Department of Health and Human Services
File Code CMS-9982-P
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Comments – File Code CMS-9982-P
Proposed Interim Final Rule
Regarding Summary of Benefits and Coverage and the Uniform Glossary

This document provides comments to the proposed Interim Final Rule published in the Federal Register / Vol. 76, No. 162 / Monday, August 22, 2011 / Proposed Rules regarding the Summary of Benefits and Coverage and the Uniform Glossary ("SBC Document") being considered to meet requirements of Section 2715 of the PHS Act, added by the Affordable Care Act.

These comments were prepared from the perspective of three affiliated small size insurance carriers (herein referred to as the "carriers") that have operated and have existing business *primarily in the individual market* in most states across the country. We offer the following information regarding the background and product offerings of the carriers, as we believe it is relevant as you consider the impact of the SBC Document on carriers in terms of cost and feasibility of implementation. We believe our carriers are not unique in this situation.

Background

The carriers combined have approximately 106,000 health benefit plans ("plans") in force across the country today, mostly in the individual market. The carriers have closed their blocks of health benefit plans in all but five states. About 95% of the existing health benefit plans are grandfathered health benefit plans, many of which have not been offered for new sales in a number of years. A majority of the plans are basic hospital-surgical medical type plans (what we refer to as "scheduled benefit" plans) that are not excepted insurance plans under HIPAA and, therefore, are subject to PPACA reforms. The carriers have very few plans that are major medical type insurance plans.

The plans issued by the carriers offered many coverage choices for customers so that they could tailor a plan around their needs and budget. A typical scheduled benefit plan included options such as the following:

Base Plan – Options Selected by Customer:

Deductible options: (per period of confinement)	$1,000	$2,000	$3,000	$4,000	$5,000			
Hospital room and board (daily benefit limit options)	$300	$400	$500	$600	$700	$800	$900	$1,000
Hospital miscellaneous / Outpatient surgery facility (subject to coinsurance; per period of confinement limit)	$15,000/ $ 9,000	$20,000/ $12,000	$25,000/ $15,000	$30,000/ $18,000	$35,000/ $21,000	$40,000 $24,000		

Surgeon benefit – Inpatient/ Outpatient (subject to coinsurance; per period of confinement limit)	$5,000/ $3,000	$10,000/ $ 6,000	$15,000/ $ 9,000	$20,000/ $12,000	$25,000/ $15,000

Optional Benefit Riders (subject to separate cost sharing from base plan):

Ambulatory care benefits (for outpatient x-rays; lab; therapies)	Deductible Options Coinsurance Options Maximum Benefit	$500 or $1,000 (calendar year) 80% or 50% $500, $1,000 or $2,000 (per day)
Outpatient accident benefits	Deductible Options Maximum Benefit	$0, $50 or $100 (per injury) $600, $1,200 or $1,800 (per injury)
Physician's office visit benefits	Subject to copayment and maximum benefit Two options for benefits	
Chemotherapy & radiation therapy benefits	Subject to coinsurance & maximum daily benefit	
Accumulated covered expense benefits	Provides 100% coverage for covered expenses during a period of confinement after accumulated covered expenses reach a set amount – Two options for benefits	
Air ambulance benefits	Subject to a maximum per trip, plus additional benefit per mile, up to calendar year maximum	
Continued care benefits (skilled nursing; home health care; hospice care; private duty nurse)	Subject to daily maximum and maximum numbers of days / visits	
Emergency room benefits	Subject to copay, coinsurance and maximum benefit per visit	
Wellness benefits	Subject to copay and maximum benefit per calendar year	
Prescription drug coverage	Two plan options – subject to deductible and benefit maximum per calendar year	

Customers had the choice of selecting the options described above for their base plan and any optional benefits they wished to include in their coverage. This could potentially result in up to thousands of different plan options that could have been selected by our customers. The above plan representation is just for one health benefit plan. Over the years, the carriers have offered (or assumed) at least 426 different generic base plans (not including state variations) with and 1,679 different optional benefit riders (again, not including state variations), which would have been structured in a similar format with respect to coverage options available to our customers.

In addition, the health benefit plans differ by state based upon the mandated benefit requirements of the state. For example, coverage for mental illness was not typically a covered benefit under the generic version of the health benefit plan; however, many states have adopted a mandated benefit that requires coverage for mental illness. As a result, this benefit differs state-to-state.

The end result is that there are potentially tens of thousands of different plan combinations that cover our in force population today. The number of variations of the SBC that would need to be created to accommodate each insured's choice of benefits would be overwhelming (and virtually impossible) for a small carrier to produce.

As we look at the structure of most of our in force health benefit plans and the proposed SBC document and Glossary, we have the following concerns with being able to meet compliance requirements:

- ***Number of required versions of the SBC.*** Literally every member will need to be provided with an SBC designed specifically for their health benefit plan to take into account the variations in deductibles, internal plan options and optional benefit riders as well as mandated benefit requirements applicable to their specific plan. In addition, the SBC is customized to include the member's premium amount. We have estimated that it would initially take at least 30,700 hours to complete the development and programming efforts in order to provide the SBC in its current template format, at a cost in excess of $2,000,000. Additional time and expense would be required for quality control initiatives, mailing, maintaining copies in our files, increased calls to our Customer Care Center, and annual revision and distribution of the SBC, just to name a few. Much of the information required in the SBC template is not systematically captured in our computer system and, therefore, would require a manual process to incorporate into the tens of thousands of SBCs.

- ***The template design does not support health benefit plans that are not traditional major medical / PPO plans.*** For example:

  - **The "Important Questions" section** includes the following:

    - **What is the Premium?** The instructions for the template do not allow flexibility to state that the premium amount reflects the base plan premium, plus any additional premium that is included due to the selection of optional benefit riders. The date a member's premium changes may not coincide with the annual mail time of the SBC. It is not clear if carriers are required to send an updated SBC to a consumer upon the change in premium. This could require that consumers receive an SBC more than once per year (again significantly adding to the cost to produce the SBC).

    - **"What is the overall deductible?"** – Most health benefit plans in force do not include a calendar year deductible, but instead include a deductible "per sickness or injury," "per period of confinement" "per period of treatment," or "per admission" with a limit on the number of deductibles that may be taken each year. The instructions do not allow for a deductible that applies on a basis other than annually (per calendar year or policy year). Using the required descriptions is misleading to consumers and will not portray such plans in an accurate manner for comparison purposes.

- **"Are there other deductibles for specific services?"** – The optional benefit riders attached to base health plans typically include their own deductibles, copayment and/or coinsurance. These deductibles will vary based upon the member's choice of benefits. The instructions do not provide flexibility to state that there may be other deductibles based on whether or not optional benefit riders are purchased.

- **"Is there an Overall Annual Limit on What the Insurer Pays?"** – The template and instructions only contemplate annual limits. They do not allow flexibility for plans that pay benefits on a "per confinement" or "per injury or sickness" or similar basis. In some plans, the limits are not annual limits, nor do the plans provide unlimited benefits and, therefore, to answer "Yes" or "No" and the allowed descriptions for those answers would force the insurer to be misleading in its description of the plan.

- **The "Common Medical Event" section** – The template and instructions do not allow for flexibility to note that certain benefits may only be available if an optional benefit rider was selected by the insured with payment of additional premium.

- **The "Coverage Examples" section** – The template includes claims examples that represent how benefits for certain medical conditions would be paid under a plan. We have provided detailed information above about plan options that were available under the majority of our plans. In light of these plan options, it would be necessary for us to calculate claims examples specific to an individual's plan in order to provide an accurate representation of coverage for the medical conditions described in the template examples. This would again be a manual process for us, as our claims system is not set up to provide claims examples in the format of the template.

- **The "Uniform Glossary" section** – This section of the template includes definitions that do not align with the definitions used in the majority of our plans. For example, the definition of "Deductible" does not contemplate deductibles that may apply to periods other than a calendar year or policy period basis (such as "period of confinement" deductibles), nor separate deductibles that apply under optional benefits riders. The template also defines "Out-of-Pocket Limit." The scheduled benefit plans typically do not include an "Out-of-Pocket Limit" that would apply to covered expenses. Page 4 of the Glossary that shows how cost-sharing would apply does not align with the application of cost sharing to the scheduled benefit plans that are not traditional medical major type plans.

- ***Risk of Customer Confusion***

The carriers are concerned with providing their customers with a SBC document that varies so drastically from the terms of their plan. It will be extremely difficult to line up the benefits, limitations, exclusions, definitions and other terms and conditions of the existing plans with the SBC template. This will lead to significant customer confusion and increased customer inquiries. As a small insurance company, this could potentially require us to double our customer care staff in order to manage our customer inquiries.

Please also consider that for carriers in the individual market, most states' laws already require a carrier to provide an outline of coverage document when a policy is issued that provides a brief outline of the benefits under the policy. The outline of coverage is general in nature for the policy form, and is not specific in nature to the individual. Individual market

carriers will potentially be looking at issuing three different documents to an individual – the actual policy form, and outline of coverage and an SBC – all provided to advise the individual of her / her coverage. In addition, customers are provided with a product brochure at the point of sale that describes the benefits, exclusions, limitations and other terms of coverage. The customer will be provided with duplicative and somewhat conflicting information as you look at all of the sources of policy information being provided to a customer and consider that the SBC document does not align with the other policy documents.

- ***Risk of Litigation***

  As indicated above, the SBC template does not allow us to accurately or effectively communicate the benefits, limitations, exclusions, definitions and other terms and conditions of the existing plans. The carriers will be subject to complaints and litigation to the extent that differences between the policy form and SBC create ambiguity or misunderstanding by our customers of their coverage.

- ***Time to Implement***

  We understand that the intent of the underlying PPACA legislation was for the SBC document to be available as of March 2012 which is just around the corner. As indicated above, we have estimated about 30,700 hours initially for development and implementation of the SBC document. This would require us to have at least 15 employees dedicated full time for a year in order to implement the SBC. Given other priorities under PPACA and other federal requirements (such as MRL rebates due in 2012; administrative simplification initiatives, etc.) this is simply not feasible.

  The above estimates do not include the resources that will be required to maintain and provide updated SBCs as we go forward.

Recommendations

The carriers would like to recommend the following for consideration by HHS as ways in which implementation of SBC requirements could be achievable by small carriers in a situation similar to ours:

- Limit requirements to provide an SBC document in line with the template to *non-grandfathered major medical policies that are currently being offered by carriers*. This is consistent with the plan types that exist on the federal Plan Finder Portal and would allow consumers to truly compare like plans. As an alternative for carriers with closed blocks of grandfathered and non-grandfathered business, consider a requirement to provide a simplified SBC document (perhaps consistent with a plan's generic schedule of benefits or an outline of coverage document in line with the NAIC Model that individual market carriers may already have available) upon request by a customer. At a high level, carriers could advise customers that their basic plan does not compare to a major medical plan. This would ensure that customers are able to obtain information about their plan to help with comparison against other plans if they are searching for other coverage, without the burden and resource expenditure to carriers to provide an SBC document that may never even be needed by a consumer.

- Extend the time frame for compliance beyond March 2012. Section 2715 required the standards for the SBC to be developed within 12 months of the enactment of PPACA with the implementation of the standards no later than 24 months after the enactment of PPACA. This time frame would have allowed carriers 12 months for implementation after the development of the standards. In keeping with the spirit of the law, we would like to request that the implementation date for the SBC be delayed until at least 12 months after the final determination of the standards.

We appreciate HHS's consideration of our comments. While we believe it is an admirable goal to proactively provide consumers with the detailed information that the HHS proposed rule suggests, we also must be mindful of the cost of compliance and ability to achieve such initiatives. We believe revising the proposed rule in line with our comments above will still provide consumers with access to meaningful information they need regarding their insurance plans, but in a manner that can be achieved by small carriers.