

October 21, 2011

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9982-P
PO Box 8016
Baltimore, MD 21244-1850

RE: File Code CMS-9982-P (Summary of Benefits and Coverage and the Uniform Glossary)

Dear Sir or Madam:

We appreciate the opportunity to offer comments on key issues related to implementation of Section 2715 of the Patient Protection and Affordable Care Act (ACA), which is intended to help consumers better understand their insurance coverage, as well as other coverage options that may be available to them. The Georgetown University Center for Children and Families is part of the Georgetown University Health Policy Institute and we develop and disseminate research, strategies, and ideas to improve the health of America's low- and moderate-income children and families. In addition, I served on the Congressionally-chartered Children's Health Insurance Program Working Group chaired by the Secretaries of Health and Human Services and Labor. This working group considered issues related to the integration of group health plans and publicly funded programs serving families (i.e. Medicaid and CHIP) including the development of a model coverage and disclosure form.

Section 2715 requires the creation and use of a standard form for describing health insurance coverage, called the Summary of Benefits and Coverage (SBC), which is understandable to the average consumer. The SBC will be perhaps the most important document consumers will obtain to allow them to make "apples to apples" comparisons of health plans, select the plan that best meets their needs, and better understand their health insurance coverage. Section 2715 also calls for a consumer-friendly Uniform Glossary of Medical and Insurance terms (Glossary) to be developed and made available to help consumers understand their health plans and provide greater consistency in the usage of terms across plans.

The benefits of a standard disclosure form and glossary are great. Consumer confusion regarding health plan terms is well documented. If consumers can't understand the coverage offered by a plan, they can't make an informed selection. When consumers do not understand their choices, they often make a decision based on premium alone and find themselves in plans that don't have the coverage they need.

A standard, clear SBC will also likely prove useful to families with children in public coverage in states that serve families through a "premium assistance" model where Medicaid and CHIP funds are used to purchase employer-sponsored or other private coverage. A standard SBC will be important for a number of reasons. First, in some states such as Illinois, families are asked to choose whether their children are enrolled in private insurance with a premium subsidy or the public program for which they are eligible (i.e. Medicaid or CHIP). Standard materials will assist families in making an informed choice. This is especially important for families that have low-incomes for whom cost-sharing can pose a significant barrier to care, given that private insurance options are likely to have much higher cost-sharing obligations.

Second, in premium assistance programs where states provide “wraparound” services to assure that children receive the full Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and cost-sharing protections of Medicaid, a clear standardized SBC will help ease administrative challenges for states in assessing the adequacy and cost-effectiveness of their premium assistance programs. States have found it difficult in the past to obtain such information from employers. Families will also benefit in understanding what services are covered through their ESI and what services they may be able to obtain through Medicaid.

Additionally it is likely that by 2014, when states implement key provisions of the Affordable Care Act, including the expansion of the Medicaid program, efforts to coordinate public and private coverage will become of even greater salience. We believe that it is essential that the SBC requirements be applicable to large employers as well to ensure consistency across sources of coverage.

The proposed rule makes great strides in providing an 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.

Availability of SBC to all private health plan enrollees

The ACA requires 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 in understanding how to use the form pays off because they can apply their knowledge regardless of the source of private health insurance.

Provision of the uniform SBC to enrollees in employer-sponsored group health plans—both small and large—is particularly important. The vast majority of privately insured people – 150 million non-elderly Americans in 2011 – are covered by employer-sponsored group health plans. If the SBC is not provided to people in all of these plans, the protections Congress intended under Section 2715 would be denied to most privately insured Americans.

RECOMMENDATION: Adhere to the requirement in the ACA and require all private health insurance plans and issuers to use the same form, including in the large employer group market.

Language Access

To assure that all consumers can benefit from the SBC, the Departments should strengthen the proposed regulation’s provisions on language access. The current proposed county-based thresholds for providing translated materials have the potential to increase barriers for many families with members who have limited English proficiency. Further, oral assistance should be available to all those with limited English proficiency. To ensure that speakers of languages other than English are aware of the resources available to them, all SBC communications should contain taglines in multiple languages.

RECOMMENDATION: The Departments should reconsider translation thresholds to make certain they comply with PHSA § 2715 as well as Title VI and the nondiscrimination provision of the ACA. Require plans to provide oral language services – through

competent bilingual staff or interpreters – for all LEP individuals with questions about the SBC. Require plans to provide taglines in 15 languages with all SBCs.

Premiums/Cost of Coverage

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/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 emphatically recommend that cost of coverage information be included for enrollees in group health plans; that is, the SBC should indicate the cost of coverage to employees and their dependents net of the employer contribution to the premium.

The premium, or monthly cost of coverage, is critically important information to families. It is not possible to select among 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, not 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, as mentioned above, this is of great importance for some families in public coverage premium assistance programs as well. Along with premium information, SBCs should include a statement that insurance affordability programs are available to pay some or all of the cost of coverage for those who qualify.

RECOMMENDATION: Retain the requirement to include information on premiums or cost of coverage and add a statement on the availability of insurance affordability programs.

Coverage examples

The ACA requires that the SBC contain a “coverage facts label,” referred to in the proposed rule as “coverage examples,” that would illustrate how a plan’s coverage would apply to claims scenarios for common conditions to assist patients in selecting the plan that best addresses their health care needs. The statute requires that the examples illustrate common benefits scenarios, including specifically “pregnancy and serious or chronic medical conditions” for which recognized clinical practice guidelines are available.

Consumer testing of the prototype coverage examples found the examples to be extremely valuable to consumers.¹ They provided a sense of how much the plan would pay for certain conditions – information that consumers couldn’t calculate on their own. They also helped crystallize the fundamental concept of insurance for many consumers, who otherwise approached their shopping task as an effort to acquire pre-paid health care. Indeed, this was one of the most valuable parts of the SBC form for many consumers. In light of their value to consumers, we recommend that the Departments require inclusion of six medical scenarios in the SBC beginning immediately in 2012.

¹ 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

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

- Prevalence of conditions in the population overall.
- Prevalence of conditions in key subpopulations. 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.
- Scenarios that illustrate 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, rehabilitative services, etc. Selection of coverage illustrations should show consumers how these coverage differences work under each plan.

RECOMMENDATION: 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 and include at least one example relevant to children and young adults, such as immunizations.

Glossary of Health Insurance and Medical Terms

The ACA requires that the Departments consult with the National Association of Insurance Commissioners (NAIC) and a working group of consumer and health industry stakeholders to develop a uniform glossary defining key health insurance terms. As part of this work, the NAIC and its working group recommended the inclusion of a separate definition for “habilitation services” in recognition of the use of this term in the statutory definition of the essential health benefits package. Because habilitative services are provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition, they are most often provided to children with congenital and developmental disabilities. We strongly support the definition of habilitation services recommended by the NAIC and urge that it be retained in the Glossary without change.

We also suggest that the following additional commonly used health insurance and medical terms be added to the glossary: preventive care; mental health services; substance abuse services; and family planning services. These terms are very important to consumers and are often not clearly understood. However, the definitions should not be written in such a way that would limit benefits and services for children and adolescents. We would urge the Department to work with the pediatric community to define these terms. The definitions should be consumer-tested and vetted with experts in child and adolescent health.

RECOMMENDATION: Retain without change the definition of “habilitation services” proposed in the Glossary. Expand the listing of terms to include preventive care, mental health services, substance abuse services, and family planning services without defining the terms in such a way that would limit the benefits and services covered.

Consumer Testing

Plain writing is essential to help individuals better understand health coverage, the differences in coverage options, and terms and concepts commonly used in health coverage. Plain writing is consistent with the requirement in Section 2715(b)(2) that the SBC “utilizes terminology understandable by the average plan enrollee.”

The NAIC working group, which designed the recommended template for the SBC and uniform glossary that the Departments propose for adoption, strived to meet “plain language” requirements but strongly advised that testing and assessment be done in consultation with representative consumer organizations. We support the NAIC’s recommendation.

RECOMMENDATIONS: Before the Secretary authorizes the SBC and uniform glossary, the Departments 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.

Thank you for your consideration of our comments. Please contact me if you have any questions about our submission.

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