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Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

Family Voices-NJ Comments on the Summary of Benefits and Coverage and the Uniform Glossary-submitted September 6, 2011

Thank you for the opportunity to comment on the Summary of Benefits and Coverage and the Uniform Glossary. Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to “keep families at the center of children’s healthcare.” Our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ’s federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and chapter of the Federation of Families for Children’s Mental Health.

I. Background

In general, we were pleased to see that “ ‘group health plan’ includes both insured and self-insured group health plans”. We understand that “State laws that with stricter health insurance issuer requirements than those imposed by the PHS Act will not be superseded by those provisions...”

II. Overview of the Proposed Regulations

A. Summary of Benefits and Coverage

1. In General

We understand that the summary of benefits and coverage (SBC) were done in consultation with the National Association of Insurance Commissioners (NAIC). We also understand that the proposed template and uniform glossary were developed by the NAIC workgroup but appreciate that the flexibility in that the “Departments recognize that changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the disclosures recommended by the NAIC”. We agree that there may be duplication if the plans already provide a Summary Plan Description (SPD) but want to ensure that consumers have ready access to the complete information under #2 below.

2. Providing the SBC

a. Provision of the SBC Automatically by an Issuer to a Plan

We agree that “If the information in the SBC changes between the time of application, when the coverage is offered, and when a policy is issued..., the proposal would require that an updated SBC be provided. If the information is unchanged, the SBC does not need to be provided again, except upon request”. We understand that “The Departments recognize that often the only change to the SBC is a final premium quote (usually in the individual health insurance market or the small group market)” and is requesting comments on if only the premium information can be provided, rather than the entire SBC. We think that is feasible but only if the information is prominently displayed and understandable to consumers.

b. Provision of the SBC Automatically by a Plan or Issuer to Participants and Beneficiaries

We agree that this information must be provided “with each benefit package offered” and that “If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage”.

c. Provision of the SBC Upon Request

We agree that this must be made available to both participants and beneficiaries.

d. Special Rules To Prevent Unnecessary Duplication With Respect to Group Health Coverage

We support avoiding duplication as long as both the “timing and content requirements are satisfied”, avoiding duplication at the same address, and providing only the SBC for the chosen benefit package unless the participant is eligible for another plan and requests that SBC.

e. Provision of the SBC by an Issuer Offering Individual Market Coverage

We agree with the Secretary setting standards for providing SBCs in the individual market comparable to the group market.

3. Content

We agree with the provision of:

“a. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage”. Terminology must be standardized and understandable to consumers.

“b. A description of the coverage, including cost sharing, for each category of benefits identified by the Departments”. Consumers must be aware of possible costs to be incurred.

“c. The exceptions, reductions, and limitations on coverage”. Consumers must know how their benefits might be reduced.

“d. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations” Again, participants must be aware of possible costs.

“e. The renewability and continuation of coverage provisions”. Consumers need to know how to keep coverage.

“f. A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines”. This will aid consumers in understanding the plan provisions.

“g. A statement about whether the plan provides minimum essential coverage as defined under section 5000A(f) of the Code, and whether the plan’s or coverage’s share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements”. This is important for consumers to clarify which benefits are covered.

“h. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage”. This must be explained fully to consumers, especially if there are disclaimers or other exemptions in coverage.

“i. A contact number to call with questions and an Internet Web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained”. This must be clear to consumers. There can’t be an automated menu, extraordinary wait times, or voicemails left unanswered. Also, there must be a direct link provided, not just the main URL.

Further, we agree with the NAIC additional elements of an Internet link listing network providers, formularies if applicable, uniform glossary, and premiums; all of these again with a direct link, not the main URL. Also we agree that there should be the option of a paper copy of not just the glossary but all of the above. We understand the NAIC tried to develop a consumer friendly glossary as well as how it may apply to different plans. We also understand that the essential coverage statement won’t be included until 1/1/14 under the ACA. We agree that using the term “coverage examples” would be more

understandable than the statutory language “coverage fact labels”. We do think that “multiple coverage examples might...hinder the ability to understand and compare terms of coverage”.

4. Appearance

We support the statute that the “SBC is to be presented in a uniform format, utilizing terminology understandable by the average plan enrollee, that does not exceed four pages in length, and does not include print smaller than 12-point font”. We also agree with the NAIC interpretation that the “four-page limitation as four double sided pages”.

We fully support the NAIC recommendation that the insurer “will provide the SBC as a stand-alone document”.

5. Form and Manner

a. Group Health Plan Coverage

We agree that the SBC must be “readily accessible” which we define as prominently displayed, direct links on the website including accessibility for people with disabilities, live telephone contact, free paper copies, and in languages other than English.

b. Individual Health Insurance Coverage

We feel that the same requirements as above must be included under individual plans as well.

5. Language

As stated above, we strongly agree that the SBC must be provided in a “culturally and linguistically appropriate” manner. This means that SBCs must be available in languages other than English. This would also include Internet accessibility for people with disabilities. Further “linguistically appropriate” must take into consideration health literacy which is the single largest barrier to healthcare access.

B. Notice of Modifications

We agree that this must be done “no later than 60 days prior to the date on which such change will become effective”. We also agree that this would include “any modification to the coverage offered under a plan...that, independently, or in conjunction with other ...changes, would be considered by an average plan participant to be an important change in covered benefits”. We also agree that “material modification” would also include “changes ...that reduce or eliminate benefits, increase premiums and cost-sharing, or impose a new referral requirement”.

C. Uniform Glossary

We agree that this must at minimum include definitions for “coinsurance, co-payment, deductible, excluded services, grievance and appeals, non-preferred provider, out-of-network co-payments, out-of-pocket limit, preferred provider, premium, and UCR (usual, customary and reasonable) fees”. We concur with the NAIC recommendation to add “allowed amount, balance billing, complications of pregnancy, emergency medical condition, emergency services, habilitation services, health insurance, in-network co-insurance, in-network copayment, medically necessary, network, out-of-network co-insurance, plan, preauthorization, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, specialist, and urgent care”. We also agree with the definitions of medical terms “durable medical equipment, emergency medical transportation, emergency room care, home health care, hospice services, hospital outpatient care, hospitalization, physician services, prescription drug coverage, rehabilitation services, and skilled nursing care”. We would also suggest the addition of coordination of benefits, adjusted amount, in-network out-of-pocket, out-of-network out-of-pocket, formulary, preexisting condition, exclusion period, denial, internal appeal, external appeal, self-funded/self-insured/ERISA, IURO (independent utilization review organization), state health benefits commission, ambulatory care, speech/occupational/physical therapy, intermediate care/nursing facility, prosthetics, personal care assistance, medical daycare, and consumer-directed care.

D. Preemption

We agree that the regulations “would not prevent States from imposing separate, additional disclosure requirements on health insurance issuers”.

E. Failure To Provide

We agree that insurers that “willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure”. We also agree that “a separate fine may be imposed for each individual or entity for whom there is a failure to provide an SBC”.

1. Department of HHS

We support the addition of the possibility “If the Secretary enforces, the statute provides for penalties of up to \$100 per day for each affected individual”.

2. Departments of Labor and the Treasury

a. Department of Labor

We understand that DOL “will issue separate regulations in the future describing the procedures for assessment of the civil fine”.

b. Department of the Treasury

We support the imposition of “The excise tax is generally \$100 per day per individual for each day that the plan fails to comply.” Although the amounts above may seem punitive, it may act as a deterrent for plans to purposefully not provide information to individuals who require complex care.

F. Applicability

We strongly support the need to “provide an SBC ‘prior to any enrollment restriction’ applies not later than 24 months after the date of enactment”.

III. Economic Impact and Paperwork Burden

A. Executive Orders 12866 and 13563—Department of Labor and Department of Health and Human Services

We agree that this “ would not have economic impacts of \$100 million or more in any one year or otherwise meet the definition of an ‘economically significant rule’ “.

1. Current Regulatory Framework

We understand that currently there are different standards for group and individual plans, ERISA, and state plans. We support states that have minimum standards for disclosure but recognize that “even within such States, consumer disclosures vary widely with respect to their required content”.

2. Need for Regulatory Action

We strongly support the requirement to “ensure that plans... provide benefits and coverage information in a more uniform format that helps consumers to better understand their coverage and better compare coverage options”.

3. Summary of Impacts

We agree with the Departments “estimate that the annualized cost may be around \$50 million”.

4. Benefits

We agree that “The direct benefits of these proposed regulations come from improved information, which will enable consumers to better understand the coverage they have and allow consumers choosing coverage to more easily compare options”. This will result in “greater transparency in pricing and benefits information will allow consumers to make more informed purchasing decisions, resulting in cost-savings”. It may reduce bankruptcies of which 62% are estimated due to medical debt, if consumers know beforehand what is covered on their policies.

5. Costs

We agree with the Departments estimated costs presented in the various tables.

6. Regulatory Alternatives

We agree with reducing costs by allowing “issuers offering health insurance coverage in connection with the individual market that make information for their standard policies available on the Secretary of HHS’s

Web portal HealthCare.gov)". As stated above, we also agreed to avoid duplication for members residing at the same address. We also agreed as mentioned previously, with the definition of "material modification".

B. Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

We agree with the Departments' determination that these regulations "will not have a significant economic impact on a substantial number of small entities, and that a regulatory flexibility analysis is not required".

C. Special Analyses—Department of the Treasury

We agree with the Department's determination that "this notice of proposed rulemaking is not a significant regulatory action".

D. Unfunded Mandates Reform Act—Department of Labor and Department of Health and Human Services

We concur with the Departments' decision that these "proposed regulations do not impose an unfunded mandate on State, local or Tribal governments or the private sector".

E. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

We agree that "the collection of information is necessary for the proper performance of the functions of the agency". We agree with "the accuracy of the agency's estimate of the burden of the collection of information." We concur this will "Enhance the quality, utility, and clarity of the information to be collected" and that the burden of the collection of information was minimized by allowing electronic submissions.

2. Department of Health and Human Services

We also agree with the HHS estimates as stated previously.

We also agree with the Departments' determination appearing later in the document that "these proposed rules have federalism implications, because it would have direct effects on the States, the relationship between national governments and States, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers".

Appendix A-1

Although we agree with the basic format, especially the "Why this Matters" column which explains in detail, we are concerned with some of the terminology is not consumer-friendly. For example, on page 2 is says "co-payments are fixed dollar amounts"; which could better be explained as "your share each time" or some similar verbiage. Also under the examples of medical events on page 2, consumers will not understand abbreviations such as "CT/PET scans, MRIs". Also under medications, terminology such as "generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs" is confusing and needs to be simplified.

Appendix B-1

On page 7, question #6 is the annual limit on what the insurer pays but this should include any other limits as well.

Appendix C-1

This was done very well with examples detailing both yes and no responses on coverage areas.

Appendix D-1

This was also done well with an example of covered expenses (e.g. doctor, hospital, medications etc.) for a particular condition.

Appendix E

The examples given seem clear for consumers. We would also like to see the definitions given we previously mentioned above under section C Uniform Glossary.

Thank you again for the opportunity to comment on the Summary of Benefits and Coverage and the Uniform Glossary.

Sincerely,

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Our Mission: To empower families and inform and involve professionals and other individuals interested in the healthy development and educational rights of children, to enable all children to become fully participating and contributing members of our communities and society.