



October 20, 2011

**VIA ELECTRONIC SUBMISSION**

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

**Re: Summary of Benefits and Coverage Form and the Uniform Glossary proposed regulations [CMS-9982-P] RIN 0938-AQ73**

Dear Sir/Madam:

Families USA is a national health care advocacy organization dedicated to expanding access to affordable and quality health care for all Americans, particularly low-income and underserved populations. In addition to drawing on our own experience, these comments reflect our conversations with state-based consumer advocacy organizations and consumer assistance programs that work to protect consumer rights and help to implement and advance policy changes that facilitate access to health coverage for millions of uninsured and underinsured consumers.

We appreciate the opportunity to comment on the proposed regulation for the Summary of Benefits and Coverage and Uniform Glossary of Medical and Insurance Terms, section 2715 of the ACA, which envisions a standard form describing health insurance coverage that is easy to understand for the average consumer. Together the Summary of Benefits and Coverage (SBC) and the Uniform Glossary of Medical and Insurance Terms (Glossary) are designed to help consumers “compare health insurance coverage and understand the terms of coverage (or exception to such coverage).” The SBC will be perhaps the most important document consumers will obtain to allow them to compare, select, and understand their health insurance coverage. To ensure that these documents are broadly available and accessible, the ACA requires that *all* private health plans provide the documents to enrollees and those shopping for coverage. Further, the statute requires that the SBC information be presented in a “culturally and linguistically appropriate manner and be understandable by the average plan enrollee.”

We are supportive of the overall proposed regulation and believe that the recommendations below will strengthen the proposed rules and allow these documents to better serve consumers. With the implementation of Patient Protection and Affordable Care Act (ACA), we believe it is critical to ensure that *all* private health care plans provide the appropriate information to *all* populations in plain language and an accessible format, including limited English proficient populations. This will significantly reduce the barriers consumers currently face to understanding and making informed choices about health coverage. One of the areas we are particularly concerned with is ensuring that the format in which this information is presented is accessible to low-income consumers, who are more likely to have low literacy

levels and limited access to the Internet. We provide recommendations on how to best reach these vulnerable consumers and enable them to use the SBC as intended.

In our conversations with consumer assistance programs, we have learned that consumers are often confused or misled about their coverage of mental health and emergency services, and we believe that these coverage areas should be addressed in more detail than is currently provided for in the proposed rules. In addition, we would like to emphasize the importance of ensuring language access as part of the process for providing the SBC to consumers. Language access is an essential component of successfully implementing the ACA. We strongly oppose adoption of the language access provisions in the proposed rule as they would severely reduce limited English proficient people's access to the SBC. We also believe that the definition of medical necessity must be amended in the glossary of insurance terms to ensure that people with physical and developmental disabilities are able to gain access to services under the definition.

There are many benefits of standard disclosure. Consumer confusion regarding health plan terms—particularly cost-sharing terms—is well documented. If consumers cannot understand the coverage offered by a plan, they cannot make an informed selection. When consumers do not understand their choices, they find themselves with plans that do not offer the coverage they need.

Though Families USA's work focuses primarily on policy advocacy and public education, we frequently receive requests for assistance from health care consumers and document the problems they report to inform our policy work. Our record of these cases demonstrates that many consumers struggle to understand the terms of their health insurance coverage and often purchase policies without a thorough understanding of their coverage or find that when they try to use their insurance it does not provide the coverage that they thought it did. We heard one such story from a self-employed couple in Nevada that had been buying health insurance at over \$800 a month for them and their two children from a single company ever since their COBRA coverage from the husband's previous job ran out. This year, their income was hard hit by the economy, and they couldn't afford to pay their premiums anymore. They applied for a Preferred Provider Organization (PPO) plan, which was only \$450 a month with this same company, but they were denied and had to start shopping around for new coverage. It was not long before they found what seemed to be ideal insurance. They would only have to pay \$100 for every \$10,000 of hospital bills, \$25 for doctor's visits, and \$50 for specialists. But when they enrolled in the coverage and went to their family doctor, they found that the situation was the reverse. Their insurance company would only pay the amount that the broker claimed the family would be paying. A little over a month after the family switched coverage, one of the couple's daughters sustained a knee injury during a cheerleading routine. Their daughter now needs ACL surgery, and the family does not know how they will pay for it. This story illustrates the dangers families face when coverage documents are confusing or misleading and insurers are not held accountable for providing plan information using language that is clear and easy to understand. In many cases, consumers do not learn about the terms of their coverage until they need to use the coverage.

The proposed rule makes great strides in providing understandable health insurance disclosure to consumers. Our comments below are intended to ensure that the SBC is useful to as many consumers as possible and that consumers' ability to use the form is monitored and improved over time.

Our comments address the following issues:

	Page
Requirement for all private health plans and health insurance issuers to provide the SBC ..	3
Inclusion of premium information.....	7
When should the SBC be made available to consumers?.....	7
How should the SBC be made available to consumers?.....	10
Adhering to Plain Writing Requirements .....	12
Language Access.....	12
Ensuring Accuracy.....	19
New/Modified Disclosures for SBC .....	21
Additions and Changes to the Summary of Benefits and Coverage Template .....	24
Coverage Examples .....	24
Additions and Changes to the Glossary of Health Insurance and Medical Terms .....	27
Additions and Changes to the Insurer Instructions.....	28
Improving the SBC Over Time.....	34

## **Requirement for all private health plans and health insurance issuers to provide the SBC**

We strongly support the requirement in the ACA that *all* private health plans provide the SBC and glossary to enrollees and those shopping for coverage—group and non-group, grandfathered and non-grandfathered, inside or outside the exchange.

When consumers use the same form across these settings, as the ACA requires, it allows them to “learn” the form. Investing the time to understand how to use the form pays off because they can apply that knowledge in the future, regardless of where they are purchasing private health insurance.

### **Application of requirement to all health plans, including employer-sponsored plans and government plans**

It is particularly important that the uniform SBC be provided to enrollees in employer-sponsored group health plans. The vast majority of privately insured people – 150 million non-elderly Americans in 2011 – are covered by employer-sponsored group health plans.<sup>1</sup> If the SBC is not available to people in such plans, the protections that Congress intended under Section 2715 of the Affordable Care Act would be denied to most Americans with private insurance.

Information disclosure for consumers in group health plans today is inadequate. For decades, the Employee Retirement and Income Security Act (ERISA) has required private sector group health plan sponsors to disclose information to enrollees about covered benefits and enrollee rights and responsibilities in a summary plan description (SPD). However, over the years, the SPD has developed into a bulky, complex document that few consumers can understand. While it is essential to retain SPD requirements so that consumers will know more about their coverage when they actually need to use benefits, the proposed SBC will better help them to choose plans. Other summary information provided by employers (for example, at open season) is inconsistent. This makes it difficult for consumers to understand how their health insurance works or what it covers. As a result, consumers don’t learn what their health plan does and doesn’t cover until they get sick and make claims. For example, one major national survey found that 23 percent of privately insured cancer patients reported their health insurance provided less coverage for cancer treatment than they expected it would, and 13 percent reported their plan didn’t pay anything for care they thought was covered.<sup>2</sup> The SBC provides consumers with illustrations of how coverage works for specific scenarios such as treatment for breast cancer. Consumer testing found these illustrations to be very helpful to consumers, but they are not generally included in the current SPDs. Working Americans and their families should not be deprived of this information.

Requiring the SBC for all private health plans is also important because current ERISA health plan information disclosure requirements do not apply to tens of millions of public employees who are covered under state, county, and municipal governmental health plans. As

---

<sup>1</sup> 2011 KFF Employer Health Benefits Survey, available at <http://ehbs.kff.org/>

<sup>2</sup> USA Today, Kaiser Family Foundation, Harvard School of Public Health, “National Survey of Households Affected by Cancer,” November 2006, at <http://www.kff.org/kaiserpolls/upload/7591.pdf>

written, the proposed rule implementing Section 2715 would close that gap. We urge that FEHBP plans also provide this information for federal employees, retirees, and their dependents.

### **The SBC serves other important consumer information needs**

We strongly support the requirement in the proposed regulation which specifies that in addition to helping consumers understand their health insurance options and how their health insurance works, the SBC will give consumers critical information they need to know and document regarding whether plans are in compliance with the new requirement to be enrolled in minimum essential coverage in 2014. The SBC must describe the extent of coverage and cost-sharing for essential health benefits. It must also indicate whether coverage under the plan or policy has an actuarial value of at least 60 percent. Additionally, as described in the proposed regulation and recommended by the National Association of Insurance Commissioners (NAIC), the SBC must indicate the share of premiums that the employee must pay. All consumers, including those enrolled in employer-sponsored group health plans, will need such information to prove that they are enrolled in minimum essential coverage. In addition, consumers will need information about their group health plan's actuarial value and its cost in order to determine whether they may be eligible for subsidies that will be offered through the Exchange. Furthermore, consumers whose job-based health plans do not constitute affordable minimum essential coverage will need documentation of this fact in order to seek adequate coverage and subsidies in the Exchange.

### **The rules should clarify when employers can make use of the information provided in the SBC to fulfill other reporting requirements**

The information that plan sponsors will need to compile in order to provide the SBC is the subject of other employer reporting requirements under the ACA. The Administration should clarify that providing the SBC to all enrollees and prospective enrollees also satisfies the requirement under Section 1512 of the ACA (Section 18B (a)(2) of the Fair Labor Standards Act) that employers shall provide written notice to employees about whether the group health plan has an actuarial value of at least 60 percent. In addition, the Administration should clarify that the SBC will constitute a portion of the documentation that employers must provide to the Internal Revenue Service (IRS) in order to avoid tax penalties for failure to offer minimum essential coverage, as required under Section 1513 of the ACA. Such dual use will minimize duplicative information reporting requirements on employers.

### **Do Not Incorporate SBC into SPD**

The proposed rule requests comment on whether the SBC should be incorporated into the SPD that ERISA now requires. This would defeat the purpose of the disclosure requirements under Section 2715. The SPD has become so bulky and legalistic that few consumers today find it practical to rely on this document to understand how their health coverage works. In fact, one study found that the typical SPD was written at a college reading level whereas most consumers are more comfortable reading at the 6<sup>th</sup> to 8<sup>th</sup> grade level.<sup>3</sup> The short and concise SBC will be easier for consumers to understand, keep handy, and consult frequently. While employers certainly should be able to deliver the SBC in the same envelope

---

<sup>3</sup> [http://www.ebri.org/pdf/notespdf/EBRI\\_Notes\\_10-20061.pdf](http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf)

used to deliver the SPD, the SBC must remain freestanding and not buried within a larger, unwieldy document.

### **Private health insurance issuer concerns about cost are not justified**

The main argument private insurers have raised for incorporating the SBC into the SPD would be to reduce employer costs. However, we believe it is unlikely that employers would see significant cost savings as a result of combining the two documents. Under the rule, consumers have a right to receive the SBC for all health plan options for which they are eligible, but ERISA only requires distribution of the SPD for the plan in which an employee enrolls. Incorporating the SBC into the full SPD would add to employer cost burdens because plan sponsors would have to distribute copies of the full SPD for *all* plan options to prospective enrollees when they are hired, during special enrollment opportunities, and upon request during annual open seasons.

There has also been discussion as to whether it is too costly for health insurance issuers to produce this form at all, particularly if they offer many plans. Some self-insured employers note that they already provide summaries of coverage to their employees and wonder if the cost of this new version (the SBC) is merited. However, the summaries provided today by employers and insurers are not standardized and do not include the coverage examples. Under the SBC approach, the government dictates the form, content, appearance, and “location” (i.e., rules for distribution) of the labels. It is precisely these standards, absent today, that assure that the information helps consumers understand and interpret differences in health insurance offerings in order to make informed choices.

In particular, some have pointed to the cost of producing the new coverage examples, which are referred to as Coverage Facts Labels in the ACA. Producing the coverage examples requires insurance providers to evaluate their offerings and create information systems that will accurately describe benefits in the prescribed format. However, the departments’ analysis shows that the annualized costs to industry of complying with these rules, as tabulated in the regulatory impact analysis, are an estimated \$50 million. These costs (estimated only for the first years of implementation) are clearly very modest relative to the estimated 176 million people who will be covered. When distributed over those people, the cost of these rules is merely \$0.28 per person. The costs are also low considering the number of people shopping for coverage annually.

The benefits, on the other hand, are substantial. Although the agencies do not attempt to quantify the aggregate benefits of the reform, we are confident that a welfare analysis would show that the benefits of standardizing information about health insurance plans would substantially outweigh the costs. The departments’ analysis, for example, cites research by Maestas et al. on search costs in Medigap (i.e., the cost to consumers of finding the lowest cost option among equivalent plans). This research finds the consumer costs to be quite high. In that research, Maestas demonstrates that “the implied aggregate welfare loss is approximately **\$798 million**, or \$484 per policyholder.” That estimate, based on 2004 data, refers to the much smaller Medigap market, in which there are fewer shoppers and products are standardized, but prices vary widely. It is reasonable to suggest that the welfare gains to nonelderly consumers shopping for health insurance in the private insurance market, which is not standardized, will be even greater than for Medigap. The welfare gains will therefore outweigh the estimated \$50 million annual cost.

**RECOMMENDATION: The costs associated with the SBC do not outweigh its benefits. Adhere to the requirement in the ACA that mandates that all private health insurance plans and issuers use the same form. We further recommend that FEHBP plans provide the SBC for federal employees, retirees, and their dependents to ensure greater uniformity across consumers with group and non-group coverage.**

### ***Inclusion of premium information***

The proposed rule follows the NAIC recommendation that the SBC should display prominently, in the top right corner of the first page, the premium or cost of coverage for policyholders or group health plan enrollees. The proposed rule also notes, however, that premium information is not a specific statutory requirement under Section 2715 and requests public comment on whether such information should be included. We emphatically recommend that premium information should be included on SBCs for non-group health insurance policies for individuals and families. Further, we strongly recommend that information about the cost of coverage be included for enrollees in group health plans, including the cost of coverage to employees and their dependents after the employer contribution to the premium.

The monthly premium is critical information for consumers. It is impossible to choose between health plan options without this information. A primary purpose of the Affordable Care Act is to get insurers to compete on the basis of 'value' instead of just price. Therefore, the SBC must contain information about **both** the cost of coverage and the content of coverage so that consumers can evaluate this information together.

In addition, consumers who are offered or enrolled in employer-sponsored group coverage must have information about premiums and cost of coverage in order to know whether their coverage meets the Affordable Care Act's 'affordability' test, which is key for determining eligibility for subsidies in the Exchange. Information about premiums and other cost sharing in the SBC must also be provided for coverage options other than individual coverage. For example, if a plan or policy offers family coverage, the premium and cost of coverage for families must be depicted, as well as the annual deductible, the out-of-pocket maximum, and other coverage features that would be different under a family policy.

**RECOMMENDATION: The SBC must contain information about the health plan premiums and cost of coverage for consumers, including cost of coverage features for coverage options other than individual coverage, such as family coverage.**

### **When should the SBC be made available to consumers?**

#### **Effective date for compliance with SBC requirements**

The proposed rule seeks public comment on the feasibility of timely implementation of Section 2715 requirements. We strongly urge prompt publication of a final rule with the requirements of this section taking effect no later than two years after the date of enactment of the Affordable Care Act, as the statute requires. We note that the NAIC working group invested hundreds of hours of study and deliberation involving a broad range of subject matter experts to arrive at its recommendations for the SBC, including the coverage examples. Drafts of the SBC and coverage examples were tested with plans and consumers to validate both the costs and benefits of this new resource. The Administration, in turn, took another four to five months to consider the NAIC's March 2011 recommendations before publishing its proposed rule this

summer. In light of the thorough work undertaken by so many to design the SBC, we urge timely implementation. We further urge the Administration to engage in ongoing efforts to monitor the costs and benefits of the SBC as it is implemented and to make future refinements and improvements based on such monitoring.

Timely implementation will help consumers better understand their coverage options and will reduce the costs and frustrations of trying to decipher the confusing coverage documents that people must rely on today. One industry survey found that most people would rather go to the gym or work on their income taxes than try to read their health insurance policy.<sup>4</sup> Consumers will appreciate this Administration's leadership in forcing the private market to provide better and more understandable health insurance information, and this, in turn, will likely enhance public support for the ACA overall.

In addition, timely implementation of Exchanges and other key reform initiatives will require the availability of information contained in the SBCs. As noted elsewhere in these comments, employers will need to compile the same information in order to satisfy other reporting requirements. State Exchanges will need to collect the same information in order to evaluate eligibility for tax credit subsidies. Individuals and families will need this information in order to document compliance with the individual mandate. Delayed implementation threatens progress on these other fronts.

**RECOMMENDATION: Implement the SBC on time, no later than March 23, 2012, as the ACA requires.**

### **Providing the SBC to consumers**

We strongly support the requirements in the proposed regulation, which specify that the SBC must be provided free of charge "with respect to each benefit package offered by the plan or issuer for which the participant is eligible" when an employer or individual is comparing health coverage options (§ 147(a)(ii)(A)). The proposed rule recognizes that there are different scenarios for when an SBC should be made available to a consumer. We agree that the SBC should be provided (1) when the issuer renews or reissues a policy, (2) any time an applicant or group plan requests it, (3) whenever application materials are distributed by the plan or issuer for enrollment, and (4) whenever there is a change in plan information or benefits. We agree that a printed SBC must be provided within 7 days of a request.

- For group plans, the SBC should be provided to the employer when the employer is shopping for coverage along with any plan marketing materials. It should be provided to current employees annually at the beginning of the open enrollment season or plan year, 60 days prior to a change in benefits, and in events that trigger special enrollment rights. It should be provided to new employees as soon as practicable after a hire. New employees that have a choice of plans should be provided with an SBC for each of the plans for which they are eligible no later than 7 days after hire. This timeframe is consistent with the requirement for providing the SBC upon request and will ensure that the employee is able to enroll in coverage as soon as possible after hire, while having adequate time to review the available plans. For new employees who do not have a choice of plans the SBC must be provided no later than the first date coverage is effective. The proposed instructions for group plans are unclear and may

---

<sup>4</sup> ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008, available at [http://www.insurancenewsnet.com/article.asp?a=top\\_news&id=89712](http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712).



allow the plan to provide the SBC to the employer rather than the employees. We believe it is essential that the SBC reach each covered employee, and that the instructions should be modified to clearly state this requirement.

- For individual plans, the SBC should be provided to prospective enrollees with any marketing materials, upon request, and upon application. It should be provided to current enrollees in individual plans upon enrollment, at renewal, 60 days prior to a change in benefits, and at the start of the open enrollment season if applicable.

We recommend that the insurers additionally be required to provide the SBC along with marketing materials for a plan that may be provided to prospective plan applicants. Applicants do not always review all of the materials that are provided, and therefore the first package of materials a consumer receives should include a comprehensive and comprehensible document that will explain coverage details.

We concur with the rule's proposal to make the SBC available within seven days of a request and in the case of special enrollment. We believe this gives consumers sufficient time to review the information. We understand that some insurers are concerned about the potential administrative burdens if a significant number of consumers request the SBCs outside of enrollment periods. While we do not believe most consumers will want or need an SBC at other times, we suggest that the Departments monitor the number of requests during the first year to determine whether changes in the policy are warranted.

We also want to ensure that the requirement that issuers provide the SBC upon request at any time should permit consumers to request an additional copy of the SBC for their plan if they misplace, damage, or lose the document.

If an applicant's final premium quote is different than the premium cost information provided in the SBC, the insurer should issue an amended SBC that provides the updated premium information for the plan. In 2014, when the prohibition on health status rating in the ACA goes into effect, there will be less frequent changes in premium information. At that point, insurers should provide premium information for each plan based on age, smoking status, and geographic location.

**RECOMMENDATIONS:** As called for in the proposed rules, the SBC must be made available within seven days of a request. Further, insurers should provide the SBC along with marketing materials for a plan that may be given to prospective employers and individual applicants. For group plans, the SBC should be provided to employees at the beginning of the open enrollment season and at the onset of any special enrollment opportunity, and to new employees as soon as practicable after hire, no later than 7 days after hire for new employees that have a choice of plans and no later than the first date coverage is effective for new employees that do not have a choice of plans. If premium or any other information that is included in the SBC changes, insurers should be required to provide an amended SBC within the timeframes specified in the regulation. The requirement that issuers provide the SBC upon request should permit consumers to request an additional copy of the SBC for their plan if they misplace, damage, or lose the document.

## How should the SBC be made available to consumers?

### General requirements

The SBC serves a unique function by “accurately [describing] the benefits and coverage under the applicable plan or coverage” (PHS section 2715) using plain language and a format that is more accessible to consumers than the documents that insurers currently provide. The proposed regulation includes a draft template for the SBC. This template creates a standard format that is uniform across plans, allowing consumers to more easily compare the benefits of each insurance product. We therefore recommend that insurers be required to use the standard template for the SBC that is established through this regulatory process. Providing the SBC as a separate document is also crucial to the intended purpose of the SBC. This enables consumers to identify the SBC among other plan documents easily. As discussed above (pages 3 and 4), the SBC should not be incorporated into the summary plan description (SPD), as this would make it more difficult for consumer to understand their plans.

Because applicants and enrollees may receive a large number of documents relating to their coverage, we believe it is important to make the separate SBC prominent and visible among other health plan disclosure documents. Specifically, we recommend that insurers provide the SBC on a different color or texture paper than the other documents. The SBC should also be clearly marked as an important document by including a note at the beginning or in a header stating, “KEEP THIS DOCUMENT WITH YOUR OTHER IMPORTANT PAPERS if you enroll in this health plan.”

**RECOMMENDATIONS: The SBC should be provided as a stand-alone document and should be made visible among other plan documents by using a different color or texture paper. Insurers should be required to use the standard SBC template. The SBC should be clearly marked as an important document by including a note at the beginning or in a header stating, “KEEP THIS DOCUMENT WITH YOUR OTHER IMPORTANT PAPERS if you enroll in this health plan.”**

### Form of Disclosure

We strongly recommend that the SBC be provided in paper form as a default option. The applicant or beneficiary can explicitly elect to receive the form through electronic means if they prefer. The consumer should have multiple mechanisms for requesting an SBC (e.g., via mail, phone, fax, or email). Consumers submitting a request through any of these mechanisms, including online, should be able to specify the method in which they prefer to receive the SBC. Through discussion on this regulation with state health care consumer assistance programs, we have learned that, although consumers frequently submit requests for assistance through program websites, they often have low computer literacy and do not provide email addresses for online communication. Even when consumers submit a request for information or assistance online, this does not guarantee that they have continuous access to a computer or the level of computer literacy required to access or use information provided through electronic means. According to 2010 U.S. Census Bureau Internet usage statistics, almost 40 percent of households with an annual income between \$25,000 and \$34,999 that report using the Internet do not have a computer with Internet access in their home. Of households with an annual income of less than \$15,000, more than 60 percent who reported that they use the Internet do

not have computers with Internet access in their home.<sup>5</sup> This indicates that, although consumers may be able to submit requests for assistance and plan documents electronically, they may not have consistent access to a computer and the Internet. Therefore, we recommend that applicants and enrollees be permitted to specify the format in which they prefer to receive the SBC, even if they submit their request for the SBC request online. If issuers do not have to comply with this requirement, they must at least be required to send a paper copy of the SBC to any applicant or enrollee who requested it via the Internet but did not acknowledge receipt of the document, as required in section 4(A)(i) of the proposed rule, within 7 days of sending the electronic copy of the SBC.

As discussed in the comments above, we recommend that all applicants and enrollees receive the SBC in paper form unless they explicitly elect to receive the document electronically. In addition, we agree that the SBC should also be made available by posting the document on the Internet. Specifically, we recommend that the SBC for each benefit package offered by the issuer be posted on the insurer's website as well as state and federal websites that aggregate health insurance information for consumers, such as state Exchange websites and healthcare.gov. Posting the SBC on these websites will enable consumers to review benefits information before requesting plan documents. This may result in fewer requests for SBCs, saving administrative costs. SBCs posted on state Exchange websites and on healthcare.gov should be posted in a uniform format that is compatible with the search functions of these websites, allows side-by-side comparison of plans, and is accessible for a broad range of computer operating systems, platforms, and Internet broadband speeds. All websites must also be section 508 compliant and compatible with assistive products, including screen readers that translate the content of a computer screen into automated audio output and refreshable Braille displays. Users should not be required to leave the website or download additional software in order to view SBCs. Additionally, consumers should not have to set up a password-protected account with the site in order to view the SBC, although this could be provided as an option for consumers who would like to save information on the plans they are comparing. These extra steps would create unnecessary confusion and barriers, especially for consumers with low computer literacy.

**RECOMMENDATIONS: The SBC should be provided in paper form as a default option, unless the applicant or enrollee explicitly elects to receive the form electronically. Consumers should be able to specify the format in which they prefer to receive the SBC, even when they submit a request for information and plan documents via the Internet. If issuers provide the SBC electronically to those who submit requests online, but the applicant or enrollee does not acknowledge receipt of the SBC, then issuers must be required to automatically send a paper copy of the SBC to the consumer within 7 days of sending the electronic copy. SBCs should be available on the Internet on the insurer's or plan's website, Healthcare.gov, and state Exchange websites, in addition to being provided in hard copy or electronically upon request. SBCs must be posted on Internet websites in a uniform format that is compatible with search functions, section 508 compliant and compatible with assistive products.**

---

<sup>5</sup> U.S. Census Bureau, "Table 1155: Household Internet usage in and outside of the home by selected characteristics: 2010" (Washington: U.S. Census Bureau). Accessed online on September 30, 2011 at <http://www.census.gov/compendia/statab/2012/tables/12s1155.pdf>.

## Adhering to Plain Writing Requirements

Plain writing is essential to the successful achievement of the legislative and administrative goal of helping individuals better understand their health coverage, the differences in coverage options, and terms and concepts that are commonly used in health coverage.<sup>6</sup> Plain writing is consistent with the requirement in Section 2715(b)(2) that the SBC “utilizes terminology understandable by the average plan enrollee.”

As defined in the Plain Writing Act of 2010, plain writing is writing that is clear, concise, and well-organized.<sup>7</sup> By October 13, 2011, Federal agencies must write all new or substantially revised documents in plain writing.<sup>8</sup> The SBC template that HHS releases should meet the requirements of this Act. Avoiding vagueness and unnecessary complexity will make it easier for individuals to understand and compare plan features.

The NAIC working group designed the recommended template for the SBC and uniform glossary that the Departments propose for adoption. When developing this template, the NAIC strived to meet “plain language” requirements but strongly advised that testing and assessment be done in consultation with representative consumer organizations.<sup>9</sup> A review of the current SBC by ThoughtForm provides illuminating examples of how the SBC could be designed to be clearer.<sup>10</sup> We support the NAIC’s recommendation.

**RECOMMENDATIONS: Before the Secretary authorizes the SBC and uniform glossary, HHS should 1) contract with recognized literacy/plain writing experts to test the proposed SBC and uniform glossary templates for language, structure, and layout; 2) focus test the revised forms with the intended audience so they can examine and comment on the content and the presentation of the materials; and 3) make appropriate revisions to provide additional information to individuals or to improve the efficacy of the disclosures. This additional testing with experts and consumers should be accomplished before the SBC is released on March 23, 2012.**

## Language Access

The use of plain language increases the accessibility of the SBC and glossary, but only if it is a language known to the applicant or enrollee.

Section 2715(b)(2) of the Public Health Service Act states that the SBC should be presented in a “culturally and linguistically appropriate manner.” The Departments have attempted to satisfy this statutory mandate by incorporating the rules for providing appeals notices pursuant to section 2719 of the ACA (hereinafter “appeals rules”).<sup>11</sup> The appeals rules state that, in counties in which at least ten percent of the population residing in the county is literate in only the same non-English language, both translation and interpretation services must

<sup>6</sup> See, Memorandum from Cass Sunstein, Office of Management and Budget, Office of Information and Regulatory Affairs to Heads of Executive Departments and Agencies, “Final Guidance on Implementing the Plain Writing Act of 2010” (April 13, 2011), available at <http://www.whitehouse.gov/sites/default/files/omb/memoranda/2011/m11-15.pdf>.

<sup>7</sup> 5 U.S.C. § 301 (3)(3).

<sup>8</sup> 5 U.S.C. § 301 (4)(b).

<sup>9</sup> Letter from the National Association of Insurance Commissioners to Secretary Sebelius and Secretary Solis (Dec. 17, 2010), available at [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_ppaca\\_letter\\_to\\_sebelius.pdf](http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf).

<sup>10</sup> [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_110505\\_literacy\\_review.pdf](http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf)

<sup>11</sup> 26 C.F.R. § 54.9815-2715(a)(5); 29 C.F.R. § 2590.715-2715(a)(5); 45 C.F.R. § 147.200(a)(5).

be provided upon request.<sup>12</sup> In the preamble to the SBC rules, the Departments expressly state however, that nothing in the proposed regulations should be construed to limit rights conferred by Federal or State civil rights laws, including Title VI of the Civil Rights Act of 1964, which prohibits recipients of Federal financial assistance from discriminating on the basis of race, color, or national origin. (76 Fed. Reg. 52450, Aug. 22, 2011). This requires recipients of Federal financial assistance to take “reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons.” *Id.*

We strongly opposed the proposed rule as it applied to appeals notices and oppose applying the same standards to this rule. The Departments proposed rule would severely reduce limited English proficient (LEP) people’s access to what is arguably the most important document regarding their health insurance. We contend not only that this is unwise, but also that it violates PHSA § 2715, Title VI and Section 1557 of the ACA.

### **Title VI and Section 1557 of the ACA Require Broader Access for LEP Individuals**

Unlike the appeals rules, the proposed SBC rules expressly state that the intention is to meet the requirements of Title VI, 42 U.S.C. § 2000d *et seq.*, which prohibits discrimination by any entity receiving Federal financial assistance. In addition, Section 1557 of the ACA prohibits discrimination in any “health program or activity, any part of which is receiving Federal financial assistance, “including credits, subsidies, or contracts of insurance . . . .” Every health plan that participates in an Exchange will receive Federal financial assistance, at least in the form of advanced payment tax credits. Thus, every one of those plans is obligated under both Title VI and Section 1557 not to discriminate, and that means that they must provide culturally and linguistically appropriate services, independent of the appeal or SBC rules. Further, the language of § 2715 itself requires that the SBC be provided in a culturally and linguistically appropriate manner. We do not believe that a 10 percent threshold for translation and the availability of oral language assistance would ensure the provision of culturally and linguistically appropriate services, as that threshold is much higher than standards currently adopted by the Departments of Justice and Health and Human Services in their “LEP Guidances” (see [www.lep.gov](http://www.lep.gov)) and the Department of Labor in its regulations governing group plans for the provision of notices of appeals.

It is well documented that language barriers affect access to health care. The Institute of Medicine has stated that:

Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.<sup>13</sup>

It is therefore critical that consumers have access to vital information about their insurance plan in a language in which they are comfortable.

---

<sup>12</sup> 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136(e).

<sup>13</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002)(citations omitted).

The Departments acknowledge the complexity of selecting and understanding a health plan. For example, the Departments have required that a copy of the uniform glossary be made available to all individuals to whom the SBC is provided in recognition of the fact that even English-proficient consumers may have difficulty fully understanding the terms in the SBC. If insurance is so complicated that even native English speakers need a uniform glossary, then those who are LEP will surely struggle to understand the SBC without language access services.

The Departments recognize the importance of the SBC. It is the most basic document that provides information about what services are or are not covered by different plans. This information helps individuals make informed decisions about what plan to select. However, because under the proposed rule the minimum population of people in a county who speak the same language is so high, the SBC will essentially only be translated into Spanish. Even then, only a small segment of Spanish-speakers will have access to translation services. Those who speak most other languages will be left without help altogether. If this critical information is not accessible to LEP individuals, it will only further hinder LEP individuals' access to care, as they will be unable to make informed decisions about selecting a plan.

This is exactly the kind of discrimination that Title VI and Section 1557 is supposed to prohibit. Although the Departments have not yet issued proposed or final regulations interpreting Section 1557, the Department of Health and Human Services has, over the years, issued guidance on LEP under Title VI.<sup>14</sup> This Guidance built upon Executive Order 13166, which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons.<sup>15</sup> In that Guidance, HHS recognized that “[t]he more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed.”<sup>16</sup> The Guidance provided two “safe harbors” or rules that recipients of Federal funds could follow and be sure they were in compliance with Title VI: (1) the HHS recipient provides written translation of vital documents for each eligible LEP language group that constitutes five percent of the population or 1,000 people, whichever is less; and (2) if there are fewer than 50 people in a language group that reaches the five percent threshold, the recipient can provide written notice of the right to receive competent oral interpretation of the written materials, free of cost.

If these criteria were feasible for all recipients of Federal financial assistance for more than eight years, why are they suddenly impracticable for insurers participating in an Exchange? Further, the LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed. The proposed regulations adopt a 10 percent per county threshold for the provision of oral communication assistance, again ignoring longstanding interpretations of Title VI.

In the LEP Guidance, HHS took great pains to consider the cost of compliance to recipients of Federal financial assistance. Indeed, there was recognition that large documents such as enrollment handbooks might not have to be translated *as long as the vital information*

---

<sup>14</sup> “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” 68 Fed. Reg. 47311 (August 8, 2003).

<sup>15</sup> This Executive Order was reaffirmed on June 28, 2010 and again on February 17, 2011.

<sup>16</sup> 68 Fed. Reg. 47314.

*contained in such documents is translated.*<sup>17</sup> Surely, a four-page double-sided SBC that contains basic plan information is both vital and short. Indeed, it may be the most vital information a consumer receives about their health plan. If HHS believes that its own LEP guidance is necessary and appropriate to implement Title VI in other contexts, those same thresholds should apply to the SBC (and to appeal notices, as well). The failure of a plan to comply with these rules violates Title VI and Section 1557 of the ACA.

### **Public Policy Concerns Militate in Favor of Stronger Rules for LEP Individuals**

The adoption of a 10 percent per county threshold is not useful for determining translation needs. First, as a practical matter, county demographics may not be reflective of a plan's demographics because a plan may market specifically to particular ethnic/cultural/language groups in a county, region, or nationally, or it may serve employers that have high populations of LEP employees. These plans clearly have greater numbers of LEP enrollees than a given county in which the plan operates. We strongly believe that a plan must track data on its LEP enrollees and provide translated notices when the thresholds that we recommend below are met for enrollees in each specific plan rather than county populations.

Second, the appeals rules omitted a numeric threshold for plans participating in the group market and merely require translation of notices when 10% of a county's population is LEP. Again, this fails to recognize that plan demographics may differ from a county. As recognized in the appeals rules, very few counties meet the 10% threshold generally, and only six counties meet the threshold for any language other than Spanish. Existing DOL regulations, as well as LEP Guidance from the Department of Justice and HHS, (see [http://www.lep.gov/guidance/guidance\\_index.html](http://www.lep.gov/guidance/guidance_index.html)) recognizes the need for a dual standard for translating documents and includes both numeric and percentage thresholds. We believe that, because the law states that the notices must be provided in a "culturally and linguistically appropriate manner," the current guidelines must be enhanced rather than weakened. By removing the numeric threshold in favor of only the 10 percent threshold, the guidelines to protect people who are LEP are actually weaker after enactment of the Affordable Care Act. As a result, fewer people will have access to language assistance.

We therefore recommend that the Departments adopt a combined threshold using the existing DOL regulations and DOJ/HHS LEP Guidances. We suggest that the threshold for language assistance should be 500 LEP individuals or 5 percent of a plan's service area or an employer's workforce, whichever is less. The 5 percent threshold is used in both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans. It is imperative that the threshold be pegged to a plan's service area or an employer's workforce and not to the make-up of enrollees in a plan. The SBC is a document that will be used by consumers to compare plans and to help them determine which plan best fits their needs. Not providing language assistance to LEP consumers in a workforce or service area that meet the proposed threshold is discriminatory and has the potential to lock out LEP consumers from enrolling in plans.

Further, the Departments must ensure that the translation is accurate and not done through machine translation. "Machine translation" refers to the use of a computer program to automatically translate information from one language to another. Currently, neither free nor

---

<sup>17</sup> 68 Fed. Reg. 47319.

commercial machine translation programs provide sufficiently accurate translations to rely upon for use with LEP people. It is vital that the translations be completely accurate in order to serve the purpose of the SBC. Thus Exchanges, QHPs, and others should be prohibited from using machine translation. Instead, best practices that are recognized by the American Translators Association (ATA) for translating documents must be used. ATA offers a guide called “Getting it Right” that offers advice on what to look for when evaluating translation services. The Guide is available at [https://www.atanet.org/docs/Getting\\_it\\_right.pdf](https://www.atanet.org/docs/Getting_it_right.pdf).

## **Disability and Language Access Supports**

Since some plans may undertake specific marketing and outreach activities to particular chronic disease/disabilities/ethnic/cultural/language groups, we also recommend that the Departments adopt a secondary requirement to provide language services and effective communication for people with disabilities to any group to which the plan specifically markets. This must be *in addition to* the basic thresholds. This standard would recognize that a plan could not conduct marketing and outreach to enroll LEP members and then fail to provide assistance when those members need additional information.

We also strongly believe that the Departments should require plans and insurers to provide an advisory that the SBC is available in alternative formats for people with low vision or blindness including Braille, large print and audio, by contacting XXX by email, phone, or mail. Additionally, all websites providing information about the SBC must be Section 508 compliant and compatible with assistive products, including screen readers that translate the content of a computer screen into automated audible output and refreshable Braille displays.

For LEP individuals, plans and insurers should be required to provide taglines in at least 15 languages with the SBC. These taglines should inform LEP applicants or enrollees how to access language services. The request for 15 languages is based on existing government practice. The Social Security Administration, through its Multilanguage Gateway <<http://www.ssa.gov/multilanguage/>>, translates many of its documents into 15 languages, and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish <<http://www.cms.gov/EOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>>. For example, some of the forms Medicare will be translating that involve benefit coverage include “Dialysis Facility Compare,” “Medicare’s Nursing Home Compare,” “Medicare’s Home Health Compare,” “Medicare: Getting Started,” “Welcome to Medicare,” and “Get Help With Your Medicare Costs: Getting Started.”<sup>18</sup>

These taglines should be required regardless of whether a translation threshold is met, again to ensure that applicants and enrollees are informed about how to obtain assistance when questions or issues arise. Plans that operate in California are already required to do so. For example, Standard Insurance Company sends an insert with all Coverage of Benefits documentation that includes the following tagline:

---

<sup>18</sup> See CMS, Office of Equal Opportunity and Civil Rights, FY 10 CMS Strategic Language Access Plan Outcome Report, Appendix: Vital Documents/Forms to Translate, available at <https://www.cms.gov/EOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>.



“No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or xxx-xxx-xxxx. For more help, call the CA Department of Insurance at xxx-xxx-xxxx.”

Taglines are an effective and cost-efficient manner of informing LEP individuals of resources available. It will also help plans determine which languages to provide additional materials in. To reduce the costs to plans, the Departments could provide generic translated taglines if plans did not wish to develop their own.

We do want to emphasize, however, that taglines must be accompanied by an English SBC so that individuals have a record of communication and may be able to obtain information from advocates or others about its content. Providing oral information or a tagline is insufficient to meet the requirement of providing applicants and enrollees with SBCs.

We also recommend that the Departments require that, once a consumer has requested materials in another language, all subsequent communications with that consumer should be in that same language. For a variety of reasons, plans should be collecting data on their enrollees' language needs, both to ensure services are available and to provide culturally and linguistically appropriate information. For example, Standard Insurance Company recently sent enrollees a Language Assistance Survey to gather data on enrollees' language needs. Once an LEP enrollee identifies his or her language needs, the plan should track this information and automatically send the enrollee information in that language, rather than be forced to continuously request a translation.

Finally, we strongly believe that, ***regardless of whether a plan is required to provide written translations*** of SBCs, the Department must ensure that oral assistance through competent interpreters or bilingual staff is provided to ***all*** LEP individuals. The current appeals rules only require plans to provide language services when the thresholds are met. We do not believe this satisfies PHSA § 2715, Title VI, or the nondiscrimination provision of the ACA since this would leave millions of LEP individuals without any assistance for their plans when trying to understand information about coverage. Without translations of this information, it is impossible for them to make an educated decision about what plan to choose. It is hard to understand how the statutory requirement in PHSA § 2715 to provide the SBC in a culturally and linguistically appropriate manner is upheld if plans can ignore the most basic communication needs of LEP individuals. In addition, it has been a longstanding recognition under Title VI of the Civil Rights Act of 1964, reiterated with the enactment of the nondiscrimination provision in Section 1557 of the ACA, that oral communication with LEP individuals must be provided to every individual, regardless of whether thresholds to provide written materials are met. Therefore, the same should be required here.

### **Practical Considerations Do Not Weigh Against Language Access**

The appeals rules mention that some commenters cited the “high cost associated with implementing translation requirements pursuant to California State law and the low take-up rates of translated materials in California.” We trust that they would also object to a broader rule pertaining to the SBC. A review of the comments by California health plans to the July 2010 regulations shows that plan cost estimates are exaggerated and up-take estimates are unclear.

## 1. Cost of compliance

California health plans must provide written translations of numerous “vital documents,” including applications; consent forms; letters containing important information regarding eligibility and participation criteria; notices pertaining to the denial, reduction, modification, or termination of services and benefits; an explanation of the right to file a grievance or appeal notices advising LEP enrollees of the availability of free language assistance and other outreach materials; the explanation of benefits (EOB) or similar claim processing information if the document requires a response; and specified portions of the plan’s disclosure forms regarding the principal benefits, coverage, exclusions, limitations, and cost-sharing requirements.<sup>19</sup> With the SBC, we are concerned only with the translation of one double-sided four-page document, a small fraction of what health plans are required to translate under California law. Thus, when health plans refer to the costs associated with the implementation of the California Language Assistance Program, they are referring to a much more comprehensive program that includes costs outside the scope of the SBC or appeals rules. Additionally, the thresholds in the California law are much lower than the IFR – 1 percent for a plan with 300,000-1,000,000 members and .75 percent for a plan with over 1,000,000 members. Thus, California plans have to translate a wider variety of documents into a greater number of languages, and therefore the costs of complying with California’s laws are not a good comparison for complying with a more limited IFR, which is only focused on translation of notices of appeals and external review into fewer languages.

In addition, the costs identified by California plans include implementation costs, which are not ongoing. Similarly, the initial translation of the SBC would be a one-time cost. Also, the costs to California plans likely include implementing tag and track IT systems because they are required to collect language data on enrollees.<sup>20</sup> If California plans also operate in other parts of the country, they will have much lower costs in expanding the use of this software. Finally, in California, the Department of Managed Health Care helped health plans cut costs by translating taglines for them.<sup>21</sup>

## 2. Uptake estimates

When California health plans refer to “low take-up rates” of translated materials, in their comments to the July 2010 regulations, it is unclear which materials they are referring to since they are required to translate the extensive list of “vital documents” referenced above. Also, not all California health plans are complying with the state law language access requirements; a California report shows deficiencies by health plans in advising enrollees of language

---

<sup>19</sup> See California Department of Managed Care, Comment on FR Doc # 2010-18043, Doc. ID No. HHS-OS-2010-0019-0041, Sept. 21, 2010.

<sup>20</sup> The greatest challenge so far has been setting up and reworking existing information technology (IT) systems to support the collection and management of data on members’ primary written and spoken languages.  
<http://www.ahrq.gov/populations/languageservicesbr.pdf>.

<sup>21</sup> California DMHC funded and posted on its public website the translation of a language assistance notice in Spanish, Chinese (traditional), Arabic, Armenian, Khmer, Farsi, Hmong, Korean, Laotian, Russian, Tagalog, and Vietnamese. See California Department of Managed Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at <http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf>.

assistance and includes a list of the number of complaints recorded.<sup>22</sup> There may actually more complaints than those listed in the report since, if a plan is not providing enrollees with the proper notice in their language, they may not know that they can call the HMO helpline to file a complaint.

In contrast, the SBC is only one document and it will be provided to all prospective and current enrollees in a plan. Near-universal take-up is fair to assume because all individuals will be required to enroll in a plan, and the SBC is the most basic and vital document describing the terms of the plan. Thus, even if we were to give credence to the claims of low take-up rates, it is unreasonable to assume that the SBC will be subject to the same problem.

### 3. Translation at the plan's request

Many employers and plan sponsors know that they employ a large number of LEP workers and should be able to request translation of information, including SBCs, by health insurance issuers. If an employer or plan sponsor knows that the number of LEP workers meets the thresholds we recommend (5 percent or 500 LEP individuals in a plan), the health insurance issuer should be required to provide translated notices at the request of the employer or plan sponsor. This would help guarantee that the law's intent to ensure access to the SBC in a culturally and linguistically appropriate manner without adding any additional burden on employers. Most employer and plan sponsors do not have enough market power to negotiate the addition of a new translation practice by an issuer, which is why the translation does not occur now. We expect there are many employers and plan sponsors that want plan enrollees to receive the full benefit that is being paid for, which includes knowledge of the plan's benefits and coverage information.

In conclusion, the SBC is one of the most vital of all documents that will be issued by a plan. To provide anything less than the same language access that is required of other recipients of Federal financial assistance would be to undermine the intent of the ACA's requirement of linguistic and cultural appropriateness, as well as Title VI and Section 1557's promise of non-discrimination. The rule should be amended to bring it into compliance with the HHS Guidance, at the very least.

**RECOMMENDATIONS: Require plans to accurately translate the SBC into any language spoken by 500 or 5 percent off LEP individuals in the plan's service area or an employer's workforce, whichever is less. Require plans to provide oral language services through competent bilingual staff or interpreters for all LEP individuals who have questions about the SBC. Require plans to provide taglines in 15 languages with all SBCs and an advisory that the SBC available in alternative formats for people with low vision or blindness, including Braille, large print and audio.**

### Ensuring Accuracy

The proposed regulations recognize that, as plan coverage documents like summary plan descriptions (SPDs) "have increased in size and complexity—for example, due to the insertion of more legalistic language that is designed to mitigate the employer's risk of

---

<sup>22</sup> California Department of Managed Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at <http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf>.

litigation—they have become more difficult for participants and beneficiaries to understand.” (76 Fed.Reg. 162). It is clear from the provisions of the ACA and the proposed regulations that the Departments understand that the language of SPDs is often too complex for consumers to understand. As the SBC becomes a vital tool for consumers to compare plans and select coverage, consumers should be able to rely on the accuracy of the SBC.

It is critical for state insurance departments, HHS and DOL to establish mechanisms to monitor the accuracy of the SBCs. Given the importance that the Departments acknowledge consumers will place on the SBC, the health insurance issuers and self-funded governmental and non-governmental plans must be accountable to consumers for misrepresentations that conflict with the underlying SPD or certificate of coverage.

State consumer assistance and ombudsman programs, which help consumers understand their coverage options or the terms of their current policy, and provide assistance in solving the complicated problems that can arise in using health insurance coverage, have found that there is no easy or consistent way for consumers to compare benefits, and that consumers struggle to understand their coverage and often find the summary of benefits documents that some plans currently provide to be confusing and misleading. These programs report many instances in which summaries of benefits supplied by a plan have conflicted with an SPD or certificate of coverage. These programs often advocate on behalf of consumers who relied on a summary of benefits document that misstated coverage and in the majority of cases, this advocacy has resulted in the insurer acknowledging the error and honoring the coverage as it was represented. These cases underscore the importance of ensuring that the information provided in the SBC is accurate. Insurers should be held responsible for inaccuracies in the SBC that lead to consumer coverage complaints.

State consumer assistance programs, many of which received grant funding under the ACA in 2010, can also be a resource for monitoring the efficacy of the SBCs. As a condition of ACA grants, all consumer assistance programs are required to collect extensive data on individual consumer cases. We recommend that the Center for Consumer Information and Insurance Oversight (CCIIO) ask consumer assistance programs to report instances where SBCs are helpful, confusing or problematic; and that CCIIO and DOL similarly collect data from their own helplines. This will provide a robust set of data that can be shared with state insurance departments and used to determine improvements that can be made to the SBC to ensure that it achieves the intended goal of providing a complete and accurate description of plan benefits that will enable consumers to make informed decisions in selecting health care coverage.

**RECOMMENDATIONS: State insurance departments should review and approve SBCs, including revisions to SBCs that may be made over time, and establish guidelines for monitoring the accuracy of SBCs and enforcing SBC requirements that are consistent with those used at the federal level by HHS and DOL. As part of evaluating the accuracy of SBCs, we recommend that state insurance departments, HHS, and DOL conduct coordinated and random audits of the information provided in coverage examples on a periodic basis. In addition, we recommend that CCIIO ask consumer assistance**

programs to report instances where SBCs are helpful, confusing or problematic; and that CCIIO and DOL similarly collect data from their own helplines to help identify areas in which improvements can be made to the SBC.

## **New/Modified Disclosures for the SBC**

### **Existing and Proposed Disclosures for 2012**

As a primary document that will be viewed by most consumers enrolling in health coverage, the SBC is well suited to providing key health insurance disclosures to consumers. In addition to the disclosures already included or contemplated for 2014, we recommend a few additional disclosures that could provide great benefit consumers shopping for coverage.

Too many warnings/disclosures, poorly worded or poorly placed, will detract from consumers' ability or willingness to use the SBC form.<sup>23</sup> HHS should carefully test existing and proposed disclosures to assess the critical tradeoff between providing consumers with valuable information and protections, and making the form unappealing.

Beyond the specific plan features, the SBC includes information about using the health plan, such as information on grievances and appeals. There are also statements that are akin to warnings, such as the lead statement reminding consumers that the summary is not their policy.

For warnings to serve the purpose of protecting consumers without making an otherwise helpful document unappealing, consumers must be able to comprehend the warning. It must also be clear how it affects them and whether there is an action they can take to reduce the potential danger to themselves.

The SBC should also include a statement explaining that plans are required under state and federal law to pay out-of-network providers a reasonable rate, and consumers have the right to information on out-of-network rates paid by their plan. States should be able to require modifications to this statement to ensure that it reflects state requirements. For instance, where there are state law requirements, the notice should inform consumers of restrictions on charges of out-of-network providers and/or tell consumers that they should call their state insurance department for further information about restrictions.

### **RECOMMENDATION: Consumer-test the language and best placement for the following new disclosure requirements:**

- **KEEP THIS DOCUMENT WITH YOUR OTHER IMPORTANT PAPERS if you enroll in this health plan.**
- **This plan [is/is NOT] a grandfathered health plan. Grandfathered health plans may meet your needs but under law contain fewer consumer protections than non-grandfathered plans. For a list of differences, see [web address].**
- **Need help comparing your health coverage options? Contact [state's] consumer assistance division at [phone number/website].**
- **Call [state insurance department] for information on the rates paid under this plan to out of network providers and to learn about your rights regarding how much you can be charged by out of network providers.**

<sup>23</sup> See <http://www.bis.gov.uk/files/file44367.pdf> or [http://findarticles.com/p/articles/mi\\_hb3250/is\\_2\\_35/ai\\_n28879116/](http://findarticles.com/p/articles/mi_hb3250/is_2_35/ai_n28879116/)

- **Until pre-existing condition exclusions are banned in 2014, include a statement such as “Your plan [may / may not] exclude coverage of pre-existing conditions.**

**Disclosures planned or recommended for 2014**

In 2014, consumers will face a new obligation to purchase coverage, as well as new opportunities to access coverage at subsidized rates. As already contemplated by this NPRM, the SBC should include the relevant disclosures that help consumers function in this new world.

Coverage that fulfills the individual’s requirement to have “minimum essential” health coverage includes: coverage under a government-sponsored health care program (e.g., Medicaid, Part A of Medicare); an “eligible” employer-sponsored plan; coverage under a plan offered in the individual market; a grandfathered health plan; and other health coverage as recognized by the Secretary of Health and Human Services. It is not explicitly required that this coverage meet a specific actuarial value threshold.

However, the coverage offered by employers with at least 50 full-time-equivalent employees is required to meet certain conditions, or employers may face penalties.<sup>24</sup> For full-time employees and their dependents, employers must provide coverage that covers “essential benefits,” has an actuarial value of at least 60 percent, and has premiums that are less than 9.5 percent of employees’ household incomes.

To help consumers and employers understand whether or not the coverage meets these requirements, the ACA requires the SBC to include *a statement that includes the following elements:*

*(i) Whether the plan or coverage provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986)*

*(ii) Assurance that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs*

**RECOMMENDATION: The detailed recommendations in this section should be effective with the SBCs describing plans that are effective January 1, 2014, although consumer testing of the phrases should occur much earlier.**

**Is the Coverage at or above 60 percent Allowed Costs (60 percent actuarial value)?**

The 60 percent actuarial value threshold is a standard that is widely used by the ACA and one that consumers should become familiar with. Hence, we recommend that this disclosure be required for all plans (non-group, group, grandfathered, non-grandfathered), as envisioned by the ACA.

However, consumer testing indicates that using the phrase, “On average, this plan will pay at least 60 percent of the total allowed costs for the benefits listed in the policy” is NOT

<sup>24</sup> One area of concern is “self-insured” plans offered by small employers. Because these employers have less than 50 full-time-equivalent employees, they aren’t subject to the penalties facing larger employers if their coverage falls below a 60% actuarial value threshold. In reality, however, employers of this size aren’t really self-insured. They actually purchase large “stop gap” insurance policies with low attachment points. Unless HHS or individual states enact rules to prevent it, a small, self-insured firm could offer a plan that doesn’t conform to the rules for qualified coverage.

clear for consumers.<sup>25</sup> Testing found that consumers “skipped over” this information because it appeared to be a required, but unimportant, disclaimer. Also, consumers questioned how it could be of use since it was the same on every plan (also likely to be true in 2014). Consumers also reported that they didn’t understand the phrase. The term “on average” made participants think the percentage paid by the plan was not stable and could vary a great deal. Additionally, they were unfamiliar with the term “allowed cost,” and guessed (incorrectly) that only certain types of treatments would be covered. Finally, many participants overlooked the term “at least.” So, instead of understanding “this plan pays **at least** 60 percent of total allowed costs,” participants would typically read it as “the plan pays 60 percent.” Moreover, as we have commented elsewhere, under the proposed rules, plans with very limited benefits and plans with generous benefits could each be covering 60 percent of allowed costs, and consumers could mistakenly assume that they provide the same value.

These testing results illustrate the value of rigorous consumer testing for warnings and disclaimers in the SBC.

**RECOMMENDATIONS: Consumer test language and placement for the 60 percent disclosure. Disclosure language must reveal the purpose of the disclosure and use terminology that most consumers can understand. Alternate phrases for testing could include: “This plan offers coverage that is at or above federally recommended minimums.” Alternatively, include the phrase “This health plan is below federally recommended minimums. You may want to consider other coverage options.” ONLY when the value is below 60 percent, reflecting the fact that there is no specific action for the consumer to take when a plan is above the 60 percent threshold.**

**Add the plan’s “metal tier” designation, if non-group or small group**

Early consumer testing of the proposed “metal tiers” (Bronze, Silver, Gold, Platinum) shows that these designations are very helpful to consumers, as they quickly convey the relative strength of coverage under their health plan options. This small, but useful consumer aid should be incorporated into the SBC in 2014.

**RECOMMENDATION: Consumer-test language and placement for a metal tier designation (Bronze, Silver, Gold, Platinum) for non-group and small group plans to be displayed on plans that are effective January 1, 2014 or later.**

**Does the premium exceed 9.5 percent of income?**

If a consumer is offered coverage by an employer that does NOT meet the standard for “qualified coverage” (described above), they may have access to subsidized coverage in the Exchange. There is not a ready way for the SBC to indicate whether the premiums exceed 9.5 percent of income for an individual consumer, but the SBC could usefully provide the benchmark income and explain the significance of the income threshold for consumers who are offered group health plans. This disclaimer should appear in the same row as the premium on page one.

---

<sup>25</sup> *Early Consumer Testing of Actuarial Value Concepts*, Kleimann Group and Consumers Union, September 2011. [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org\\_testing\\_actuarial\\_value\\_concepts.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf)

**RECOMMENDATION:** For Large group plans that are effective January 1, 2014 consumer test the following phrase for the premium line in the “Why this Matters” box: If your household income is below [insert an amount that is the employee premium amount/.095], you may be able to get help purchasing coverage in your state’s Exchange. See [website] for details.

## **Additions and Changes to the SBC Template**

### **Facility Fees charged for Office Visits**

Some consumers report that their local hospital acquired many local physician practices and now charges a facility fee for routine office visits. The SBC only includes facility fees for inpatient and outpatient care.

**RECOMMENDATION:** Query insurers and consumer assistance groups as to the prevalence of this type of charge and consider whether a modification to the form is needed.

### **Non-network providers providing care at In-Network Facilities**

A leading complaint heard by consumer assistance programs is that patients were caught off guard when they received large bills from out-of-network providers offering care in an in-network facility. As a common “trap” experienced by consumers, the SBC should take steps to address this. We note that the Insurer Instructions include a requirement that health plans highlight that some out-of-network specialists are often used by in-network providers (instruction 7f). This important warning has not been consumer tested and standard language has not been provided.

**RECOMMENDATIONS:** Consumer test standard language to convey the warning that some out-of-network specialists are often used by in-network providers. Require the use of this standard language by insurers as appropriate in instructions. Provide a new coverage example that includes a mix of in-network and out-of-network providers to illustrate balance billing and the fact that in-network facilities do not work exclusively with in-network doctors. We recommend an in-network ER visit, combined with an out-of-network ER physician, unless consumer testing shows that another example would better meet this need.

## **Coverage Examples**

The NPRM invites comment on a number of issues related to the coverage examples that are to be included in the SBC and possibly online. Consumer testing of the prototype coverage examples found the examples to be extremely valuable to consumers.<sup>26</sup> They provided a sense of how much the plan would pay for certain conditions. This is information that consumers could not calculate on their own. The examples also helped crystallize the

---

<sup>26</sup> See, for example, *Early Consumer Testing of Coverage Facts Labels: A New Way of Comparing Health Insurance*, Kleimann Group and Consumers Union, August 2011. [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A\\_New\\_Way\\_of\\_Comparing\\_Health\\_Insurance.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf)



fundamental concept of insurance for many consumers, who otherwise approached their shopping task as an effort to acquire pre-paid health care. Overall, this was one of the most valuable parts of the SBC form for many consumers.

### **Number of coverage examples**

The Departments requested comment on the development of multiple coverage examples and how such examples might promote or hinder the ability to understand and compare coverage. We recognize the competing interests that the Departments are trying to balance by limiting the coverage examples that health plans would have to provide. Currently, three are required, and a maximum of six will be mandated. In light of their value to consumers, however, we recommend that the Departments require inclusion of six medical scenarios in the SBC beginning immediately in 2012.

### **Selection of coverage examples**

When selecting the treatment scenarios to include, the Departments should choose examples that are relevant to as wide and diverse a population as possible. Specifically, we urge the Departments to take the following factors into account:

- Prevalence of conditions in the population overall.
- Prevalence of conditions in key subpopulations. There should be coverage examples that are relevant to both men and women. At least one example should be for a condition prevalent in children and young adults. There should also be at least one example relevant to family coverage since cost sharing operates significantly differently under family coverage compared to self-only coverage.
- Differences in how health insurance coverage varies for different types of care. Typically health plans apply different coverage rules, limits, and cost sharing for certain types of benefits – hospitalization, outpatient prescription drugs, mental health care, rehab services, etc. Selection of coverage illustrations should show consumers how these coverage differences work under each plan.

### **Phase-in of coverage examples**

As with the SBC overall, the requirement to make coverage examples available to all health care consumers must be implemented in a timely manner. Consumer testing conducted by Consumers Union and by the health insurance industry found that coverage illustrations added significantly to consumers' understanding of health insurance coverage. Further, NAIC relied on private insurers to test the methodology and feasibility of generating coverage illustrations as part of the SBC. We appreciate that it may take some additional time for insurers and third-party-administrators to upgrade computer systems in order to automate the computation of coverage illustrations.

Accordingly, we would support a phased in requirement for this component of the SBC. Specifically, we would agree that in the first year of implementation (2012), group health plans that offer multiple plan options would only be required to include coverage illustrations in the SBCs for the four most popular plans offered. Similarly, for health insurance issuers, the requirement to include coverage illustrations in the SBCs beginning in 2012 would only apply for up to 4 plans – the two most popular plans the issuer sells in each market and two other plans

that the issuer has most recently introduced in each market. Such a phase-in would make it practical for plan sponsors and issuers to manually generate coverage examples during the first year while they implement changes to produce automated coverage examples in subsequent years. And it would assure that people enrolled in the most popular plans – or who may be considering new products that insurers are most interested in selling – would see coverage illustrations in the first year.

### **Insurer vs. Consumer generation of coverage examples**

The proposed rule requests comment on whether plans and issuers might be required only to provide consumers raw information about coverage features that consumers would then use to generate their own coverage illustrations. We would strongly oppose such a change. As noted throughout these comments, consumers already face tremendous barriers to understanding their health insurance coverage today. Consumer testing underscores that the public has difficulty understanding the meaning of basic coverage features, such as deductibles, co-pays, and coinsurance. It would hardly be reasonable to expect consumers to know how to successfully estimate out-of-pocket costs that could result from such features. Asking consumers to take on the burden of generating their own coverage illustrations would be unfair and would mean that few if any consumers would ever be able to obtain this information.

The proposed rule also requests comment on whether plans and issuers should input plan- or policy-specific information into a central web site, such as [www.healthcare.gov](http://www.healthcare.gov), that would then generate coverage examples for each plan or policy. We would also strongly oppose this change. Given the ambitious agenda of implementation activities to be accomplished by 2014 and limited resources appropriated to the federal government, this transfer of responsibilities would be unwise. It would be far easier and more economical for plan sponsors and insurers to develop coverage illustrations for each of the few dozen plans they offer than for the federal government to generate them for tens of thousands of plans.

We do, however, favor requiring plans and issuers to display SBCs, including coverage examples, on [healthcare.gov](http://healthcare.gov) so that the public can readily find and compare this information. Further, we favor requiring the federal government to establish support resources and technical assistance to plans and issuers as they begin to generate SBCs. We note in particular that technical support provided by HHS has been highly effective and made it possible to report and display extensive information about all individual and small group market health insurance plans in a short period of time. We trust that HHS and the DOL will continue to provide this level of technical assistance to health insurance issuers and health plan sponsors so that they can comply with Section 2715 disclosure requirements in a timely and efficient manner.

**RECOMMENDATIONS: Require inclusion of six medical scenarios in the SBC beginning immediately in 2012. The six examples should be chosen for their relevancy to as wide and diverse a population as possible. We further recommend that the Departments closely monitor consumer satisfaction with the coverage examples featured in the SBCs, and, if warranted, consider requiring insurers to generate additional coverage examples that would be made available on the Internet for enrollees or applicants seeking examples for additional conditions. Plans and issuers, not consumers, must be responsible for generating these coverage examples.**

## Additions and Changes to the Glossary of Health Insurance and Medical Terms

Consumer testing<sup>27</sup> found that a number of the definitions contained in the glossary were unclear, often because the definitions used additional terminology that consumers did not understand. For example, the definition of “coinsurance” relied on “allowed amount” that, in turn, referenced “balanced billing,” all terms the respondents did not understand. Some changes were made to the glossary since that research was conducted, but the glossary has not been retested.

**RECOMMENDATION: Conduct additional consumer testing of the glossary (including the new recommended additions below), modifying definitions until they are understandable to the average enrollee. Incorporating more examples of the concepts may help.**

Several consumer testing studies<sup>28</sup> have demonstrated that key terms are missing from the glossary. In addition, many consumers are not familiar with the phrases network, preferred, or participating providers. While very brief descriptions of particular services may suffice for purposes of a general glossary of terms, we also suggest adding a consumer-tested definition of “covered services,” something like “the care, services, treatment, and other measures that your health insurance or plan will pay for or cover. Covered services are defined in the insurance policy.”

**RECOMMENDATION: Add consumer tested definitions for “network,” “preferred,” or “participating providers” (and explain that they are similar in terms of their import for consumers), “covered services,” and the following terms:**

- HMO/Health Maintenance Organization
- PPO/Preferred Provider Organization
- EPO/Exclusive Provider Organization
- Actuarial Value (or corresponding term used on materials)
- Out-of-network provider
- Catastrophic plan
- Cost sharing
- Prescriptions—generic, non-preferred brand, preferred brand
- Prescriptions – retail vs. mail-order
- Medical underwriting
- Prescription drug “tiers”
- Specialty drugs
- Formulary

---

<sup>27</sup> *Early Consumer Testing of New Health Insurance Disclosure Forms*, People Talk Research and Consumers Union, December 2010,

[http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU\\_Consumer\\_Testing\\_Report\\_Dec\\_2010.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU_Consumer_Testing_Report_Dec_2010.pdf)

<sup>28</sup> See, for example, *Early Consumer Testing of Actuarial Value Concepts*, Kleimann Group and Consumers Union, September 2011, [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org\\_testing\\_actuarial\\_value\\_concepts.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf)

### **Definition of “medical necessity”**

In addition, we suggest that the definition of medical necessity be amended. As written, the definition excludes a broad range of individuals who will need health care: those whose needs are the result of conditions such as developmental disabilities and congenital problem. Under the currently proposed definition, individuals will be informed that their insurance policy will cover an individual who needs a prescription or medical equipment due to an injury but it will not cover an individual whose needs result from a physical disability. The exclusion of populations with physical and mental disabilities from the definition of medical necessity ignores the purposes of the Americans with Disabilities Act. As pointed out by Professor Sara Rosenbaum, the proposed medical necessity definition is “the absolute embodiment of the very types of discriminatory practices the Affordable Care Act is intended to stop.”<sup>29</sup> Also, some states have statutory definitions of “medical necessity” that should be substituted in those states. Finally, if plans are not required to use a standard definition for medical necessity under other parts of the ACA, add the phrase: “Ask your plan for more information” in reference to requirements to qualify for services based on medical necessity, since this will matter when consumers appeal a denial of care.

**RECOMMENDATION: To accommodate these concerns, we propose that the definition of medical necessity be amended to add the word “condition” in listing, as follows “... illness, injury, disease, condition, or its symptoms...”. If plans are not required to use a standard definition of medical necessity, add the phrase: “Ask your plan for more information.”**

### **Additions and Changes to the Insurer Instructions**

During the two rounds of consumer testing, insurers populated the SBC templates with real plan designs. This provided valuable testing documents, but also illustrated the profound importance of having complete, unambiguous instructions for populating the SBC. If insurers do *not* adhere to plain language guidelines or do not provide unambiguous responses in the empty boxes of the SBC, the document will not serve its intended purpose, no matter how carefully crafted the template is. As such, the insurer instructions have an enormous impact on consumers’ ability to use the SBC.

**RECOMMENDATION: Augment the insurer instructions, as needed, to reflect the recommended changes described below.**

Regarding instructions used to implement *existing* features of the SBC:

#### **Requirements to provide/deliver the form (page 1)**

We must anticipate that requirements to provide the form will be interpreted as narrowly as possible. We recommend strengthening this section as follows:

- In the first paragraph of this section it says the form must be provided “to an applicant, to the Policyholder, and to the policyholder at renewal.” In (a) of this section it talks about when the insurer or agent meets with a “potential applicant.” In the General Instructions

---

<sup>29</sup> Sara Rosenbaum, ‘Medical Necessity’ Definition Threatens Coverage for People with Disabilities, Health Affairs Blog (Sept. 16, 2011 @ 9:13am), at <http://healthaffairs.org/blog>.

section under the subsection labeled “(1) What is the Premium,” it talks about how a carrier should fill out the form in the case of a consumer shopping for plans who has yet to fill out an application. These are critical distinctions. If the first directive is the one that applies, then carriers will define “applicant” very narrowly and will say they don’t have to supply the form until someone actually starts filling out--or perhaps even finishes but hasn’t submitted--an application.

**RECOMMENDATION: Define, at the beginning of the instructions, the phrase “enrollees and potential applicants” as those enrolled in coverage as well as those shopping for coverage. Use this phrase throughout the document. Moreover, clarify when in the process of applying an applicant must be given the form and at what point the form can include an estimated versus the actual premium cost. The questions raised below should be addressed before final instructions are issued.**

- This section, also under (a), gives options for what happens when an insurance representative meets in person with the potential applicant. It is not clear exactly at what point the form has to be supplied. Can the requirement to supply the form be met by: supplying it to the consumer only after he/she has decided what plan to apply for (relying up until that point on the insurer’s glossy materials), but not when simply shopping for insurance; when the person actually starts filling out an application; after the application is filled out but before it is submitted; or after it is submitted but before the policy is issued?
- On a related note, (a) allows for various ways for an insurance rep to get a copy of the form to the potential applicant. But the start and end dates and their relation to actual submission of an application are unclear. For example, it says an electronic copy delivered to an email address provided by the individual is an acceptable means of delivery. But within what timeframe must it be delivered? If the applicant has a lot of health problems, could the insurer take a week or two to do this? The same question exists for hand delivery.
- Subsection (b) discusses electronic applications. It says the insurer must make the form available on the electronic site. But at what point in the process? **We recommend that the instructions be augmented to require this to be the first step in the process.** It also says the insurer must require the applicant to acknowledge receipt of the form as a necessary step to completing the initial application process. We do not want the experience to mimic what happens when you order tickets online: you’re on your sixth screen of answering questions and submitting things like credit card information, and then it says click this box to indicate you’ve read the terms and conditions. You’ll just go ahead and click it without really reading the statement.
- Subsection (c) has the same problems as noted above with respect to subsection (a).
- Subsection (e) discusses what happens at renewal. It says that the form has to be provided along with renewal documents. **We recommend defining “renewal documents.”** Will the consumer get the form before he/she signs renewal papers or when his/her renewal is confirmed?

Consumer assistance programs report that losing or misplacing insurance forms is actually quite common.

**RECOMMENDATION: Add language that makes it clear that policy or certificate holders can request a copy of the SBC at no charge if they lose their original copy.**

**General Instruction, (pages 2-3)**

**RECOMMENDATIONS:**

- 1st bullet. If this form will ever be completed (or partially completed) by an agent, the first line should direct insurers or representatives of insurers to fill out the form accurately and in good faith.
- 4th bullet. Based on the rest of the content in the general instructions section and the instructions for completing the important questions chart, this information on listing in-network and out-of-network data belongs in the instructions for the important questions chart. To be consistent with many of the instructions in the important questions section, this information should be repeated for each applicable row in the important questions section (What is the overall deductible? Are there other deductibles for specific services? Is there an out-of-pocket limit on my expenses? And other applicable questions). Also, on instructions page 9, 2b, we see for the first time a note to insurers that consumer testing shows consumers understand the terms in-network and out-of-network better. This important information should be included in each section where insurers are granted flexibility to use the plan's terminology.
- Bullet 5, bottom of page 2. The directions say all the items on page 1 must always appear on page 1, the chart rows on page 2 may extend to page 3 if space requires, and the chart rows on 4 may appear on page 4. Many things could make these sections longer and instructions should account for this eventuality (i.e. an insurer may not be able to meet the formatting, font, and description of benefits requirements in the space provided). However, consumer testing shows that consumers want to be able to line up the forms so they can comparison shop. **During redesign, perhaps allow more room at the bottom of each section so there is some flexibility in length without losing the convenience of being able to line up the pages of two different health plans. Consumer testing should be used to determine the best balance.**
- Second bullet on page 3. Insurers are directed to “use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual.” **We recommend more precision. Consistent with the discussion above, HHS should define “plain language,” “culturally and linguistically appropriate,” and “understandable by the average individual.” In the spirit of this requirement, we recommend striking “utilize” and replacing with “use”.**
- Consider using lower case letters, instead of bullets, so that it is easier to reference and modify this section.

**Important questions chart (pages 4-8):**

**RECOMMENDATIONS:**

- Under ‘(1) What Is The Premium?’ **precisely define the term “base premium.”** It needs to be absolutely clear to the carrier filling out the form what this means and how a carrier arrives at this figure so that all carriers do it the same way.
- 2h (page 5): **Provide an example of how policy period information (instruction 2.b) and individual/family deductible details are to be combined.** For example:

Individual: \$2,000 for calendar year

Family: \$4,000 for calendar year.

A second example may need to be used to show in-network and out-of-network amounts, in addition to period information and individual family designations. Additional consumer testing may be needed to find a method that is understandable to consumers.

- 3g (page 6): The language provided -- “because you don’t have to meet deductibles for specific services, this plan starts to cover costs sooner” -- won’t always be true. If a plan has a \$2,500 overall deductible, but only a \$300 pharmacy deductible, a person who only gets prescription medicine in the policy year will have their Rx coverage start much sooner (after only \$300) with a separate Rx deductible than they would if the Rx coverage was under the overall deductible of \$2,500. **Replace this phrase with a more accurate phrase. Perhaps something like: “After you meet this deductible, your plan will begin to pay for covered services.”**
- 4c (page 6): This subsection says what to do if there are other types of annual limits, such as annual or plan limits on visits, etc. If applicable, the carrier is supposed to add on the second line, “Other limits apply—see the chart that starts on Page 2.” The generic use of the term “limits” is confusing, as these are two different types of limits: a limit on my out-of-pocket expenses (a good thing) and a limit on what the plan will pay for certain services (a bad thing). **Recommendation: clarify what type of limit, using a phrase that has been tested with consumers such as benefit limit.**
- **On page 7, add to instructions 6b and 6c the instruction “Do not respond with a one-word answer.”**
- 7c (page 8): The instructions here grant insurers flexibility to use either the terms preferred/non-preferred or in-/out-of-network providers. 7c provides instructions for just the Answers column. **The instructions should clarify whether insurers can alter the relevant text in the Important Questions column (Does this plan use a network of preferred providers?) and Why This Matters column. We recommend that the same method of referring to in/out-of-network providers be used throughout the document. We also strongly recommend that the terms most easily understood by consumers (in/out) be used whenever possible.**
- 7d (page 8): For consumers to accurately be able to assess the network, they must be told the *name* of the network to search under when accessing the insurer’s website (or phone number). Often insurer websites display several different networks, and the consumer must select the applicable network when running a search to get the correct list of preferred providers for their policy. Also, this section should require plans to indicate what percentage of the providers in-network speak languages other than English, broken down by language. (ex: 50% of providers speak Spanish, etc.) The website they are referred to should allow consumers to sort providers by language.
- 7e (page 8): **This instruction should be written as a complete sentence and should provide the exact language or example language that can be used to satisfy the requirement in 7e**, so that language is as consistent as possible across different SBCs. The instructions could provide a list as in 5b of what must be included, and what may be included, if applicable.
- 7f (page 8): **This instruction should provide the exact language or example language that can be used to satisfy the requirement in 7f**, so that language is as consistent as possible across different SBCs. This should be made clearer and bolded or otherwise highlighted. Many consumers are surprised by an out-of-network bill from a

provider working at an in-network facility. This is a huge problem, especially for people with EPO plans who do not pay anything at all for in-network care.

We note: Including all of the information required in the instructions will take up much more room than is available in the space provided. We recommend consumer testing to identify the standard phrases that are understandable to the average consumer.

This subsection says plans “should highlight that some out-of-network specialists are often used by in-network providers (e.g., anesthesiologists).” It is not true in certain states, like Colorado, that enrollees will be charged more in this case. Colorado has a law that says all care provided at an in-network facility is considered in-network.

**Perhaps the general instructions could say, “This is how you are to answer the questions unless it would conflict with state law,” and then give an example like Colorado.**

- 7g (page 8): **Delete the phrase: “Plans use the term in-network, preferred, or participating for providers in their network.”** 7c instructs insurers to use the plan’s language when differentiating between in- and out-of-network providers. If the insurer does as instructed and customizes the entire form to use plan’s terminology, this phrase should not require terms not used by the plan. Insurers should use just the applicable term in the list of three provided (in-network, preferred, or participating) so that the same single term is used consistently throughout the document. The glossary should explain that the terms are interchangeable.
- 7h (page 8): The instructions say that if the plan doesn’t use a network of providers, then under “Why This Matters,” the carriers should write in, “Your costs are the same no matter which providers you see.” This is confusing as, of course, the providers you see may well affect your costs, particularly where there is co-insurance. This statement only makes sense if you make it clear that this is as opposed to plans that have in- and out-of-network providers. **Consumer test a clearer phrase, perhaps a sentence that reads “Since this plan does not have preferred and non-preferred providers, the providers you choose won’t affect your cost-sharing provisions.”**
- Question 8 (page 8): **As in other sections, 8 should provide the exact language that should be included in the answers column with either a yes or no answer. It should also remind insurers not to use a one word answer.**
- 8b and 8c (page 8): **Like other similar sections, these sections should provide exact language or example language to use, to help ensure consistency across SBCs.**
- 9a (page 8): **This appears to be the only section in the chart where insurers are instructed to provide a one-word yes or no answer. We recommend making this response a little more useful by making the ‘yes’ answer read “Yes. See page 4.” (or page 3 as appropriate).**
- 9b (pages 8-9): **There should be an instruction for insurers that don’t have excluded services OR additional covered services. The current instruction won’t work if the “other covered services” box on page 4 is empty.**
- 9c (page 9): **The current instruction isn’t really an explanation of “why this matters.” Consider instead: Excluded services are services you must pay for. See page 4 for a list of some excluded services.”**



**“Covered Services, Cost Sharing, Limitations and Exceptions” (page 9)**

**RECOMMENDATION:** Guidance regarding the “Information Box” and the fourth sub-bullet in that box says that for non-networked plans, insert “The providers you choose won’t affect your costs.” As discussed in 7h above, this is misleading and a new phrase should be developed and consumer tested.

**“Chart starting on page 2” (page 10)**

Under “(2) Your Cost columns” in (e)(2) of this section, the example doesn’t fit. This section is all about inserting co-insurance and co-payment amounts. The example given is, “Yes, \$5,000 deductible for prescription drugs and \$2,000 for physical therapy.”

In some cases, limitations are based on other factors – for example, a plan might only cover home care in conjunction with a skilled service; or a plan may only cover treatment of severe mental health conditions. The instructions should require insurers to provide information about this type of limit in addition to the explanation of other types of limits included in the proposed template.

**RECOMMENDATION:** Provide a new example. Clarify other types of limitations that must be described.

**“Your Rights to Continue Coverage and Your Grievance and Appeals Rights” (Page 13)**

The second sentence of the grievance bullet on the example SBC does not read correctly: “You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance.”

**RECOMMENDATION:** Consider whether the “or” should be an “over” or if the words “to protest a” should be included before “denial”.

It appears the grievance bullet directs consumers to call the insurer to file a written complaint, and the appeal section directs the consumer to call the office of health insurance customer assistance, but the instructions do not provide direction.

**RECOMMENDATION:** The instructions need to spell out how to correctly populate these two bullets with the contact information for different entities. The instructions need to direct an insurer how to adapt the text in the appeals line (need wording other than “state office of health insurance customer assistance”) and what contact information to fill in if a state does not have an office of health insurance customer assistance that helps consumers with appeals. Should consumers in states without customer assistance offices that help with appeals be directed to the state insurance department or to HHS?

**“Coverage Facts” (pages 13-15)**

**RECOMMENDATION:** Following the fourth paragraph, include these additional instructions:

- Patient costs do not include premiums
- Patient’s condition is not an excluded pre-existing condition

- All services and treatments start and end in the same policy period
- There are no other medical expenses for any member covered under the plan; out-of-pocket expenses are based only on treating the condition in the example
- The patient receives all care from in-network providers

There are no instructions related to the questions and answers about coverage examples. Insurers may only need to know that they should use the text, font, graphics, and colors provided in the example SBCB exactly, which is covered in the general instructions. It probably makes sense to at least acknowledge this section in the instructions and direct its placement on page 6, or on the back of the coverage example illustrations.

### **Group Instructions**

**RECOMMENDATION:** The proposed instructions for group plans would allow the plan to provide the SBC to the employer rather than the employees. We believe it is essential that the SBC reach each covered employee, and the instructions should be modified accordingly.

### **Improving the SBC over Time**

Even with additional consumer testing, consumers' ability to use the SBC and the glossary will not be fully revealed until the form is in widespread circulation. The Departments should anticipate that additional problems will be identified.

**RECOMMENDATIONS:** Establish a mechanism whereby problems and proposed improvements can be funneled to a central clearing house operated by HHS. Establish a process for annual review and improvement of the form, allowing input from consumer, provider, and insurer stakeholders. Conduct periodic consumer testing, including with non-English speaking and hard-to-reach populations, to monitor consumers' ability to use the form.