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|---|---|
| **From:** | Gray, Wally |
| **To:** | E-OHPSCA2715.EBSA |
| **Subject:** | Comments on Summary of Benefits Coverage Proposed Notice |
| **Date:** | Tuesday, September 27, 2011 9:29:54 AM |
| **Attachments:** | Scanjob_2703_20110927_090825.pdf<br>Health Reform SBCSampleCompleted Word 092711 RL Final.doc |

Attached please find comments and a Red Lined template in reference to the Summary of Benefits Coverage proposed notice template.

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KEY
BENEFIT
ADMINISTRATORS, INC.

September 27, 2011

Department of Labor
RIN 1210-AB52

Re: Comments on Proposed Summary of Benefits Coverage Template
For Self-Funded Health Benefit Plans

To the Department of Labor;

On behalf of my company, which is a third party administrator ("TPA") of self-funded employer sponsored health benefit programs, I would like to comment on the proposed Summary of Benefits Coverage (Summary) template produced by the NAIC at the request of HHS. We appreciate that you have offered to work with TPAs so as to give us the opportunity to properly comply with the regulations surrounding this template. I have worked on a red-line version which I have attached. I will address general comments, then work through the red-line for you so that you understand my approach.

First and foremost, I appreciate the hard work it took to create this template. It appears that it was created with the fully-insured world of health benefits in mind. That is to be expected as the NAIC works with state insurance departments in their management of the fully-insured health marketplace. Under ERISA's preemption provisions, state insurance departments do not have authority over self-funded welfare benefit plans (other than in many states where self-funded programs are sponsored by Multiple Employee Welfare Arrangements) so its approach is, understandably, towards fully-insured programs.

Unfortunately, the template is not user friendly to the self-funded plan sponsor nor to TPAs that will be managing the process for its self-funded employer clients. Using it as is with persons who will be covered by a self-funded program could lead them to believe that the programs they are looking at are fully-insured programs, which they would not be. Providing a self-funded version of the Summary will not add to the belief that the program being reviewed is fully-insured.

As has been pointed out, the vernacular used in self-funded programs does not always match up with that used by insurance carriers in their fully-insured policies of insurance. Here are examples of some of the differences:

| Fully Insured (FI) | Self-Funded (SF) |
|---|---|
| Policy of insurance | Plan of coverage |
| Health insurance | Benefit coverage |

| | |
|---|---|
| Premium | Total cost of claims and administration |
| Individual premium | Contribution |
| Insurer | Benefit plan or Plan Administrator when referring to the entity that controls the plan |
| Insured | Participant or beneficiary |
| Certificate of Coverage | Summary Plan Description |
| State Insurance Department | Department of Labor |

And many more

I believe that a second version of the template should be developed that recognizes the self-funding approach to health coverage and which uses several of the above words. I believe this can be accomplished with little change to the current template and would result in separate fully-insured and self-funded templates but which convey the same concepts. I will walk through my suggestions for the self-funded template page by page as follows:

Page 1.

- Top left header. SF plans are most often named for the employer. As long as the type face is at least 12 points this should not be an issue.
- Replace the word "policy" to "plan" or "benefit plan" where it appears.
- Replace the word "insurer" with "plan" or "benefit plan" or "network" where that information was held by the Preferred Provider Organization.
- Replace in the first "Important Questions" area the word premium with "standard employee contribution." The reasoning is that in the SF world our participants pay a contribution towards the total cost of the program but do not pay the entire cost of the coverage. Further, using the word "standard" allows the plan to charge a higher contribution if continuation coverage is offered under COBRA. I would consider adding "standard" to this term in the FI template for this reason.
- Recognizing that the comments in the "Why this Matters" areas are free form, I would not refer to variations in an employee's premium as being based on underwriting. This would only be for the individual market as in the group market under HIPAA health care coverage or contributions may not vary based on a medical condition or extent of claims.
- Footer. Delete the word "insurance" in all footers.

Page 2.

- Delete references to "insurance."
- Disregard incorrect page number in Footer in the attachment. Program problem at my end.

Page 3.

- Delete reference to "insurance."

Page 4.

- Replace "policy" with "plan or Summary Plan Description."
- Under "Your Rights to Continue Coverage:"
    - Intro lines in the first and second blocks. Replace "premium" with "contribution" in both places.
    - First bullet is incomplete. PPACA allows rescission for fraud or providing intentionally misleading information. The template should be consistent with PPACA.
    - Second bullet is changed from "the insurer discontinuing the policy of insurance" to the "employer stops offering the plan of coverage."
    - The original third bullet on the loss of coverage if the person moves outside the coverage area is an HMO concept. I know of no SF plans that are on an HMO chassis but there may be. Since this bullet is "hard coded" into the template I believe it needs to be deleted for the SF version.
    - New third bullet addresses COBRA continuation. The introductory line to the section says that the person keeps their coverage as long as they pay their premium/contribution. This is true for active coverage but not for COBRA coverage which runs out in 18/29/36 months depending on the situation. Please consider making this a hard coded bullet for both the FI and SF versions of the template.
- Under "Grievance and Appeals Rights:"
    - Replace "insurer" with "benefits."
    - Replace "insurance" with "plan."
    - In the second bullet, since state Departments of Insurance do not have authority over SF plans, and do not have jurisdiction over the SF plan's appeal process this should be changed. I suggest that this be a reference to the Summary Plan Description which is required to set out appeal rights or have the individual call customer assistance, with the number going to the plan supervisor/TPA where customer service professionals are trained in advising how an appeal may be submitted.

Page 5.

- The first example of "Having a baby" is very concerning to me. Group plans subject to the requirements of the Pregnancy Discrimination Act under Title VII of the Civil Rights Act must be sure that maternity is treated the same as any other benefit, and thus be covered by the group FI or SF plan. Just having it in the Summary as a non-covered service will be misleading and cause more questions to be asked of the employer about the coverage. Further, the words in the left hand column under the heading "About these Coverage Examples" intimates that the plan being displayed has these benefits or, in this case, a non-benefit as maternity is displayed as a non-covered benefit. I suggest that a different example of a common non-covered service be used in both the FI and SF template. For example: "Excluded Voluntary Cosmetic Surgery."

- How examples number two and three came up with their numbers is a mystery to me. The explanation on page 6 is inadequate for the consumer to look at the columns and discern which coverage details from the first and second pages of the Summary were used to create the "You Pay" numbers. Were generic drugs or brand name drugs used? Was chemotherapy the cost of the drug, administration, in-office, at home, etc.? Perhaps providing a quick matrix of the coverage that the calculation was based on would be helpful.
- Delete references to "insurance."

Page 6.

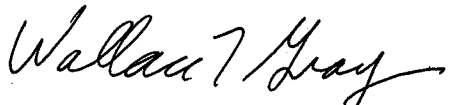
- First and third column, change "premiums" to "your contributions" or "contributions."
- First column, 4th bullet change word "policy" to "coverage."

Lastly, and very critically, there is going to have to be a lot of human time put into creating these Summaries. In the SF world each plan has customized features. They are not the "canned" plans used by many insurance carriers. Each summary will have to be individually crafted at a significant expense to the SF client. If a client has an indemnity plan, PPO plan, and a High Deductible HSA compatible plan, with 4 tiers of coverage each (single, single and spouse, single and children, and family) the number of separate Summaries multiplies quickly.

I would request that significant thought be put in to delaying the effective date of the Summary requirement for at least a year, and then have it applicable only at renewal of the group. PPACA requirements are putting a significant strain on the benefits industry. Trying to meet the current March 23, 2012 deadline without adequate time to react to the final templates is a recipe for non-compliance. As I said in a meeting between regulators and TPAs on September 12 of this year, the benefits industry needs time to be in compliance. Please give us the opportunity to be in compliance by helping with changes that fit the self-funded benefit world and by giving the benefits industry enough time to help our thousands of clients be in compliance.

Your continuing considerations are noted and appreciated. Should you have questions of me I may be reached at wgray@keybenefit.com or at 317-284-7702.

Sincerely yours,



Wallace T. Gray, JD, MBA
General Counsel
Key Benefit Administrators, Inc.

~~Insurance Company 1~~ABC MANUFACTURING EMPLOYEE HEALTH PLAN: PPO Plan 1~~PPlanolicy~~ Period: 1/1/2011 ~~1/01/2011~~

**Summary of Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse | **Plan Type:** PPO

**This is not ~~a policy~~the benefit plan ("plan").** You can get the plan ~~policy~~ at www.~~insurance~~company.com/PLAN1500 or by calling 1-800-XXX-XXXX.
The plan~~A policy~~ has more detail about how to use the plan and what you and the plan~~your insurer~~ must do. It also has more detail about your coverage and costs.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the standard ~~premium~~employee contribution?** | **$481** monthly | The contribution~~premium~~ is the amount you pay~~paid~~ for this health coverage~~insurance~~. ~~This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.~~ This amount may change during the year after notice is given to you or you continue coverage under COBRA. |
| **What is the overall deductible?** | **$2,500** person **/ $7,500** family<br>Doesn't apply to preventive care if plan not Grandfathered | You must pay all the costs up to the **deductible** amount before this health ~~insurance~~ plan begins to pay for covered services you use. Check your plan~~policy~~ to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes; **$300** for pharmacy expenses | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$2,500** person **/ $7,500** family | The **out-of-pocket limit** is the most you could pay during a ~~policy~~plan period for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Co-payments, premium, balance-billed charges, prescription drugs, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage. |
| **Is there an overall annual limit on what the ~~insurer~~plan pays?** | No. | The chart starting on page 2 describes any limits on what the ~~insurer~~ plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.network~~insurancecompany~~.com for a list of participating doctors and | If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network. |

**Questions:** Call 1-800-XXX-XXXX or visit us at www.~~insurance~~company.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.



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|---|---|---|
| | hospitals. | |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed in the "Exduded Services & Other Covered Services" section. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health ~~insurance~~ plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $35 co-pay/visit | 40% co-insurance | none |
| | Specialist visit | $50 co-pay/visit | 40% co-insurance | none |
| | Other practitioner office visit | 20% co-insurance for chiropractor and acupuncture | 40% co-insurance for chiropractor and acupuncture | none |
| | Preventive care/screening/immunization | $0 | 40% co-insurance | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% co-insurance | 40% co-insurance | none |
| | Imaging (CT/PET scans, MRIs) | 0% co-insurance | 40% co-insurance | none |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about drug coverage is at www.~~insurance~~company.com/prescriptions. | Generic drugs | $10 co-pay (retail); $10 co-pay (mail order) | 40% co-insurance | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) |
| | Preferred brand drugs | 20% co-insurance (retail and mail order) | 40% co-insurance | ——————none—————— |
| | Non-preferred brand drugs | 40% co-insurance (retail and mail order) | 60% co-insurance | ——————none—————— |
| | Specialty drugs (e.g., chemotherapy) | 0% co-insurance | | ——————none—————— |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Physician/surgeon fees | 0% co-insurance | 40% co-insurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Emergency medical transportation | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Urgent care | 0% co-insurance | 40% co-insurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Physician/surgeon fee | 0% co-insurance | 40% co-insurance | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 0% co-insurance | 40% co-insurance | After 8 visits, not covered. |
| | Mental/Behavioral health inpatient services | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Substance use disorder outpatient services | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Substance use disorder inpatient services | 0% co-insurance | 40% co-insurance | ——————none—————— |
| **If you become pregnant** | Prenatal and postnatal care | Not Covered | Not Covered | ——————none—————— |
| | Delivery and all inpatient services | Not Covered | Not Covered | ——————none—————— |



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| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a recovery or other special health need** | Home health care | 0% co-insurance | 40% co-insurance | none |
| | Rehabilitation services | 0% co-insurance | 40% co-insurance | none |
| | Habilitation services | 0% co-insurance | 40% co-insurance | none |
| | Skilled nursing care | 0% co-insurance | 40% co-insurance | none |
| | Durable medical equipment | 0% co-insurance | 40% co-insurance | none |
| | Hospice service | 0% co-insurance | 40% co-insurance | none |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | none |
| | Glasses | Not Covered | Not Covered | none |
| | Dental check-up | Not Covered | Not Covered | none |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your ~~policy~~plan or Summary Plan Description for others.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Routine hearing tests
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your plan or Summary Plan Description~~policy~~ for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

## Your Rights to Continue Coverage:

You can keep this coverage~~insurance~~ as long as you pay your contribution ~~premium~~ unless one or more of the following happens:

- you commit fraud or intentionally provide misleading information in making application for coverage or benefits
- ~~the insurer stops offering services in the state~~your employer stops offering the plan of benefits
- if covered under a coverage continuation provision of the plan and the term of continued coverage ends
- ~~you move outside the coverage area~~

## Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health benefits~~insurer~~ or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this ~~health insurance~~plan. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxx.com.

- An **appeal** is a request for your health ~~insurer or~~ plan to review a decision or a grievance again. For more information on the appeals process, ~~call your state office of health insurance customer assistance~~consult your Summary Plan Description or call customer assistance at: 1-800-XXX-XXXX ~~or visit www. Xxxxxxxxxxxxx.gov~~.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*



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## About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much ~~insurance~~ protection you might get from different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $10,000
- **Plan pays** $0
- **You pay** $10,000 (maternity is not covered, so you pay 100%)

**Sample care costs:**

| | |
|---|---|
| First office visit | $100 |
| Radiology | $300 |
| Laboratory tests | $200 |
| Routine obstetric care | $2,000 |
| Hospital charges (mother) | $4,100 |
| Hospital charges (baby) | $1,900 |
| Anesthesia | $1,000 |
| Circumcision | $200 |
| Vaccines, other preventive | $200 |
| **Total** | **$10,000** |

**You pay:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $10,000 |
| **Total** | **$10,000** |

### Treating breast cancer
(lumpectomy, chemotherapy, radiation)

- **Amount owed to providers:** $98,000
- **Plan pays** $94,800
- **You pay** $3,200

**Sample care costs:**

| | |
|---|---|
| Office visits & procedures | $4,000 |
| Radiology | $4,000 |
| Laboratory tests | $2,400 |
| Hospital charges | $3,300 |
| Inpatient medical care | $200 |
| Outpatient surgery | $3,400 |
| Chemotherapy | $64,000 |
| Radiation therapy | $13,000 |
| Prostheses (wig) | $500 |
| Pharmacy | $2,000 |
| Mental health | $1,200 |
| **Total** | **$98,000** |

**You pay:**

| | |
|---|---|
| Deductibles | $2,500 |
| Co-pays | $200 |
| Co-insurance | $0 |
| Limits or exclusions | $500 |
| **Total** | **$3,200** |

### Managing diabetes
(routine maintenance of existing condition)

- **Amount owed to providers:** $7,800
- **Plan pays** $6,800
- **You pay** $1,000

**Sample care costs:**

| | |
|---|---|
| Office visits & procedures | $960 |
| Laboratory tests | $300 |
| Medical equipment & supplies | $40 |
| Pharmacy | $6,500 |
| **Total** | **$7,800** |

**You pay:**

| | |
|---|---|
| Deductibles | $300 |
| Co-pays | $260 |
| Co-insurance | $400 |
| Limits or exclusions | $40 |
| **Total** | **$1,000** |

# Questions and answers about Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include ~~premiums~~your contributions.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an exduded or preexisting condition.
- All services and treatments started and ended in the same ~~policy~~coverage period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the contribution~~premium~~ you pay. Generally, the lower your contribution~~premium~~, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.