State of California
HEALTH BENEFIT EXCHANGE

EDMUND G. BROWN JR.
GOVERNOR

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-9982-P
PO Box 8016
Baltimore, MD 21244-1850

Via electronic delivery

Dear Dr. Berwick:

The California Health Benefit Exchange (HBEX), in consultation with the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), has reviewed the proposed regulations, form templates and documents for the Summary of Benefits and Coverage (SBC) and the Glossary of Health Insurance and Medical Terms (Uniform Glossary). We acknowledge the effort underlying the proposed SBC and Uniform Glossary to date and the goal of uniformity in disclosure and plan comparison forms. However, we find the proposed SBC regulations and form templates and Uniform Glossary potentially problematic in helping consumers to understand health coverage and to aid them in comparing health insurance, managed health plans known as Health Maintenance Organizations (HMOs), coverage, and prices. This letter reflects agreement amongst all three agencies on the overarching issues outlined immediately below. However, the letters sent by each agency also include separate comments that reflect our unique concerns, given our respective jurisdictions.

<u>Concerns Shared by the DMHC, the CDI, and the California Health Benefit Exchange</u>

We are concerned that the information required by the form templates and Uniform Glossary may not provide consumers with the most complete and helpful information to facilitate plan comparison and understand their coverage. Significantly, we are concerned that the terminology in both the SBC and the Uniform Glossary may be different from the actual controlling language in a contract or policy, confusing consumers about their coverage when the policy and contract terms are brought to bear once they access services. Understanding that standard definitions are required by the ACA, these definitions should be as clear as possible, so that consumers will comprehend the concepts and be better equipped to understand the definitions contained in

their policies or contracts, if different.

Terms like “practitioner,” “habilitation,” and “urgent care” may need additional clarification in the SBC through parenthetical examples to be meaningful to consumers (e.g., habilitation further referenced as physical, speech and occupational therapy.) It would further assist consumers in comparing coverage options to include additional related categories of service, such as emergency room physician services, to provide a more complete view of the cost components in a hospital emergency room visit.

In addition, much of the terminology proposed does not track with the coverage categories and terminology generally used in managed care plans, or with related California state law, and may be confusing to consumers in HMOs. For example, HMOs generally provide no coverage for out-of-network providers except in emergency care situations, but the Uniform Glossary implies that there will be some coverage out-of-network in all cases. Overall, many of the definitions seem to relate only to preferred provider organizations (PPOs). We recommend that all definitions be scrutinized and edited to make sure that they reflect how each term relates to both HMOs and PPOs.

Attached are the specific comments and questions of the California Health Benefit Exchange.

Sincerely,

Peter V. Lee, Executive Director, California Health Benefit Exchange

Comments of
The California Health Benefit Exchange (HBEX)

PROPOSED RULES FOR
SUMMARY OF BENEFITS AND COVERAGE AND THE UNIFORM GLOSSARY

26 CFR PARTS 54 & 602
REG-140038-10
RIN 1545-BJ94

29 CFR PART 2590
RIN 1210-AB52

45 CFR PART 147
CMS-9982-P
RIN 0938-AQ73

Reg Page	Proposed Regulatory Requirement Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.	CA HBEX Comments
41911	**Summary of Benefits and Coverage and Uniform Glossary (147.200)**	As stated in the cover letter, CA-HBEX, the California Department of Managed Health Care and the California Department of Insurance have some overarching concerns about the proposed SBC and uniform glossary.
52443-52450	**a. Summary of Benefits and Coverage (SBC)** Pg 52472 (a)(1)(i): Issuer must provide the SBC to a group health plan upon an application or request for information no later than seven days after the request. An issuer must provide a new SBC if and when the policy, certificate, or contract is renewed.	Proposed Section 155.205 (b) (ii) in the August 17, 2011 NPRM relating to Exchanges and Qualified Health Plans requires exchanges to provide SBCs on the mandatory exchange Internet Web site. This requirement gives state exchanges a very high stake in making sure the SBCs are clear and understandable for consumers as well as amenable to a user-friendly Web-based presentation of coverage options for exchange applicants. For this reason, HBEX below asks for changes,

Reg Page	Proposed Regulatory Requirement Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.	CA HBEX Comments
		clarification and state flexibility to facilitate effective disclosure and communication of the SBC by exchanges.
52443-52450	Pg 52473 (a)(1)(iii): The requirement to provide an SBC is deemed satisfied for all entities if it is provided by any entity. If a participant and any beneficiaries reside at the same address, providing a single SBC to that address will satisfy the obligation to provide the SBC for all individuals residing at that address. The plan and issuer need to provide a new SBC with respect to the benefit package in which the beneficiary or participant is enrolled. Pgs 52473-74 (a)(2): The regulation requires SBCs to include the elements specified in PHS Act Section 2715(b)(3), plus four additional elements from the NAIC model SBC: 1) an internet address for obtaining a list of the network providers; 2) an internet address where an individual may find more information about the prescription drug coverage under the plan; 3) an internet address where an individual may review and obtain the uniform glossary; and 4) premiums. Pg 52474 (a)(3): an SBC must be a stand-alone document. It must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font. Pg 52474 (a)(4): The SBC provided by an issuer to a plan may be provided in paper form or electronically. Electronic forms must have a format readily accessible by the plan; the SBC must be provided in paper	HBEX seeks clarification on the definition of "any entity" for purposes of meeting the responsibility of health insurance issuers and plans to provide the SBC to applicants. HBEX recommends that the provision of the SBC by a state exchange meet the obligation of exchange QHPs to provide an SBC to an applicant for coverage, in the way that information on the federal health care reform Web site *(http://www.healthcare.gov)* is deemed compliance. HBEX seeks clarification as to whether all of the identical information in the proposed SBC and uniform glossary will be provided in the same proposed format, content and appearance on the federal Web portal. HBEX requests state flexibility to revise the form and manner in which the SBC is communicated on the HBEX Web site to reflect actual QHP offerings in California and to ensure that the HBEX QHP comparison and selection tool is user-friendly and state of the art. *Request for comment on cost calculators*: State exchanges must establish and make available an electronic cost calculator for exchange QHP options (Proposed 155.205 (c)). HBEX recommends that a cost calculator be made available on the

Reg Page	Proposed Regulatory Requirement Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.	CA HBEX Comments
	form free of charge upon request; and for internet postings, the plan must be notified by paper or e-mail that the documents are available on the internet, and given the web address. Unless otherwise specified by an individual, an issuer must provide an SBC in paper form if, upon the individual's request for information or request for an application, the individual makes the request in person, by phone or by fax, or by mail; or if, when submitting an application, the individual completes the application for coverage by hand, by phone or fax, or by mail. An issuer that provides the SBC electronically must 1) request that the individual acknowledge receipt; 2) make the SBC available in an electronic format that is readily usable; 3) if the SBC is posted on the internet, display it in a location that is prominent and readily accessible and provide notice to each individual who requests an SBC that apprises the individual that the SBC is available on the internet and includes the applicable internet address; 4) promptly provide a paper copy of the SBC upon request without charge and inform individuals of their ability to request an SBC; and 5) ensure an SBC provided in electronic form is provided in accordance with the appearance, content, and language requirements of this section.	federal health care reform Web site *(http://www.healthcare.gov)* for coverage available outside of exchanges, as well as coverage inside exchanges. We recommend that HHS work with states to coordinate the development of the federal cost calculator to ensure ease of use and consistency with state exchange calculators. In addition, HBEX is concerned about the potential for proliferation of inaccurate or misleading cost tools developed by private entities with a financial interest in the plan selection outcome. For this reason, we recommend that HHS also provide guidance and direction for any Web-based cost calculators developed by health insurance issuers and plans to ensure that information provided is fair and balanced and provides accurate, useful information for consumers. (Proposed 155.205 (b) (1) (i)), we agree with the requirement that health insurance issuers and group health plans include the premium or cost of coverage on or attached to the SBC. This requirement will give consumers, particularly those in the individual and small group market, the same information for comparison purposes.
52450-52451	**c. Uniform Glossary** Pgs 52450-51 In addition to the requirements for glossaries in Section 2715(g)(2) of the PHS Act, the Department proposes additional terms recommended by NAIC for the uniform glossary: allowed amount, balance billing, complications of	The uniform glossary includes definitions for a wide variety of concepts and terms commonly used in health care coverage, some of which are overly broad or potentially inconsistent with either state requirements or actual contract and policy terms.

Reg Page	Proposed Regulatory Requirement **Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.**	CA HBEX Comments
	pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network co-insurance, in-network co-payment, medically necessary, network, out-of-network coinsurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist, and urgent care.	Importantly, the NPRM also states clearly that different definitions in the contract or policy would ultimately prevail. This will be very confusing for consumers if they are given information up front that is inconsistent with the actual terms of their coverage. **To limit consumer confusion, HBEX recommends that definitions not explicitly required in the ACA should be deleted from the uniform glossary.** If HHS maintains glossary definitions beyond those required in the ACA, HBEX suggests that there may be alternative ways to craft a consumer-friendly glossary that does not directly conflict with contract and policy terms. The glossary could include more generic descriptions of <u>concepts</u> like medical necessity to educate consumers about how terms are used and applied for coverage purposes. For illustration purposes: *"Medical necessity" is a clinical term for evaluation of whether a particular medical service, device or treatment is medically indicated or appropriate for a specific individual. The definition of medical necessity varies by policy and contract but coverage decisions based on medical necessity should be made by appropriately qualified health professionals. Individuals who experience a coverage denial based on medical necessity are entitled to an independent external review of that*

Reg Page	Proposed Regulatory Requirement **Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.**	CA HBEX Comments
		decision consistent with state and federal law.
52452	**f. Applicability Date** Pg 52475 The section is applicable beginning March 23, 2012.	Given that the proposed SBC becomes effective in early 2012, it will be important to test and evaluate early the effectiveness of the tool in helping consumers better understand and choose among health coverage options. Any required SBC or uniform glossary should be subject to rigorous review and consumer testing in a manner that will support quality improvement and timely updates prior to the time when state exchanges and health insurance issuers must begin offering coverage choice options in 2013.