



Honorable Kathleen Sebelius, Secretary  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9982-P  
P.O. Box 8016  
Baltimore, MD 21244-1850

SUBMITTED ELECTRONICALLY VIA [www.regulations.gov](http://www.regulations.gov)

October 21, 2011

Re: File Code CMS–9982–P  
Summary of Benefits and Coverage and the Uniform Glossary  
File Code CMS–9982–NC  
Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and  
Related Materials under the Public Health Service Act

Dear Secretary Sebelius:

On behalf of Harvard Pilgrim Health Care (Harvard Pilgrim), a non-profit regionally based health plan covering approximately 1.1 million lives in Massachusetts, Maine and New Hampshire, we thank you for this opportunity to provide written comments on behalf of Harvard Pilgrim and our wholly owned third-party administrator, Health Plans, Inc., regarding the proposed rule, Summary of Benefits and Coverage and the Uniform Glossary and Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials under the Public Health Service Act.

Our written remarks are offered in order to express our comments regarding the questions presented in the proposed rule, as well as to identify areas that need further clarity. We would also like to express our support for the written comments submitted separately by America's Health Insurance Plans (AHIP). Our comments are outlined below.

### **Implementation Date**

While we appreciate that the Affordable Care Act (ACA) requires that health insurance issuers comply with the Summary of Benefits and Coverage (SBC) requirement by March 23, 2012, due to the complexity associated with this requirement as well as the open issues that need further clarity, we support AHIP's recommendation that compliance be pushed out and take effect 18 months after the issuance of the final rule. This delay will allow for the necessary lead time needed in order to implement the requirements under this rule. However, as AHIP's comment letter points out, the final rule must be released promptly in order to provide sufficient implementation time.

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## **Delivery of the SBC**

### Definitions for Applicant and Enrollee

The ACA requires that health insurance issuers provide an SBC to applicants, enrollees and policyholders. There may be some ambiguity with the terms applicants and enrollees; therefore, we propose the following definitions and request that the Departments amend the rule by inserting these definitions.

**Applicant:** an individual or group applying for health insurance coverage who is not currently enrolled by the health insurance issuer from which the applicant is seeking coverage.

**Enrollee:** an individual whose application for health insurance coverage has been approved by the health insurance issuer or an individual currently enrolled with the health insurance issuer who is seeking renewal of the health insurance coverage during open enrollment.

**Group Adopter:** a group whose application for health insurance coverage has been approved by the health insurance issuer or a group currently an employer offering coverage from a health insurance issuer which is seeking renewal of the health insurance coverage during open enrollment.

### Electronic vs. Paper Delivery

While we appreciate that some individuals may need to receive their SBC in paper format, we strongly encourage the Departments to amend the rule by allowing electronic delivery to be the default for individuals and employer groups. Individuals that cannot obtain their SBC electronically will have the option to select paper disclosures. Providing the SBC in paper is significantly more expensive than providing the SBC through an electronic format. Many industries, including the health care industry, are committed to reducing the amount of paper consumed. Therefore, we recommend that electronic delivery be the default mechanism for delivery unless paper delivery is requested on an individual basis.

### SBC Delivery and Open Enrollment Periods

The proposed rule currently identifies those instances in which a health insurance issuer or group administrator is required to generate an SBC for individuals and groups. However, the proposed rule does not tie these instances to applicable open enrollment periods. For example, in Massachusetts, there is a defined open enrollment period for individuals seeking individual health insurance coverage. The only exception to obtaining coverage during the open enrollment period is in the event of a HIPAA qualifying event. Furthermore, the proposed rule on Exchanges, entitled Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, outlines timeframes for the initial open enrollment period as well as the annual open enrollment periods going forward. Given that individuals and groups will only be allowed to apply for coverage during the open enrollment periods, applicants, as referenced in the ACA and the proposed rule, should not be permitted to request an SBC outside of the open enrollment periods unless there is a qualifying event. To allow such requests outside of the open enrollment periods will increase consumer confusion and will provide consumers with information that will be outdated. In addition, these requests will drive up the costs associated with the SBC requirement. Tying the SBC requirements to open enrollment periods and

qualifying events for applicants will simplify the requirements and will cut down on the administrative costs associated with producing the SBC. Therefore, we respectfully request that the final rule include language that ties the SBC requests to open enrollment periods.

#### SBC Delivery to Employer Groups

The proposed rule lacks clarity on how the SBC must be delivered to employer groups in order to meet the statutory requirement. Furthermore, the proposed rule does not contemplate the role of insurance brokers and the established relationships that they have with their employer accounts. Given that these relationships should be preserved and that brokers play an important role in the health insurance market, we strongly encourage the Departments to amend the proposed rule to recognize the role of insurance brokers. More specifically, we recommend that the rule specifically state that a health insurance issuer meets its obligation to provide the SBC to the employer account if the SBC is provided to its insurance broker. This amendment will streamline the process and will preserve the employer account and broker relationship.

#### SBC Delivery to Employees of the Employer Group

We recommend that the rule be further amended to allow health insurance issuers to provide the SBC for an employer group's employees directly to the employer group's human resources or benefits manager. In many instances, health insurance issuers do not have access to information regarding employees that would be necessary in order to provide an SBC to the employees directly. This is especially true for new employer accounts or employer accounts with new employees. Therefore, unless the request came directly from the employee, there is no way for a health insurance issuer to obtain contact information for these employees unless the employer group provides that information upfront in a timely manner. Given that this is not currently industry practice, we respectfully request that the rule be amended to allow health insurance issuers to deliver the SBC to the employer group's human resources or benefits manager in order to satisfy the requirement that the employees of the group receive the SBC.

#### Delivery Requirements: Calendar versus Business Days

The proposed rule states that the SBC must be provided within 7 days or 30 days depending on the circumstances. However, the rule does not state whether these requirements are to be counted as calendar days or business days. Therefore, we recommend that the rule clearly state whether compliance is measured based on calendar or business days.

#### Renewals

The proposed rule requires health insurance issuers to issue an SBC to groups 30 days prior to renewal. Unfortunately, this requirement is inconsistent with current industry practice given that employer groups often do not select the health benefit plan that far in advance. This 30 day requirement would result in requiring employer groups to select the health benefit plan at least 15 days in advance of the 30 day requirement in order for health insurance issuers to meet their obligation. Otherwise, employees would only have 4 days to make plan decisions instead of 15 days, which is the standard today. Therefore, we recommend that the rule be amended to require the SBC be issued as soon as practical after an employer has selected the health plan but no later than the date of enrollment.

### Material Modifications

The proposed rule states that health insurance issuers must provide a new SBC 60 days in advance of any material modifications occurring outside of renewal. Currently, if Harvard Pilgrim makes a benefit change, we notify subscribers pursuant to applicable state law, which is 60 days in advance for Massachusetts and New Hampshire. However, if the employer makes a benefit change, we would not know that 60 days in advance and would not be able to comply with this requirement. Therefore, we recommend that the rule be amended to require the SBC to be issued as soon as practical after the employer group notifies the health insurance issuer or administrator of a material modification but no later than the effective date of the material modification. In those instances where the health insurance issuer makes a material modification, state law should apply.

### **Applicability to Self-Funded Accounts**

As outlined by the National Association of Insurance Commissioners (NAIC), the proposed SBC template was created from the fully-insured point of view and the proposed rule does not distinguish between the fully-insured and self-insured markets, which is necessary given that they are separate and distinct markets. We support AHIP's position that the Departments provide a safe harbor for self-funded accounts to allow for further discussion on how to use existing requirements to satisfy the SBC requirement for self-funded accounts. We also outline specific challenges relating to self-funded accounts below.

### Terminology Differences between the Self-Funded and Fully-Insured Markets

The terminology used in self-funded programs does not usually coincide with that used by fully-insured policies. For example, the term "plan" is used in the self-funded market while the term "policy" is used in the fully-insured market; likewise "contribution" is used in the self-funded market, while "premium" is used in the fully-insured market; and the term "grievance" does not apply to most self-funded plans.

Furthermore, self-funded group health plans refer to Summary Plan Descriptions (SPDs) and Plan Descriptions (PDs) as the complete statement of plan benefits. In contrast, terms such as "contracts" or "policies" are used in the fully-insured market. These issues affect both the SBC and the companion Glossary. Therefore, the final rule needs to use the appropriate terminology in order to reflect the differences between these markets.

### Scope and Design of the SBC

The template developed by the NAIC does not accommodate more than three coverage tiers. Many of our self-funded plans offer an additional coverage tier for other groups of participating providers which would have to be included on the SBC in order to provide the snapshot of benefits under the plan that the ACA envisioned. In addition, some benefits may be common across 2 or 3 tiers, so extending the row out to the next page would be confusing to consumers. In light of these challenges and circumstances, greater flexibility is needed in developing the SBC. Using a smaller font (9 or 10 sans serif) and not putting exclusions and limitations in a different sized font would accomplish the goal of presenting the plan information objectively.

## Content of the SBC

### Premium Information

After thoughtful consideration, we have serious concerns with including the premium information on the SBC given that the form is meant to be a **summary** of the benefits and coverage offered and not a comprehensive document. Furthermore, the ACA does not require the form to contain this information and we believe that providing this information could lead to more confusion than clarity. Premium development is complex and requires certain group or individual attributes and demographic information in order for Harvard Pilgrim to provide accurate information. **Rates vary by anniversary or effective date, and in some instances the rating engines (systems used to develop rates) may not be ready for release in the market place.**

Furthermore, health insurance benefit plans are not like other products purchased in a department store, which have the same price for all customers. Instead, the price of a health insurance benefit plan depends on particular information about the potential purchaser. As a result, **it is impossible to show one unique price for each health insurance benefit plan product.** If the purchaser plans to buy health insurance as a non-group individual subscriber, then s/he must provide all the relevant rating information required to generate a rate quote. If the purchaser is a member associated with an employer group, then that individual's price can only be determined if all the relevant information about the employer group has been provided in order to generate a rate quote. This information includes data about all the subscribers (and/or members) and other attributes of that employer group and it is highly unlikely that any one member would possess that information. As a result, **a rate could not be produced for a potential purchaser who is obtaining insurance as a participant in an employer group.**

In the case of the Connector (the Massachusetts Exchange) or Intermediary business (health benefit plans sold through membership organizations such as the Small Business Service Bureau, Inc.), the premium information is not readily provided to Harvard Pilgrim to generate the new disclosure for members of the Connector or groups sold through our Intermediary partners, as the rate quote is issued by these agencies. This would require these agencies, including the Connector, to develop processes and/or programs to comply with this mandate.

In addition, there are potential risks associated with providing the premium information from a competitive standpoint. For example, there is a potential for competitors to use premium information on the SBC for strategic initiatives. Additional risks include managing the market place and providing premium information that is not current. Lastly, individuals and groups obtain premium information in other formats. For the reasons stated above, we strongly urge the Departments to remove the premium box from the SBC template.

### Assumptions

We request that the Departments allow health insurance issuers to add additional assumptions on page 6 as needed given that there may be more applicable assumptions that are product specific. Some of the assumptions required may not be applicable; therefore the Departments should allow greater flexibility on providing appropriate assumptions.

### Why This Matters Section

Our comments under this section are as follows:

1. Under the out of pocket limit exclusions – The Why This Matters language states: “...a long list of expenses means you have less coverage...” However, this will not always be true and would depend on what is on the list (example: small co-pays of a variety of types) and whether the out-of-pocket limit under that option is higher or lower than under another option.
2. Deductibles – The Why This Matters section on the lack of deductibles for specific services could be confusing by indicating that in the absence of a deductible for coverage on a specific service, coverage begins “sooner.” Based on the proposed rule, it is not clear what the comparator is, especially where there could be an overall deductible applicable to most benefits. On the other hand, in the absence of an overall deductible and specific service deductibles, nothing begins sooner.

### **Technical Questions Regarding the SBC, Coverage Examples and Instructions**

1. We seek clarification on the instructions for "limitations and exceptions column," which states “examples , include, but are not limited to limits on number of visits, specific dollar amounts and **prior authorization requirements**, unusual exceptions to cost sharing, lack of applicability to a deductible and a separate deductible.”

We interpret the reference to prior authorizations to mean the notification that a prior authorization is necessary as opposed to the medical criteria needed to obtain prior authorization. We also recommend that the SBC only include a general reference to the fact that prior authorization may be required. An issuer should be permitted to direct the member to its website for the most current list of services that require a prior authorization to ensure that the most up to date information is provided in the most efficient manner.

2. In the instructions for the data element for "is a referral required for a specialist," it says that the plan has to state whether a written or verbal referral is required. We do not require a referral to be either written or verbal. The PCP can make the referral in any way that the practice has set up (phone call, POS, etc...). In addition, there are also some practices that do have a written referral form that they use for all patients, no matter what the insurance. Therefore, this element should be modified by providing a third option that combines written and verbal referrals as an option.
3. We seek clarification on what is meant by "other practitioner office visit" which is listed under the Common Medical Event found on page 2 of the SBC template under "Services you may need." Is this meant to only include chiropractors and acupuncturists, or is this meant to include all practitioners that are not primary care providers or specialists?
4. We seek clarification on the reference to diagnostic test (x-ray, blood work). Is this field only meant to capture, for example, x-rays, for a fractured arm or does this include

diagnostic procedures such as endoscopic procedures? If it does include endoscopic procedures, this element does not take into account the location in which the care is provided (outpatient setting versus Ambulatory Surgery). The location of the service will impact the level of cost sharing, which will be different depending on the location. The inclusion of a disclaimer or explanation box is necessary for this field.

5. We seek instruction and clarification on how to display individual versus family deductible information.
6. We seek clarification on how to treat carve outs and pharmacy benefits. We recommend that these items be excluded from the SBC requirements given that the information may come from other vendors.
7. We seek clarification on the use of preferred brand drugs, and non-preferred brand drugs. We do not use these terms and therefore ask that the Departments allow health insurance issuers to modify the use of these terms in order to be consistent with internal pharmacy benefit tiering formulary. For example, preferred brand is described as brand drugs on the formulary from pharmacy and or mail order. However, our tiering includes a combination of brand and generic drugs for both tier 1 and tier 2 drugs. Therefore, the current proposed listing would not accurately reflect how we classify drugs. We ask that the Departments provide additional flexibility for these fields.
8. The template also requires information regarding specialty drugs and provides chemotherapy (which can be intravenous or oral) as an example, and can include prescription medications that require special handling, administration or handling. However, some drugs will pay under our medical benefit instead of our pharmacy benefit. In these instances, the cost sharing will depend on how it is billed; in an outpatient setting, it will be covered in full and in an office visit, the office visit copayment will apply. And, if dispensed to the member, then an Rx copayment will apply. Therefore, a distinction or disclaimer would be necessary in order to provide this information accurately.
9. The template requires information regarding hospice services. Like the issue addressed under diagnostic tests, the cost of this benefit and the cost sharing depends on the location in which the services are provided. For example, this benefit can occur in an inpatient or outpatient setting, as well as in the home. The inclusion of a disclaimer or explanation box is necessary for this field.
10. We seek clarification on what the exclamation point means that is inserted within the triangle of the Coverage Examples document? Is this meant to represent a warning to the consumer?

## Uniform Glossary

While the ACA requires health insurance issuers to provide a Uniform Glossary of prescribed terms, we are concerned that the Glossary will create member confusion given that the definitions do not replace a health insurance issuer's definitions in Benefit Handbooks. Members are likely to be confused when they see completely different terms used in the Glossary (i.e., Preferred Provider and Non-Preferred Provider when we use Plan and Non-Plan Providers). Moreover, the definition of Preferred Provider in particular is very confusing as it states that: "Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more." This distinction will now require members to consider what a "Preferred Provider" is versus a possible "Participating Provider" in addition to any issuer specific terminology.

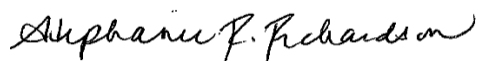
In addition, the Glossary defines habilitation services as services which help a person develop skills and functioning for daily living. However, we would treat these services as our functional therapies and would exclude some services, such as vocational training. Given that this is also a field required in the SBC, the inconsistencies between the Glossary definitions and the health insurance issuer definitions will generate a great deal of consumer confusion in terms of what services are covered under this category.

Therefore, we recommend that the Glossary provide sufficient disclaimers and warnings for consumers so that they understand that the definitions in the Glossary may not be the same as those used by their insurance issuer and that the issuer's definitions should be applied when reviewing health plan documents. In the alternative, additional flexibility regarding the Glossary terms is needed.

## Conclusion

We thank you for your consideration of our comments and we appreciate your attention to these very complex matters. Please feel free to contact me directly should you have any questions regarding our written testimony at [stephanie\\_richardson@hphc.org](mailto:stephanie_richardson@hphc.org).

Sincerely,



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