DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Phone: (916) 322-6727
Fax: (916) 322-3968
http://www.dmhc.ca.gov

October 21, 2011

Donald Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9982–NC and CMS–9982–P
P.O. Box 8016
Baltimore, MD 21244–1850

RE: **CMS–9982–NC** and **CMS–9982–P** (Summary of Benefits and Coverage)

Dear Dr. Berwick:

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

Concerns Shared by the DMHC, the CDI, and the California Health Benefit Exchange

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

Terms like "practitioner," "habilitation," and "urgent care" may need additional clarification in the SBC through parenthetical examples to be meaningful to consumers (e.g., habilitation further referenced as physical, speech and occupational therapy.) It would further assist consumers in

comparing coverage options to include additional related categories of service, such as emergency room physician services, to provide a more complete view of the cost components in a hospital emergency room visit.

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

The DMHC's Regulation of Health Coverage

California's bifurcated regulation of health insurance coverage is unique in the nation. The DMHC is the California agency that licenses and regulates health care service plans (health plans), including HMOs and some PPOs, under the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene Act," Cal. Health & Safety Code § 1340 et seq.). The DMHC is responsible for regulation of health plans that provide hospital, medical, and surgical coverage to 21 million Californian enrollees. By comparison, fewer than three million Californians are covered under insurance policies, which are regulated by the CDI. Under California law, HMOs are distinct legal entities, *not* health insurance companies.

The DMHC was established more than a decade ago as the only stand-alone agency in the country dedicated solely to regulating managed health care plans, aiding consumers, and enforcing consumer rights. The DMHC maintains a Help Center, dedicated to ensuring that consumers understand their rights and receive effective assistance. Collecting data from these consumers enables the DMHC to be aware of developing trends.

The DMHC strives to ensure that health plan materials are easy to comprehend and are linguistically and culturally appropriate. Thus, in California, the DMHC is especially mindful of how national rules, typically framed in the context of traditional insurance products, will be applied to HMO coverage. In addition, as previously explained in our October 7, 2010 letter to the National Associations of Insurance Commissioners (NAIC), the language in the proposed SBC documents does not accurately describe one of the most significant consumer protections for HMO consumers in California law, the protection against balance billing by providers.

The DMHC has the following comments and concerns:

1. Uniform Glossary Definitions and Related SBC Elements

The proposed Uniform Glossary contains some definitions that are inconsistent with the requirements of the Knox-Keene Act.

Balance Billing

The proposed definition for balance billing in the Uniform Glossary suggests that a provider may balance bill enrollees in circumstances under which balance billing is prohibited in California. Unless this Uniform Glossary is revised, there will be confusion for California's HMO enrollees and providers.

Balance billing is the practice where a provider attempts to bill a health plan enrollee for amounts owed by the health plan or for the difference between the health plan's reimbursement and the provider's billed charge. California law (the Knox-Keene Act) specifically prohibits providers that contract with the health plan (participating providers) from billing enrollees for amounts owed by the health plan. Participating providers in California may not balance bill enrollees under any circumstances; they may bill only for co-insurance, co-payments, or deductibles. Moreover, on January 8, 2009, the California Supreme Court declared balance billing unlawful in the context of emergency medical care in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497. The Prospect decision also applies to Blue Cross and Blue Shield PPOs that are regulated under the Knox-Keene Act. California law also prohibits non-participating providers from balance billing enrollees for emergency care services.

The DMHC cannot overstate the importance of the hard-won prohibition on balance billing of emergency services for California's HMO enrollees. Prior to the California Supreme Court's ruling, enrollees were routinely caught in claims disputes between their health plans and providers of emergency services. Moreover, in the case of an emergency, HMO enrollees must be assured that they will not suffer financially if they go to the nearest hospital emergency department, whether or not that hospital is a participating provider. The proposed definition for balance billing suggests that emergency providers may balance bill enrollees, potentially causing confusion for California health plan enrollees.

The DMHC recommends the below changes to the following definitions:

> **Allowed Amount**
> Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance," or "negotiated rate." The allowed amount may be lower than your provider's billed charges. ~~If your provider charges more than the allowed amount, you may have to pay the difference.~~ (See **Balance Billing**.)
>
> **Balance Billing**
> When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you. A **non-preferred** provider may **not** balance bill you for **emergency services** in some States.

These revisions would alert consumers to differences in state laws and would clearly indicate that the glossary definitions related to balance billing are not intended to preempt state law.

Similarly, the DMHC recommends changing the third bullet on Page 2 of the SBC (refer to Appendices A-1 and Appendix A-2) as follows:

- The plan's payment for covered services is based on the **allowed amount**. If your plan covers services from an **out-of-network provider** who charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) An **in-network provider** may not balance bill you. An out-of-network provider may not balance bill you for **emergency services** in some States.

Non-Preferred Provider and Preferred Provider

The Uniform Glossary definitions for "Non-Preferred Provider" and "Preferred Provider" do not accurately reflect health plan arrangements for the majority of health plan enrollees in California.

The DMHC appreciates that the SBC instructions allow health insurance issuers, including HMOs, to use plan-specific terms for its provider networks (e.g., "preferred provider" instead of "in-network provider"). (76 F.R. 52502.) This allows the SBC to reflect the terminology that the health plan typically uses in its other coverage documents, such as an Evidence of Coverage. This type of consistency will limit unnecessary consumer confusion.

However, the proposed glossary definitions for "Non-Preferred Provider" and "Preferred Provider" may cause confusion for health plan enrollees in California. In general, except for emergency health services, health plan enrollees who are members of an HMO and not a PPO will not be covered if they receive health care services from providers who are not contracted with their health plan network. The DMHC appreciates that the SBC instructions allow HMOs to use plan-specific terminology and allows the HMO to communicate that out-of-network services are not covered. However, the DMHC is concerned that the proposed SBC and Uniform Glossary may mistakenly misinform HMO enrollees in California that if they go out-of-network a portion of their health services will be covered by their HMO. Such mistaken information could put HMO enrollees at risk for unpaid health care services. Further, it is not necessary to include statements in these definitions about differences between in-network and out-of-network costs, as these differences will be clearly reflected in the different co-payment and co-insurance amounts shown in the SBC.

The DMHC recommends the changes to the following definitions in the Uniform Glossary:

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to providers who contract with your **health insurance** or **plan**. ~~In-network co-insurance usually costs you less than out-of-network co-insurance.~~

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your **health insurance** or **plan**.

~~In-network co-payments usually are less than **out-of-network co-payments**.~~

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurance or **plan** to provide services to you. ~~You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.~~

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan, if** your plan covers out-of-network services. ~~Out-of-network co-insurance usually costs you more than **in-network co-insurance**.~~

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with *your* **health insurance** or **plan, if** your plan covers out-of-network services. ~~Out-of-network copayments usually are more than **in-network co-payments**.~~

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a negotiated rate. ~~at a discount~~. A preferred provider may also be called a "participating provider." Check your policy to see if ~~you can see all preferred providers or it~~ your **health insurance** or plan has a "tiered" **network** ~~and~~ where you must pay extra to see some providers. ~~Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.~~ Some plans **only** cover services from preferred providers, except for **emergency services.**

Similarly, the DMHC recommends changing the draft Instructions Guides, Appendices B-1 (Draft Instruction Guide for Group Policies) and B-2 (Draft Instruction Guide for Individually Purchased or Non-Group Policies) as follows:

Item 7. "Does This Plan Use A Network of Providers?"

- 7.b. If the plan ~~does~~ uses a network, the insurer must briefly explain its network policy. For example "Yes, this plan uses preferred providers. You may use health care providers that aren't preferred providers, but you may pay more." Or, for States that prohibit balance billing by non-preferred providers, "Yes, this plan uses preferred providers. You may

use health care providers that aren't preferred providers, but you may pay more, except for emergency services." If the plan uses a network, but does not cover out-of-network services except for emergencies, the plan must clearly disclose this network policy. For example, "Yes, this plan uses preferred providers. Except for emergency services, this plan does not cover services outside the network."

- 7.g. If this plan uses a network, the insurer must show the following language: "If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. This plan will also pay some or all of the costs of out-of-network emergency services. Plans use the terms **in-network, preferred, or participating** to refer to providers in their network."

Covered Services, Cost Sharing, Limitations, and Exceptions.

Information Box:

- Add the following to the 2nd bullet that states "The fourth bullet will change depending on the plan:"
  - For plans that do not cover out-of-network services, other than emergency services, delete the 4th bullet and replace it with: "Your plan will not pay for services from out-of-network providers, except for emergency services. In some states you cannot be charged more for emergency services from an out-of-network provider."

Chart Starting on Page 2: Item 2. *Your Cost* columns:

d. For HMOs providing no out-of-network benefits, the insurer should insert "Not covered" in all applicable boxes under the far-right sub-heading under the *Your Cost* column (which, for policies providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column), except that the insurer should insert "Covered" for the boxes for "Emergency room services" and "Emergency medical transportation."

2. Frequently Used Terms

The SBC materials developed by the NAIC, as set forth in the proposed rules, reflect terms predominantly used in traditional insurance products. As a regulator that primarily regulates managed care products, such as HMOs, the DMHC has noted repeated use of terms that are inconsistent with California law and with general usage in managed care.

a. "Health Insurance"

Under section 2715 of the Public Health Service Act (PHSA), health insurance issuers include HMOs, and therefore section 2715 requires issuance of the SBC to California health plan enrollees.

There are references throughout the SBC documents developed to "health insurance." In addition, under the standard definitions document, the "plan" refers to an employer's "group health plan," as defined under federal law. The DMHC is concerned that the SBC that must be sent to California health plan applicants and enrollees does not accurately describe HMO coverage and has the potential to confuse consumers.

The DMHC recognizes that the term "health insurance" is a broadly understood term that is used nationwide. However, under California law, specifically the Knox-Keene Act, HMOs are referred to as health plans and not health insurance. In California, insurance products are regulated separately under the Insurance Code by the CDI. Moreover, there are many differences in the state laws affecting these two types of coverage. California HMO consumers who receive SBCs that repeatedly refer to "health insurance" may be confused and seek assistance from the wrong regulator.

It would be preferable to replace the term "health insurance" with "health plan" in the SBC. The term "health plan" may refer, in general, to health care coverage. Further, the ACA refers to a health coverage product offered through an American Health Benefit Exchange as a "qualified health plan." Section 1301 of the ACA defines the term "qualified health plan" as a "health plan" that meets specified requirements.

Alternatively, it may be possible to include clarification regarding the terms "health insurance" and "health plan" in an addendum to the SBC, if states are permitted to require the provision of a state-specific addendum (see section 3, below).

b. "Policy" and "Certificate"

Similarly, the terms "policy" and "certificate" do not accurately reflect the terminology used by California health plans. Under California law, health plan products are referred to as "plan contracts." Marketing materials used by DMHC-regulated health plans generally refer to the "plan contract" or "health plan contract." The difference in terminology is potentially confusing to consumers who will receive documents using different terms.

This issue could be resolved by including "or contract" wherever "policy" appears. Alternatively, a state could include clarification in an addendum to the SBC regarding the terms "policy" and "contract," if a state addendum to this document is allowed.

c. "Plan"

In the proposed regulations' glossary, the term "plan" is defined as a "benefit your employer, union, or other group sponsor provides to you to pay for your health care services. In California, the DMHC regulates "health care service plans," which are often referred to as "health plans" or

"plans." As noted above, the DMHC has recommended broadening the term "plan" to encompass health care coverage, generally. When referring to the employer's benefit arrangement, the DMHC recommends that the term used with this specific glossary definition should be "group health plan," consistent with terms used in the Employee Retirement Income Security Act (ERISA).

Alternatively, it may be possible to include clarification in a state addendum to the SBC regarding the term "plan" if a state addendum to this document is allowed.

3. Carve-Out Plans

In California, many heath plans "carve out" certain services, such as mental health, and instead provide them through a contract with a specialized mental health plan. In Appendix B-2, Item H directs issuers not to complete the coverage example for "carved out" services. However, under the Knox-Keene Act, health plans are required to provide certain services, including mental health services. It remains the health plans' responsibility to provide these services, even if they are provided through a contracted carve-out plan. Accordingly, in such cases, the instructions should require health plans to describe all benefits covered under the plan contract, including "carved out" benefits.

4. Grievance and Appeals Rights

The discussion of grievance and appeal rights in the SBC is incomplete. The existing bullets only inform consumers of their rights to review and re-review by the health plan – i.e., internal review. The ACA and the implementing regulations require external review of certain claims. Accordingly, the DMHC offers the following suggested language, to be inserted after the two existing bullets in this section:

- "An external review, completed by an independent person or organization outside of the health insurer or plan, may be available under State or federal law. Call your [State office of health insurance customer assistance] at [1-800-xxx-xxxx] for more information."

5. Provision of Addendum to the SBC

The proposed regulations provide that the SBC must be provided as "a stand-alone document in the form authorized by the Secretary." (76 F.R. 52747, proposed 45 C.F.R. § 147.200(a)(3).) As noted, the DMHC has identified issues and terms in the SBC that should be clarified to accurately reflect California law.

The DMHC understands that the preemption standard in section 2715 would apply only if California required *less* information than that required under the federal statute and implementing regulations.[1] In the absence of revisions that would address all of the DMHC's concerns, allowing states to require the provision of an addendum could provide necessary,

[1] 42 U.S.C. 300gg-15(e). Preemption. The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

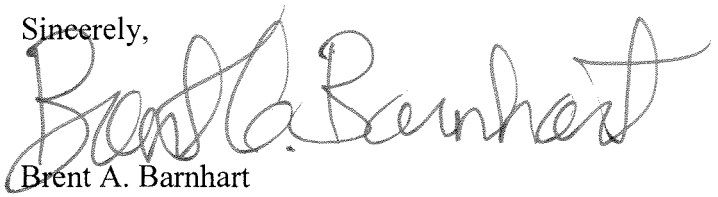
clarification to consumers, if the state has determined that the clarification of the SBC documents is necessary. The DMHC recommends that these proposed regulations be amended to allow states to require the provision of a limited, uniform, clarifying addendum.

One issue that California could clarify by attaching a state-specific addendum is the definition of balance billing. Balance billing has been of particular concern in California and the glossary's definition of "balance billing" (and the related definition of "allowed amount") does not accurately reflect California law (see section 1, above). The DMHC feels strongly that this and other state-law distinctions are vitally important for California consumers, so that consumers are aware of permissible and impermissible practices.

The DMHC continues to be committed to implementing health care reform in a manner that meets national goals, but that will also provide sufficient clarity for California consumers. The DMHC welcomes the opportunity to work alongside the federal agencies and other states that may have similar concerns to address these issues and ensure that consumers receive clear and accurate information.

Thank you for the opportunity to comment on these documents. Should you have questions, please do not hesitate to contact me at (916) 322-2012 or bbarnhart@dmhc.ca.gov, or direct staff inquiries to Sherrie Lowenstein, Acting Assistant Deputy Director, at (916) 322-5874 or slowenstein@dmhc.ca.gov.

Sincerely,



Brent A. Barnhart
Director
California Department of Managed Health Care

cc: Dave Jones, Commissioner, California Department of Insurance
Peter Lee, Executive Director, California Health Benefit Exchange