and work flow processes to accommodate the proposed changes, but no empirical basis is provided for this estimate. The estimate amounts to less than 6 months of effort by one full-time-equivalent employee. Give the complexities of decision-making, reviews and process implementation typical of large organizations, this is an incredibly low and naïve time estimate. The Departments should look to their own experiences in implementing similar IT and work flow changes. If the time requirement were merely doubled, the one-time cost component would increase from $25 million to $50 million, and the Departments have provided no analysis, empirical data or reasonable basis for denying that the plausible cost could be many times higher. The estimate provided by the Departments is arbitrary and capricious and appears designed to mislead the public and policy-makers regarding the true economic significance of the costs of the proposed rule.

4. The Departments estimate that "each issuer/TPA would need 3 hours to produce and 1 hour to review, SBCs" annually. This estimate also is arbitrary and without any empirical basis. The estimates of 3 hours to produce and 1 hour to review the SBC are incredibly low and naïve given the importance of the documents in terms of both legal liability and marketing impact. The detailed calculations shown in Table 6 of the Preamble indicate that the Departments estimate that producing the information to include in the SBC would require only 90 minutes of effort by an insurance underwriter or similar financial professional in the benefits/sales area (compensated at $41.94 per hour). It would be a simple exercise for the Departments to assign staff members from their own actuarial units to simulate the production of SBC data from available insurance plan data and reports and to report realistic time estimates for this critical compliance task. Similarly, the estimate embedded in Table 6 of only one-half hour each for attorney and financial management reviews of the draft SBC are incredibly low and naïve. If any insurer or TPA were to actually publish an SBC based on such limited effort and review, the exposure to legal liability from error would be potentially catastrophic.

5. A major element of the compliance costs estimated by the Departments is the cost of distributing the SBCs in response to public requests. The total costs are quite sensitive to the number of annual requests that each insurer/TPA will receive and to the distribution of responses between printed/mailed responses and electronic responses. The Departments' estimates of the number of responses and of the proportion of responses that will entail the more expensive printed/mailed alternative are arbitrary, without a sound empirical basis, and seem designed to under-estimate the actual likely cost of the proposed regulation. At the very least, the Departments should report costs based on ranges of likely numbers of requests and modes of responses. Preferably, the Departments should conduct a pilot test of the proposed requirement to obtain realistic empirical information. Alternatively, the Departments should conduct a survey of insurers/TPAs to obtain their experience-based estimates of these critical parameters.

The extensive flaws in the economic impact analysis of the proposed rule produced by the Department's support the conclusion that the current proposal is arbitrary and capricious and has not been developed with due regard for the requirements of the relevant Executive Orders and statutes. The claim that the proposed rule is not economically significant or major is not supported by credible facts, and review of the naïve calculations made by the Departments reveals reasonable cause to conclude that the costs will likely far exceed the relevant thresholds. Similarly, the failure of the Departments to present any monetized estimate of benefits, when it was quite feasible to have done so, puts in question the claim that the benefits of the proposed regulation will exceed its costs.

RECOMMENDATIONS: To correct these flaws, the Departments should immediately withdraw the current proposal, undertake the experiments, surveys and other research described in these comments before publishing a revised proposal more reasonable in terms of costs and benefits.

C. SPECIFIC RECOMMENDATIONS

1. Arbitrary Mid-Month Effective Date

The statute provides that the SBC must be provided "prior to any enrollment restriction" on or after March 23, 2012 without regard to plan year. The proposed rules provide no clarification of the effective date. As a result, insurers and all group health plans must be prepared to provide an SBC on March 23, 2012, without regard to plan year. This will also create an additional burden on employers. Producing the SBCs twice, once for new enrollees and again at renewal during the first year of implementation dramatically increases the work effort and expense required to comply.

RECOMMENDATION: Clarify that the requirement to provide the SBC applies based on the plan's first plan year on or after the delayed effective date or non-enforcement period.

2. Improper Regulatory Changes

As discussed above, we appreciate the role of the Departments in promulgating regulations to facilitate the implementation of the statute and understand that there are instances where regulations must slightly deviate from a strict reading of the statute to assuage conflicts, improve effectiveness, facilitate compliance and ameliorate unnecessary costs and burdens. However, unlike the modifications recommended above there are several statutory modifications made by the NPRM that will complicate implementation and increase the cost and burden of compliance. We urge the Departments to promulgate a final rule that does not extend the "how" and the "when" prescribed in the statute.

Improper Modification to Statutory "How"

We urge the Department to follow more closely the statute's requirement that allows entities to be deemed compliant if SBC is provided in paper or electronic form. The statute does not indicate that SBCs must ever be provided in paper format, much less that it be provided in paper

format "free of charge." The NPRM further fails to limit the "free of charge" provision of this material.

RECOMMENDATION: Given that there is considerable, unnecessary expense associated with providing paper documentation, we recommend that if the Departments insist on requiring paper SBCs, that issuers, plans or plan sponsors only be required to provide paper SBCs in response to an express request and only once a year, in addition to the statutory required times when it must be provided.

Improper Modification to Statutory "When"

The NRPM places a new requirement that plans or issuers must provide an SBC or UG within 7 days of a request. This burdensome short time period is not contained in the statute and in many instances – depending on the time of year and other administrative or system changes scheduled to occur – may be overly burdensome.

RECOMMENDATION: We recommend that the final rule require plans to provide SBCs as soon as practicable upon request.

3. Proper Modifications

There are several modifications that the NPRM proposes which the Chamber supports. Specifically, we appreciate the proposal to allow a single SBC to be provided when multiple participants and/or beneficiaries reside at the same address. We agree with the recommendation that plans and issuers only need to automatically provide a new SBC with respect to the benefit package in which the participant/beneficiary is enrolled, with regard to renewal when a plan offers multiple benefit packages. Finally, we agree with the interpretation that notice is only required for a material modification that affects the information on the SBC and occurs other than in connection with renewal or reissuance of coverage. We believe that notice need not come in the form of a new SBC.

RECOMMENDATIONS: We recommend that the Departments include these proper modifications in the final rule.

4. Coverage Facts Label Requirement

We are concerned that the current construction of the coverage facts label is unnecessarily complex and will lead to additional costs for employers and our employees – including both the self-funded and the insured plans. In addition, these examples would need to be updated every year with HHS data. It would be unlikely that all employers and insurers could assure that their labels were updated on the same day – leading to employees and consumers obtaining very different data from different employers and insurers.

The statute requires an issuer or group health plan to provide only two coverage examples (CEs): one for pregnancy and one for a chronic disease. The NPRM, however, requires up to six CEs including pregnancy, diabetes and breast cancer. These CEs do not serve the goal of HHS to

"illustrate benefits provided under the plan or coverage for common benefits and scenarios" because the CEs rely on skewed/complicated/ assumptions provided by HHS based on industry wide averages.

These assumptions include: course of treatment, length of treatment and the cost of treatment. We note that averages will never accurately illustrate an individual's cost sharing because illnesses, particularly complex diseases - such as breast cancer - are unique to each patient. Furthermore, the cost of treatment varies significantly based on geographic region, the provider and the health plan. Generally, we want to provide our purchasers with accurate information and not mislead them in any way. However we are particularly concerned with CEs because they will not only mislead purchasers, but they will mislead our sick purchasers because these are the individuals that will look to the CEs and rely on the cost sharing estimates. The more inaccurate the cost sharing estimates are, the greater the detriment to this vulnerable population.

RECOMMENDATION: We recommend deleting the Coverage Examples (CE) requirements, simplifying the CE requirements or creating alternative mechanisms to implement the CE requirement. Therefore, we ask that HHS either delete the CEs altogether or limit CEs to the statutorily mandated number – two – one for pregnancy and one for chronic disease, and have them be generic in nature. Next we recommend that HHS choose a chronic disease that is generally less complicated and more common, and that HHS not use breast cancer. We further think that when HHS establishes the parameters of CEs, it should limit the simulation to a course of treatment that lasts no longer than one year. This will control the potential for variables that will inevitably occur during the course of treatment over the long term and will thereby promote greater accuracy in the CEs. Finally we ask that HHS incorporate bold warning language (and possibly even graphics that indicate caution) in a prominent location on the CE coverage label to limit the extent in which individuals will rely on the estimated cost sharing data.

Finally, we recommend that HHS, TPAs and insurers work together to find an alternative mechanism to provide consumers with CEs so that the programming costs and resources and other complexities with compiling these by products are reduced. Many plans already uses cost estimator tools that can serve as an alternative to the CEs as proposed. For example, the cost estimator tool currently made available to members insured under the Federal Employees Health Benefit Plan supplies a range of the total medical cost estimates in nearly every U.S. zip code. While the tool currently provides ranges for 59 common, elective medical procedures at hospitals and other care centers, its capabilities will be expanded significantly in upcoming months.

5. Expatriate Health Plans

We appreciate the acknowledgment in the Preamble to the proposed regulation regarding the unique characteristics of expatriate and international health plans. As relates to Section 2715, coverage information that is particularly important to expatriates (e.g., medical evacuation and repatriation benefits and country-appropriate care) is not even contemplated in the SBC and there is no space allocated for this information. The forms are U.S. centric and have no applicability outside of the United States.

RECOMMENDATIONS: In recognition of those unique characteristics, we urge that expatriate health plans be exempt from these and all requirements of the Affordable Care Act as was intended under the law.

CONCLUSION

The U.S. Chamber of Commerce urges the Departments to work carefully and cooperatively with employers and to leverage and solicit input from employers based on their experience in providing plan specific information to consumers. We caution the Departments against promulgating regulations that impose unnecessary expenses onto employer-sponsored health coverage.

Sincerely,

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The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

ATTENTION: (Treasury), RIN 1210–AB52 (Room N-5653) (Labor), and CMS–9982–P (P.O. Box 8016) (HHS)

Dear Secretaries Geithner, Solis and Sebelius:

The Blue Cross and Blue Shield Association ("BCBSA") is pleased to submit comments to the:

(1) Centers for Medicare and Medicaid Services, Department of Health and Human Services, Notice of Proposed Rulemaking ("NPRM") – Summary of Benefits and Coverage and the Uniform Glossary. 76 Fed. Reg. 52442 (Aug. 22, 2011); and

(2) Centers for Medicare and Medicaid Services, Department of Health and Human Services, Solicitation of Comments – Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Service Act. 76 Fed. Reg. 52475 (Aug. 22, 2011).

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide coverage to approximately 100 million Americans. Plans provide health care options in all 50 states, the District of Columbia and Puerto Rico, in the individual, small and large group markets, including those who self-insure. BCBSA also participates in the Federal Employees Health Benefits Program ("FEHB program") and other government programs. The NPRM and Solicitation of Comments affect almost all members in our commercial lines of business and also millions of Federal employees and their dependents who participate in BCBS options under the FEHB program.

Background: Section 2715 of the Public Health Service Act ("PHSA")

The NPRM and the companion Solicitation of Comments propose standards for implementing Public Health Services Act (" PHSA") Section 2715, as adopted by the Affordable Care Act ("ACA"). PHSA Section 2715 directs the Secretary to develop a summary of benefits and coverage ("SBC") explanation to assist individuals with understanding their health insurance coverage.

Section 2715 of the PHSA requires the Secretary to develop these standards not later than 12 months after the date of enactment of the ACA, (March 23, 2011), and that insurers shall deliver SBCs not later than 24 months after the enactment of the ACA (March 23, 2012). Importantly, the NPRM was not issued until August 22, 2011 and the final rule will not be issued until at least the end of this year, nine months behind schedule. However, the NRPM maintains March 23, 2012 as the effective date in which insurers must implement SBCs.

PHSA Section 2715 specifies that the appearance for the SBC must be in a uniform format that does not exceed 4 pages in length (which the NPRM has clarified to mean 4 pages front and back - therefore it is actually 8 pages) and may not include print smaller than 12 point font. Furthermore the contents must include various enumerated requirements designed to assist health insurance purchasers with their decisions. PHSA Section 2715 also requires the Secretary to consult with the National Association of Insurance Commissioners ("NAIC") to develop SBC standards.

In the NPRM, HHS adopted the NAIC form template ("Form") in its entirety. Representatives from Blue Plans participated in the NAIC working group. However, throughout the process, we advocated for SBC standards that would work from existing disclosure rules and would generally be more flexible, streamlined, and less costly to produce than the current proposed document. We also point out that during this process the NAIC's primary focus was on developing the uniform template and not addressing the difficult implementation issues. As a result, we recommend that the agencies focus on the complexity of implementation in evaluating the NAIC's proposed SBC and in issuing final regulations.

All 39 Plans want applicants, enrollees and policyholders to understand their coverage options. Over the years we have assisted our members with their purchasing processes by providing detailed coverage and enrollment information and assisting employers in preparing summary plan descriptions ("SPDs") as required by ERISA. We also understand that methods of disclosing information to consumers is an evolving process and we are always looking for ways to better educate consumers. However, we believe that the SBC as currently proposed will not add significant value to the decision-making and/or purchasing process because, not only does the Form provide information that we already supply, but the SBC is too rigid and does not allow group health plans and issuers to adequately describe innovative plans that diverge from the standards in the Form – for example, value-based insurance design benefits. This will not only be misleading for purchasers but could potentially inhibit the creation of innovative benefit plan designs that are good for consumers and address rising health care costs. Additionally, the costs of implementation will be significant and will increase the cost of health insurance coverage in all markets.

BCBSA's Major Concerns with the NPRM and Solicitation

We have thoroughly analyzed the NPRM and Solicitation of Comments and we believe that there are significant challenges with implementing the SBC requirements as proposed. Our major concerns with the proposed rule and our recommendations to the agencies are as follows:

- **Compliance Date**: The proposed date of compliance, March 23, 2012, is simply not possible given that the Form will require industry-wide changes to internal IT systems and system-wide changes to enrollment and renewal processes.
    - **Recommendation:** BCBSA recommends that Plans and employers be given 18 months after a final rule is issued to implement final requirements.
    - **Recommendation:** We urge the agencies to issue technical guidance as soon as possible indicating that the March 23, 2012 implementation date will be delayed, given it is not possible to make such major changes in this timeframe.
- **Form:** The Form requirements as proposed would be confusing to consumers, duplicative for employers, and prohibitively expensive due to the fact that there are thousands of health insurance options and policies in the market today each of which will require a Form. Each Form is administratively difficult to prepare, particularly the customized Coverage Examples ("CEs") and premium information requirements as proposed for each Form. We would also like a confirmation in the final rule that any final required SBC need not be printed in color, which would reduce administrative costs.
    - **Recommendation:** BCBSA recommends premiums as well as customized Coverage Examples (CEs) be deleted from the Form. The agencies are encouraged to work with employers and insurers to allow alternative mechanisms, some of which are the consumer tools in place today among Plan, which assist consumers with understanding their cost-sharing provisions and estimates for the costs of covered services or anticipated procedures. If CEs remain requirements, we recommend they be generic CEs and they be posted on the HHS website.
- **Timelines:** The timelines in which Forms must be delivered to shoppers, applicants, enrollees, special enrollees, and policyholders throughout the purchasing process are arbitrary and unworkable.
    - **Recommendation:** BCBSA recommends that all 7 day proposed timelines be revised to 30 days.
- **Duplicative Disclosures**: The Form is duplicative of other disclosure documents that are required to be provided, particularly in the large group and self-insured markets.
    - **Recommendation:** BCBSA recommends that large groups, including those that self-insure, be exempt from the rule.
- **Shoppers:** The NPRM requires issuers and group health plans send SBCs to "shoppers." However, it is administratively impossible to create an SBC until information is known about the potential purchaser and possible dependents.
    - **Recommendation**: BCBSA recommends that Plans that participate in the HHS web portal be deemed to be in compliance for shoppers in the individual as well as the small group market. The ACA did not establish requirements for Plans related to shoppers and this should be acknowledged in the final rule. Relying on the information on the HHS web portal for shoppers is a viable alternative to the proposed provisions.

- **Premiums:** The NPRM requires that the individual SBC include premium information. However, it is impossible to provide accurate premium information until an offer of coverage has been confirmed or renewed. To post amounts that are not applicable to the applicant is not meaningful and will be confusing to the consumer. Premiums can only be accurately quoted when all information has been submitted to the Plan and underwriting factors applied to calculate the final premium for the applicant who has completed the process.
    - **Recommendation:** BCBSA recommends that all SBCs not contain premium information. Premium information was not included in the Affordable Care Act as a required item.
    - **Electronic Delivery**: Although the NPRM allows insurers to deliver the Form electronically, the electronic delivery requirements with respect to individuals are overly restrictive,
    - **Recommendation**: BCBSA recommends that the final rule allow greater flexibility for delivery of electronic SBC; and
- **Existing Disclosures:** It is not clear whether state laws that already require similar disclosures are preempted by or coexist with the SBC requirements.
    - **Recommendation:** BCBSA recommends that the agencies clarify the SBC as it relates to existing state and federal disclosure laws.

These concerns and others constitute the foundation of our comments. We address these concerns and offer our recommendations in more detail below. We offer alternative models, which are attached, and processes for the SBC that we believe will be more efficient, less costly, and will continue to meet the objective of providing a summary document to applicants and covered policy or certificate holders. One of our attachments is the SBC as provided in the rule but with modifications which we believe are necessary to have accuracy in benefit descriptions. A second attachment is a new alternative to the proposed SBC which we believe will accomplish the same objectives as the proposed SBC but is more streamlined and allows for Plan flexibility in the entries for each benefit categories. The other attachments are examples of disclosure documents used in the marketplace today.

We believe that many consumers today already receive useful benefit summaries and have access to consumer tools to assist with their estimated costs of covered services. Many of our comments are intended to assure meaningful information is provided to consumers and reduce duplicative disclosures that result in higher costs for coverage.

BCBSA and Plans share a common goal that applicants, enrollees and policy and certificate holders should have a comprehensive summary of their coverage and benefits under their applicable health plan. Plans, and the small and large employer groups that we work with, frequently provide summaries or statements of coverage and benefits. Adding new materials to existing disclosures presents significant challenges and we do not believe the strict requirements under the NPRM add significant value to applicants, enrollees, policyholders and certificate holders. We recommend a more streamlined approach to the implementation of PHSA Section 2715.

One example of duplication is the FEHB program which requires health plans to make available "brochures" during enrollment and renewal. Within these brochures is a "Summary of Benefits and Coverage" that provides an outline of each plan's benefits and services and the amount the member would have to pay in those categories of services. We have also attached an example of such Summary from the BlueCross and BlueShield Federal brochure for your review. Also all members of the Federal

BlueCross and BlueShield options have access to an on-line tool that could serve as an alternative to a customized SBC with customized CEs.

BCBSA launched the "MyBlue Treatment Cost Estimator" on January 1, 2011. This consumer cost tool provides Service Benefit Plan members with cost estimates for common treatments at different providers within a given geographic area, helping members make better-informed, cost-conscious healthcare decisions. A member can log onto MyBlue Customer Service, available at www.fepblue.org, to access the tool. Once logged in, he or she can select the type of treatment and zip code to be provided with a results page listing cost estimates for the treatment at different providers within the area specified. The cost tool also indicates whether providers are designated as Blue Distinction Centers, a designated given by BCBSA to certain facilities that provide quality services when compared with others, so members can search for quality in addition to cost.

This consumer tool is working well. We recommend the agencies consider this tool and others in operation among Blue Plans today, as alternative mechanisms for customized CEs in all SBCs. We would be pleased to demonstrate to the agencies other on-line tools Plans have in operation today that assist Plan members in understanding estimates for selected anticipated procedures and how their cost-sharing features might work. These tools track the same objective of having CEs in the SBCs and are working today and are part of most Plan operations.

Another example is the Medicare Advantage program ("MA program") which requires a Summary of Benefits for each option. The Summary of Benefits provides descriptions of the benefits and services within a MA plan and compares the benefits of a specific MA plan to the benefits and services available in a traditional Medicare plan. The template for these Summaries of Benefits offer drop-down menus of options to Plans to insert text to insure accuracy of coverage descriptions. Although the MA summary is longer and more detailed than the proposed SBC, the drop down menus provide greater flexibility in the text to allow for more accuracy in the benefit descriptions than the rigid and standardized SBC Form in the NPRM.

In summary, we have found that issuers and group health plans already have well developed summaries of benefits and coverage for all of their available options along with a variety of useful consumer tools that help consumer anticipate costs for selected procedures and services. For individual and small groups, benefit summaries are also available today on the HHS Plan Finder.

BCBSA's detailed comments supporting each of our recommendations follow.

Detailed BCBSA Comments on the Notice of Proposed Rule Making

1. Applicability Date

We believe the March 12, 2012 implementation date is impossible to meet. When Congress drafted the SBC provision within the ACA, it intended for the Secretary to develop standards 12 months after the ACA was enacted (March 23, 2011) and for issuers and group health plans to implement SBCs 12 months after standards were published (March 23, 2012). Given the fact that the NPRM was significantly delayed and a final rule has not even been released, HHS should provide plans with additional

necessary time to prepare for SBC implementation. We recommend 18 months for compliance after the final rule is issued. Agency guidance is also needed now announcing a delay in the effective date.

Issuers and group health plans need this additional time to develop, produce and implement associated information technology changes to their internal IT systems. They will also need time to change their enrollment and renewal processes for thousands of customers who have health care options in the individual, small and large group market. The system changes and production lead times that are necessary to create SBCs for an effective date of March, 23, 2012 is impossible because SBCs are highly customized documents. In addition, the Form includes provisions that are not finalized such as essential health benefits ("EHB"), coding data and CEs. Requiring issuers and group health plans to implement provisions that are subject to change is costly and inefficient. Therefore we do not think that it makes sense to require SBC implementation until 18 months after the final rule is issued.

The issue is further problematic because of the civil penalties that apply if an issuer does not comply with the SBC requirements. Failure to provide a compliant SBC to even a portion of contracts could generate potentially enormous penalties. The PHSA Section 2723(c)(i) already imposes a civil penalty of $100 for each day for each affected individual. Moreover, Section 2715 established a new civil penalty of up to $1,000 per day for willful violations of the SBC rule. This penalty creates an unprecedented risk for issuers because they have virtually no lead time to comply.

BCBSA Recommendation: Plans should be given 18 months from the issuance of the final rule for compliance. While we believe it will be onerous for all of the insurance markets, we believe the large group market will have the biggest burden, followed by the small group market and then the individual market. Therefore we recommend that HHS also issue a press release (or other guidance, such as a Technical Release or Insurance Standards Bulletin) to immediately indicate that it intends to delay the March 23, 2012 effective date for the SBC final rule. This will keep issuers and employers from investing significant resources to come into compliance with a proposed SBC rule that is likely to change when finalized. HHS should also include the new delayed effective date in the final SBC rule when issued.

We recommend the following schedule for implementation:

- **Glossary** – Because the Glossary is a standard form that is not customized to each policy and may be supplied online, we think that this is the least onerous aspect of the SBC rule. We think it is reasonable for all markets (individual, small and large group) to supply the Glossary within 6 months after a final rule is issued. However, we support the provision of the Glossary on an earlier deadline only to the extent that as provided in this NPRM, it may be delivered via the Plan Finder or other websites and is clearly not tied to any particular coverage provided.
- **Individual** – Individual health plans should not have to implement the SBC rules until 18 months after the date on which the final rule is issued.
- **Small Groups** – Small group health plans should not have to implement the SBC rules until 18 months after the date in which a final rule is issued.
- **Large Groups** – We believe it is reasonable and necessary for HHS to completely exempt large group health plans, including self insured health plans and student health plans, from the SBC requirements. As we noted above, it is administratively problematic and costly to implement SBCs in the large group

market. This is because the large group market has highly customized plans and already provides expansive tools to assist purchasers, such as enrollment and renewal materials, SPDs and human resources personnel to answer questions. Generally large group health plans are defined as those with 100 or more employees.

While we urge the agencies to extend the compliance date, in the unfortunate event that HHS does not extend the March 23, 2012 date as recommended above, it should adopt a transition period in which group health plans and issuers will not be subject to any penalties if they have initiated a good-faith effort to comply with the SBC requirements.

2. Scope of the Rule: "Shoppers" vs. "Applicants"

The ACA states that SBCs are intended for "applicants, enrollees, and policyholders or certificate holders." However the NPRM also requires that issuers and group health plans provide SBCs to "shoppers." Shoppers are distinguishable from applicants because, unlike applicants who submit applications for coverage, shoppers are interested in but have not yet decided to apply for coverage. Shoppers are outside the intent of Congress, and will be able to rely on the HHS Plan Finder or other channels of information. However, we were pleased to see that if an issuer of individual health insurance policies participates in the Plan Finder HHS shall deem such issuers compliant with the SBC requirements (the "deeming rule").

Recommendation: We recommend that HHS completely eliminate any requirements related to issuers and group health plans providing SBCs to shoppers.

If shoppers are not completely excluded, then we recommend the deeming rule for the individual market be extended to shoppers in the small group market as well.

3. Timelines for Making the SBC Available to Applicants

The NPRM requires issuers and group health plans to provide an SBC within 7 days upon request and upon application. The NPRM also requires issuers and group health plans to provide an SBC within 7 days of a special enrollment period. We believe 7 days is not a reasonable amount of time to provide SBCs in both situations and is not required in the ACA.

Recommendation: Due to the fact that the proposed SBCs will need to be customized, we recommend that HHS provide issuers and group health plans with significantly more time to distribute an SBC. We recommend that HHS make a global change to the NPRM and in all instances where it established a 7 day timeline (i.e. upon request, upon application, upon special enrollment) that HHS expand it to 30 days. We note that this would be similar to the DOL rules which allow plans 30 days to deliver an SPD.

4. Requirements for Members/Participants

The NPRM requires issuers and group health plans to send SBCs to both the participant and the participant's beneficiaries - such as a spouse or dependent. If participants and beneficiaries reside at the same address, then an issuer or group health plan need only send one SBC. However if any one of these individuals resides at a different address

than the participant, the SBC must be sent to that individual at his or her last address on record.

The requirement that SBCs be sent to both the participant and the beneficiaries, including beneficiaries who do not reside at the participant's address, is costly and impractical. First, the issuer or group health plan enters into a contract for individual coverage with the participant, and not the beneficiaries and for group coverage the contract is with the employer or union. Second, issuers and group health plans do not routinely keep record of the addresses of all the individuals covered under a policy and therefore would not even know if a beneficiary resides at a different address. Third, if issuers and group health plans had to send SBCs to participants they would have to frequently update beneficiary data. In summation, this requirement would not add any value to the consumer and it would be both complex and expensive to implement.

Recommendation: We recommend that HHS require that SBCs be provided only to the participant. However if HHS insists on providing SBCs to beneficiaries who reside at different addresses than the participant, it should only be upon request.

5. SBCs are Duplicative and Unnecessary in the Large Group and Self-Insured Plan Markets

Certain group health plans have existing obligations under ERISA to send their participants an SPD which provides the participants with detailed information regarding their coverage option. Large groups and self- insured plans also provide sophisticated enrollment materials and different educational tools to employees so that they understand their coverage and make wise choices. As a result, we generally think that these markets should be excluded entirely from the obligation to deliver SBCs. If exclusion is not provided, then such groups should be given greater flexibility.

Recommendation: We generally recommend that HHS exempt the SBC requirements with respect to insured and self insured large group health plans. If HHS ultimately decides to continue to require group health plans to implement SBCs, we believe HHS should deem large group health plans to have satisfied the SBC requirements if such plans have included the relevant SBC information within their SPDs or enrollment materials in one contiguous and prominent location. In so doing, HHS should not require these plans to comply with SBC formatting restrictions.

We alternatively recommend that insured and self insured large group health plans need not distribute SBCs. Instead they could include a conspicuous statement in the forefront of their SPD that all enrollees may request an SBC at a specified website or phone number.

6. Renewals/Changes to Contract Terms

The NPRM states that an insurer must provide an SBC: (1) when the policy is renewed or reissued; (2) if a written application is required, then SBCs must be provided no later than the date materials are distributed; and (3). for automatic renewals, the SBC must be provided at least 30 days in advance prior to the first day of the new policy year.

These requirements are problematic because it is common practice that health plans and purchasers, often large as well as small groups, finalize their contract terms shortly

before the next new plan year. Some plans even make changes to their policies after the policy becomes effective. Therefore it is not always administratively possible for Plans to provide SBCs 30 days in advance of a given renewal.

Furthermore, in the individual market, often policies do not have a defined policy year, but instead run month to month. In such an instance it would not make sense for an issuer to provide policyholders a new SBC each month as the terms of the policy remain constant.

Recommendation: We recommend the final rule accommodate these renewal situations by including a provision such as the following:

> *"The SBC must be provided at renewal 30 days in advance of the new contract year or when the materials are distributed during the open enrollment period. However, when a group purchaser in the large or small group market, or individual policyholder in the individual market, makes a change to their applicable policy and the Plan agrees to such changes prior to the next contract year within that 30 day period of time, or even within a reasonable time after the start of the new contract year, then the SBC must be delivered within 30 business days after the final contract terms are agreed to by the purchaser and the issuer. Such a delay in issuing the SBC to the policyholders or certificate holders will not cause the issuer to be treated as out of compliance with the requirements of this rule."*

7. Material Modifications

The NPRM requires issuers and group health plans to distribute a notice of material modification when there has been a material change in the policy during the plan year. Such notice must be sent 60 days in advance of the effective date of the modification.

It is unclear exactly what constitutes a material modification and with the SBC rules not yet finalized, we do not think it would be appropriate to require issuers and group health plans to provide material modification notices every time HHS changes the SBC required content. We also do not think it would be appropriate to apply the 60 day advance notice requirement to circumstances where a state benefit mandate imposes a change that must be reflected in the SBC.

Additionally, individual policyholders and group health plans frequently make mid year changes. An individual may have the right to voluntarily amend his or her individual policy during the policy year. For example, an individual may no longer be able to afford his or her health coverage and therefore amends their coverage by decreasing coverage, rather than terminating their coverage. Similarly, regarding group health plans, if an employer wants to impose a benefit improvement to its employees' health coverage, the employer should be able to do so retroactively or immediately and not have to wait 60 days to implement the change after they send a material modification notice. The final rule should not hinder the implementation of more favorable group health coverage.

Recommendation: We recommend that the agencies allow policyholders in the individual market to change their coverage outside of their renewal date (if there is one) as agreed to by their Plan and we also recommend group health plans be allowed to implement increases in coverage options either immediately or retroactively and not

have these situations generate an SBC under material modification provisions. A SBC should be required only when the Plan generates a material modification to the policy during the plan or contract year. This would then provide for a more reasonable notification process when the Plan, not the purchaser or the individual policyholder, generates a material modification to a policy during the contract or policy year.

8. Premium Information Included in the SBC

The NPRM has added the requirement that premium information be included in the SBC despite the fact that Congress omitted this requirement from PHSA Section 2715. We note that it is difficult to include accurate premium information until an offer of coverage has been confirmed or the issuer or group health plan has completed its renewal process. Furthermore, in the individual market, premiums are assigned only after an offer of coverage has been made and often depends on factors such as age, gender and smoking status. Moreover in the group market, employers usually pay a portion of the premium and therefore any estimate would not reflect the participant's actual out of pocket costs. We also note that it is unnecessary to provide premium information in the SBC because when rates are finalized, it is already customary for an issuer or group health plan to supply this information.

Recommendation: In the group and individual market, we strongly recommend that HHS eliminate premium and cost information from the SBC format and highlight that the ACA did not require this provision.

9. Electronic Delivery

The electronic delivery rules significantly restrict when issuers and group health plans can provide electronic rather than hard copy SBCs to individuals. For example, in the individual market an issuer may only deliver an SBC to a policyholder if the policyholder (1) requests information or an application electronically; (2) submits an application electronically; or (3) specifically requests that he or she be sent the information or application electronically. And, for ERISA plans in the group market, SBCs may be provided electronically to enrollees if: (1) the individual provides affirmative consent; or (2) without affirmative consent if the employee has access to electronic documents at his or her workstation. These rules come from the safe harbor under the DOL rules on electronic disclosure.

We believe these proposed rules are overly restrictive and do not accommodate the fact that throughout all demographics (income, age, ethnicity) individuals have substantial access to information delivered electronically - whether it be through email or the internet. HHS should facilitate electronic delivery because it is fast, accurate and efficient. It will also help control rising health care costs and further assist individuals in the purchasing process by giving them an easy to access, easy to navigate, permanent record of their coverage options.

Recommendations: We note that the electronic delivery rules that apply to issuers delivering to group health plans are significantly more flexible. The NPRM allows issuers to provide SBCs electronically to group health plans if: (1) it is in a format readily accessible by the plan sponsor; (2) the issuer would provide a paper form free of charge upon request; and (3) if the electronic form is an internet posting, the issuer timely advises the plan either through hard copy or through email that the SBC is available on the internet and states the specific website. We believe that HHS should extend these

rules where the group health plans and issuers have to send SBCs to individuals. We recommend that HHS allow for more flexible electronic delivery to reduce the costs of compliance.

10. Interaction with State Laws/Premiums

It is unclear what happens when a state law requires insurers to disclose the same information that also must be disclosed in the SBC. One example is in California where issuers in the individual and small group market must provide a Uniform Matrix that summarizes and compares coverage options. Health and Safety Code Sec. 1363. Many of the requirements of the Uniform Matrix are the same as the requirements within the SBC, such as providing information on co-pays and co-insurance. Another example is South Dakota which has a rule which requires insurers to supply an outline of coverage with each insurance policy it issues. S.D. Codified Laws Sec. 58-33A-5, 6. We note that the required information in the outline of coverage overlaps substantially with the SBC but also requires other disclosures. Furthermore if issuers and group health plans send both SBCs and state required disclosures, purchasers will receive different documents with different labels and information that describe the same plan. This will inevitably confuse participants. Instead the agencies should issue clarification on preemption issues; otherwise state regulators are likely to insist on their own documents even where they will cause duplication and consumer confusion.

Recommendation: We recommend that the agencies review state requirements and clarify preemption issues as soon as possible. We alternatively recommend that the agencies incorporate flexibility into the Form so that in the event that a state law has its own required disclosure, insurers can incorporate state mandated requirements into the Form.

11. SBCs for Every Option at Enrollment

The proposed rule currently requires an issuer or group health plan to provide an SBC for each plan option. A plan option could include each different cost sharing level and coverage tier (i.e. single, single plus spouse, single plus family) for each type of coverage (e.g., PPO, HMO). A typical plan with PPO and HMO options, with 3 different cost sharing levels and 3 coverage tiers would require 18 SBCs alone. Moreover, at the time an individual in a group plan is initially eligible, that person must receive an SBC for every option they are eligible for. The abundance of SBCs would likely overwhelm and frustrate purchasers rather than assist them in the process. Additionally it goes against the Administration's policy to conserve paper by delivering hard copies only when it is necessary to do so.

Recommendation: We recommend the agencies significantly streamline these delivery requirements.

We recommend that the agencies allow issuers and group health plans to include all of the cost sharing levels and coverage tiers of one plan option on one SBC form. This would accommodate more innovative designs such as wellness plans which often provide cost reductions (such as lower cost shares or deductibles) for individuals who participate in certain programs that promote healthy behavior. We also recommend that the agencies permit issuers and group health plans to voluntarily include plan identification numbers on the SBC to assist their implementation of delivery requirements.

With respect to initially eligible individuals in group coverage, we recommend that the agencies allow group health plans and issuers to provide an SBC for one plan option (i.e. the PPO) and then to provide other SBCs for other plan options upon request.

12. SBCs in a Non-English Language

PHSA Section 2715 requires that the SBC be presented in a "culturally and linguistically appropriate manner" which means that issuers and group health plans must provide interpretive services and SBCs upon request in non-English languages. We recognize the importance of providing non-English speaking populations with equal access to information about their health care coverage. However we are concerned that if each issuer and group health plan individually tries to interpret the SBC into the relevant languages, the SBCs will no longer be uniform in content. We also understand that some preliminary attempts to translate the SBC as offered in the proposed rule alter the format of the standardized document presenting new challenges to Plans.

Recommendation: We recommend that HHS provide the SBC templates in non-English languages to maintain a uniform template. There is precedent for this in the Medicare Advantage program where CMS provides translated versions of certain model documents to assure accuracy in the designated languages and reduce individual Plan costs.

13. Ability to Contract Who Performs Delivery Requirements

The NPRM imposes joint obligations on the issuer and group health plan to provide SBCs to plan participants in the group market. Our experience is that many employers want to deliver plan documents to their employees without the help of the issuer and as a result it would be unreasonable to hold an issuer liable for a responsibility that the employer does not want to delegate.

Recommendation: We believe that group health plans and issuers should have the right to enter into agreements regarding who shall satisfy the SBC delivery requirements. Furthermore to the extent that the parties agree, the non-responsible party should not be held liable for the other party's failure to deliver the SBCs.

BCBSA Additional Comments on the "Solicitation of Comments"

We commend the agencies for issuing the Form simultaneously with the NPRM, in the Solicitation of Comments. We have relied on it to understand the intent of the rule in regards to implementing SBC requirements. We offer our suggestions, which we believe will improve the Form by making it easier for applicants, enrollees and policyholders to use and easier for issuers and group health plans to implement. We also ask that if there are conflicting provisions in the final rule and the Solicitation of Comments, that the provisions in the NPRM prevail.

1. Glossary

We note that while a glossary of terms could serve applicants, enrollees and policyholders by helping them better understand the terms of their coverage, the Glossary may also confuse the customers if the Glossary's definitions contradict the way such terms are used in the plan document.

Nevertheless, assuming issuers and group health plans can satisfy the Glossary requirement by posting it on their websites, we believe the Glossary will be relatively easy to implement after the final rule is issued.

Recommendation: We recommend that HHS clarify that although issuers and group health plans may post the Glossary to their websites or choose to mail copies of the Glossary to enrollees and policyholders upon request, they do not have a legal obligation to do so because the Glossary is a government issued document that agencies, such as HHS and the DOL, will have available on their websites.

We ask HHS to add a disclaimer to the Glossary to explain to applicants, enrollees and policyholders that the Glossary definitions apply to health insurance in general but may not be applicable to the terms in a particular policy. For example, some policies might not allow or have balance billing features or may define out-of-pocket differently than the Glossary. We recommend the following language:

> *"This Glossary has been developed according to the requirements under Section 2715 of the Public Health Service Act. While it is intended to be educational, the terms and definitions in this Glossary may not be the same as the terms and definitions within your health plan or policy or state law. Please consult your plan documents if you have specific questions regarding the terms and definitions in your policy."*

2. Distribution of Freestanding Document

The Form requires issuers and group health plans to issue the Form to each applicant as a freestanding document. This is difficult because it is administratively inefficient for an issuer or group health plan to distribute substantially similar documents separately. Additionally, we believe it makes the most sense for applicants, enrollees and policyholders to receive their plan information at one time in an organized systematic manner rather than to receive plan documents at scattered points throughout the purchasing process. We also recommend that the form be limited to the four pages specified in the ACA and not eight pages (four pages double sided). A four page SBC would better serve the consumer because we generally believe that the average consumer would not be willing to read or readily comprehend anything much longer. This would also assume that an alternative mechanism is developed to provide CEs to consumers.

Recommendation: We recommend the final rule ease the burden of distribution by eliminating the requirement that the SBC be a freestanding document and instead allow issuers and group health plans to insert or attach the Form to other materials at the time of application.

We also recommend the final rule allow issuers and group health plans to bar code or use other labeling techniques for the documents to further assist with distribution processes.

3. Specific Recommendations to Form Language

"Policy Period" - We recommend the final rule delete the term "policy period" so that the Form does not need to be updated on a monthly basis to reflect the month in which the person requested the SBC and the month the contract year ends. Deleting the term

"policy period" also takes care of situations where the policy does not have a policy period specifically as it found in some individual policies among Plans.

"Medical Necessity" – We recommend HHS use a more detailed definition than the current one which is vague and thereby misleading to consumers.

"Type of Coverage" - We recommend that the template be reworded to read "Enrollment Options." Plans would then fill in all the available tiers, such a "Single and Family", or "Single, Two Adults, Adult and one Child, or Family" as applicable to that SBC.

Reference to the Glossary—We recommend that HHS revise the disclaimer language on the SBC that refers the purchaser to the Glossary. Instead we recommend that HHS refer purchasers to the plan documents or the plan websites because the Glossary definitions will most likely not match the plan definitions.

Deductibles, Out of Pocket Limit – We recommend that if the SBCs are electronic, the instructions allow a drop down menu for all the variations in the marketplace for definitions of deductibles and out of pocket dollar limits.

Does the Plan use a Network of Providers- We recommend that if the SBCs are electronic, the instructions allow a drop down menu to show differences in network configurations.

Referrals to Specialists- We recommend that if the SBCs are electronic, the instructions allow a drop down menu for when referrals are commonly needed and when they are not required as some plans only require referrals for certain specialists and not others.

Common Medical Event—We recommend removal of "chemotherapy" as an example of a specialty drug.

Separate Lab and X-Ray Services – We think that it is inappropriate to group these services together because they frequently have different cost sharing.

Habilitation Services – We recommend removing this category from the SBC and adding more commonly used covered benefit categories, such as prosthetics, orthotics and allergy services because there are very specific criteria for habilitation services and it is not a commonly provided benefit.

Coverage Examples ("CEs")— We recommend deleting the CE requirements from being included in the SBC, simplifying the CEs, and creating alternative mechanisms to implement this requirement. The ACA requires an issuer or group health plan to provide only two CEs, one for pregnancy and one for a chronic disease. The NPRM speaks to adding up to six CEs including pregnancy, diabetes and breast cancer. We do not think that additional CEs will serve the goal of HHS which is to "illustrate benefits provided under the plan or coverage for common benefits and scenarios." This is because CEs rely on assumptions provided by HHS based on industry wide averages.

These assumptions include: course of treatment, length of treatment and the cost of treatment. We note that averages will never accurately illustrate an individual's cost sharing because illnesses, particularly complex diseases (such as breast cancer) are

unique to each patient. Furthermore, the cost of treatment may vary significantly based on geographic region, the provider, and the health plan. Generally, we want to provide our purchasers with accurate information and not mislead them in any way. However we are particularly concerned with CEs because they will not only mislead purchasers, but they will mislead certain purchasers, who may already have a defined medical condition needing treatment. These are the individuals that will look to the CEs and rely on the cost sharing estimates. The more inaccurate the cost sharing estimates are, the greater the detriment to this vulnerable population.

Therefore we ask that HHS either delete the CEs altogether or limit CEs to the statutorily mandated number – two – one for pregnancy and one for chronic disease and have them be generic in nature. Next we recommend that HHS choose a chronic disease that is generally less complicated and more common, and that HHS not use breast cancer. We further think that when HHS establishes the parameters of CEs, it should limit the simulation to a course of treatment that lasts no longer than one year. This will control the potential for variables that will inevitably occur during the course of treatment over the long term and will thereby promote accuracy in the CEs. Finally we ask that HHS incorporate bold warning language (and possibly even graphics that indicate caution) in a prominent location on the CE coverage label to limit the extent in which individuals will rely on the estimated cost sharing data.

Finally we recommend that HHS and insurers work together to find an alternative mechanism to provide consumers with CEs so that the programming costs and resources and other complexities with compiling these by products are reduced. Many Plans already uses cost estimator tools that can serve as an alternative to the CEs as proposed. One such cost estimator tool, such as the one currently made available to our Federal members, has a range of selected medical cost estimates in nearly every U.S. zip code. While the tool currently provides ranges for 59 common, elective medical procedures at hospitals and other care centers BCBSA plans to expand its capabilities significantly in upcoming months.

Excluded Services & Other Covered Services - The Form includes a list of "services your plan does not cover." This list includes: Acupuncture, Bariatric Surgery, Non-emergency care when travelling outside the US, Chiropractic Care, Cosmetic Surgery, Dental Care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight Loss programs. We think this list is inaccurate, misleading and too rigid. First, the list fails to include the most obvious and prominent exclusion to covered services among health plans – experimental and investigational procedures. Second, the categories within the list are broad and do not accommodate exclusions. For example, infertility treatment encompasses a variety of treatments and procedures and some treatments are generally covered by health plans. An additional example is foot care; while routine foot care is often excluded for the general population, it is often covered for individuals with diabetes. Third, the list is misleading because while many of these services are generally excluded under medical plans, employers often buy supplemental policies that include these services. The most obvious example is dental care. Fourth, some treatments may be covered but on a limited basis, such as chiropractic care and acupuncture.

Recommendation: We recommend that HHS add experimental and investigational procedures to the list of excluded services. We also recommend that HHS generally incorporate flexibility into this list. HHS should indicate that while some of these services

may be excluded under the medical plan, they may be offered in a supplemental plan, such as dental or vision services. HHS should also explain that these are expansive categories and the plan may have exceptions or offer these treatments on a limited basis.

We have attached a new alternative SBC Form template for your consideration. We have also attached Plan summaries used in today's market that we thought would be useful for the agency to review also as alternatives. We highly recommend that HHS consider other formats we have suggested. We think that it streamlines SBC requirements in a way that will be more helpful for health insurance purchasers.

Implementation Costs

Federal Employees Health Benefits Program

We understand that issuers participating in the FEHB program also must comply with the SBC rules. BCBSA has two options in the FEHB program—a Standard and Basic option with a calendar year policy year. Furthermore applicants have two policy choices – single and family – and the premium rates depend on which option the applicant applies for.

If BCBSA is to issue SBCs to our enrolled federal members at renewal or during the open season, we estimate that an 8 page SBC document (4 pages double sides) would need to be printed for 5.2 million members at annual total cost of $250,000 (excluding production costs for the variations needed). Assuming we do not mail the Form to children under 18, we also estimate that it will cost an additional $600,000 to mail this document to 4.26 million persons. Therefore it would approximately cost a total of $850,000 to print and mail SBCs. We note that requiring participants in the FEHB program to distribute millions of Forms contradicts the Office of Personnel Management's "going-green" initiative which aims to decrease costs by increasing the Federal Government's reliance on electronic document delivery instead of mailing the documents in hard copy.

Recommendations: We recommend that HHS align the SBC rules with OPM's initiative and allow participants in the FEHB program to deliver the Form electronically unless a member requests a hard copy.

Specific Plan Cost Examples:

The chart below is just a mere sample of data collected from the Plans regarding what their estimated implementation costs would be. This estimate assumes an effective date of March 23, 2012, and includes SBC requirements for the individual, small, and large group market. These are estimates only and do not include any additional costs that will occur if the final rule amends the requirements. These estimates are reflective of the costs that some of our 39 plans may incur and some Plans did not report estimates in all section of the chart. We highly recommend that HHS incorporate more flexible electronic delivery rules because this will bring down the cost of implementation considerably.

Summary of Benefits and Coverage Estimated Implementation Cost

BCBS Plan	Covered Lives	Project Cost Effective date 3/23/2012	Project Costs if Effective with an Extension to the Current Compliance Date	Annual Ongoing Plan SBC and Glossary Cost	Annual Ongoing Plan Costs attributed to hiring additional staff
Plan A	Fully-insured =501K Self-funded =1.6M	$1.8M	$1.5M = Savings of approx. $300K	$350K	$200K
Plan B		$3.9M	$2.9M = Savings of approx. $1.0M		
Plan C	Fully-insured =592K Self-funded = 922K	$1.9M	$1.9M	$447K	$259K
Plan D	Fully-insured =12.0M Self-funded =14.5M	$3.5M	Unknown	$59M	Unknown
Plan E	$1.4M	$1M (IT cost)		$1M (print/postage) $50K (IT development/maintenance)	$100K –IT resources hiring $100K- business resources hiring
Plan F	Fully-insured =1.9M Self-funded =3.0M	$6.2M	$4.7M	$915K	$357K
Plan G	Fully-insured =1.2M	BCBS, MA believes the	$1.9M	$4.2M	$675K

	Self-insured =1.5M	required operational and system changes are not achievable by effective date.			
Plan H		$310K			
Plan I	Fully-insured = 1.2 M Self-funded = 1.8M	$3.3M (IT/project cost)[1]	NA	$2.0M (print/postage)[2]	
Plan J		$2.5 - $3.0M			
Plan K		$1.5 to $2.0M Start up only			

Thank you for the opportunity to provide comments on this significant rule. Questions on these comments may be addressed to Jane.Galvin@bcbsa.com .

Sincerely,

Justine Handelman

Justine Handelman
Vice President, Legislative and Regulatory Policy

Attachments:

Revised SBC template
Suggested Alternative SBC Format
FEHP Summary Page
Sample Plan Documents

[1] This estimate does not include additional cost to meet March 23, 2012 effective date or additional resources that may be necessary to implement.

[2] Estimate includes the requirement to issue as a stand-alone document. Estimate does **not** include: (1)"On-demand" request (2) Duplicate mailings (3)On-going testing and resource charges for all application and coding changes to ensure future enhancements are compliant with regulation.

(xx) *Coverage Example Safe Harbor.*

(1) An SBC shall be deemed to comply with the requirement to provide coverage examples as provided for in paragraph (xx) of this section provided that the plan or issuer providing the SBC makes available alternative coverage examples through a cost estimator that will allow group health plans, participants and beneficiaries, and individuals, as applicable, to obtain reasonable estimates (which may be provided as a range) of the amounts of cost sharing a consumer could expect to incur associated with the provision of common benefit scenarios under the plan or coverage. Such common benefit scenarios may include pregnancy and other selected common medical conditions.

(2) The cost estimator provided for under paragraph (1) shall satisfy the requirements of clause (i) and (ii) below.

(i) the plan or issuer shall make available a tool that estimates the total costs of common benefit scenarios, which may be either --

(I) a web based tool developed by HHS in conjunction with this regulation and found at www.healthcare.gov, which such Internet address shall be prominently disclosed in the SBC and a copy of requested cost estimates are provided in paper form free of charge upon request; or

(II) a web based tool developed by the group health plan or health insurance issuer found on the plan or issuer's website, which such Internet address shall be prominently disclosed in the SBC and copies of requested cost estimates are provided by the plan or issuer in paper form free of charge upon request.

(ii) the plan or issuer shall make available a worksheet for use by a consumer provided by either of the web based tools described in clause (i) above that will provide a mechanism for the consumer to estimate the amount of cost sharing associated with the common benefit scenarios under their plan or other coverage. The worksheet shall be provided free of charge upon request and the availability of the worksheet shall be prominently disclosed in the SBC.