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October 21, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Attention: **CMS-9982-P/CMS-9982-NC**

Via Electronically: www.regulations.gov

Re: CMS-9982-P: Summary of Benefits and Coverage and the Uniform Glossary.

Dear Sir or Madame:

The UPMC Insurance Services Division (UPMC) is pleased to submit the following comments in response to the Proposed Rule regarding the Summary of Benefits and Coverage and the Uniform Glossary.

I Introduction

UPMC is proud to offer the full spectrum of commercial health coverage products to consumers in Pennsylvania. UPMC's companies include its flagship UPMC Health Plan, which first began operating in Western Pennsylvania in 1997. Earlier this year, J.D. Power and Associates awarded UPMC Health Plan the "Highest Member Satisfaction among Commercial Health Plans in Pennsylvania." UPMC Health Plan's HMO and POS recently received the highest possible scores from NCQA in the categories of customer satisfaction and preventive care. Over the past 15 years, UPMC has grown and now serves more than 6,000 employers in Western Pennsylvania and 1.6 million members statewide. We attribute this growth in part to our continued commitment to adequately educate consumers as to the terms and conditions of the coverage plans available to them.

II. Comments for Consideration

We thank the Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services (collectively, the "Agencies") for their collective commitment to create member materials designed to improve the member experience. We commend the Agencies for (1) adopting many of the recommendations made by the NAIC with respect to the Summary of Benefits and Coverage (SBC) and the Uniform Glossary, and (2) wisely soliciting input from those who will be most impacted by these new materials – consumers. We at UPMC have long believed that informed consumers are our best customers.

It is with this overarching support as a backdrop that we offer for the Agencies' consideration the following comments.

A. Postpone Implementation Date

The SBC and Uniform Glossary will potentially play an important role going forward in assisting consumers and members to better understand the terms and conditions of the various health coverage options available to them. As such, we commend the Agencies for taking the time necessary to draft, test, re-draft and re-test these documents until they met the Agencies' expectations and scrutiny. With that said, we note that the drafting and review process resulted in the release of the documents five months after the release-date set forth in the Patient Protection and Affordable Care Act (the "ACA"). Despite this delay, the Proposed Rule does not extend to carriers and plans any delay or postponement in the date by which they must fully comply with the new requirements.

The time required for carriers and plans to create the SBC for each product option will be substantial. Creating these documents cannot be accomplished via complete automation; to the contrary, document-creation will be a "high touch" enterprise, particularly in the early years of implementation. Moreover, the actual creation of the SBC will not begin until existing systems, processes and procedures are modified and new ones developed, operationalized and implemented. This too will take time. Neither building the infrastructure necessary to create the requisite documents nor document creation itself can begin until carriers and plans know precisely what they must create. Because the current requirements are "proposed" requirements and may be substantially modified in the final rule, carriers and plans are forced to wait; they, like the Agencies, want to "get it right." We believe that a rushed implementation would be worse than a clearly communicated and planned delay. For these reasons, we respectfully ask that the Agencies reconsider the current March 2012 implementation date and extend to carriers and plans a delay not less than the length of time that the final regulations were delayed.

B. Excluded Services & Other Covered Services Section

We have concerns with the Excluded Services & Other Covered Services section. Our understanding of the Proposed Rule is that each of the 14 services provided in the template SBC must appear as either a covered or uncovered service. In many instances, the services listed may be covered under some circumstances but be subject to medical necessity or other qualifying criteria. As such, listing such services merely as *either* covered or not covered will not be helpful for consumers; to the contrary, it may wrongfully lead them to conclude that they are or are not eligible for certain services when the opposite is true. We do not believe that this will serve consumers or our members well. Existing certificates of coverage and other plan documents already identify those services that are covered, as well as any requirements necessary for such coverage. We respectfully submit that duplicating this information by distributing abridged and/or incomplete versions of those more comprehensive documents will not be helpful to anyone.

C. Electronic Documents

We support the Agencies for affording carriers and plans the flexibility to provide the SBC in electronic format. We also support the Agencies' proposal to allow carriers and plans to provide access to the Uniform Glossary solely via a website. Definitions in the Uniform Glossary will likely differ from definitions contained in SPDs and other plan documents. Limiting the availability of the Uniform Glossary to a website will appropriately suggest to consumers and members that it is intended to be an informational rather than legally binding document.

We also support the Agencies' proposal to deem in compliance those plans that post their SBC and Uniform Glossary for individual policies on the Federal Health Care Reform insurance web portal. At present, UPMC receives roughly 100-200 requests per day for various member materials. The costs associated with complying with these requests are substantial. The Agencies' proposal to allow electronic delivery will afford consumers and members ready access to these documents while simultaneously allowing carriers and plans to control administrative costs.

Furthermore, allowing plans to provide these documents electronically is in keeping with general trends across commercial markets; consumers are increasingly familiar with shopping, purchasing and accessing information on-line. For this reason, we also assert that password-protecting SBCs does not create an undue burden on consumers nor interfere with the "readily accessible" standard. Password protection and other electronic access requirements are commonplace. Moreover, password protection will be critical going forward, particularly if carriers and plans are required to include premium and other sensitive information within the SBC documents themselves.

D. Distribution of SBC to Participants/Beneficiaries

For individual products, we understand that carriers will be responsible for distributing SBCs to individual members either directly or via Healthcare.gov. For group products, however, carriers may be called upon and/or required to provide the SBC directly to a group sponsor *or* to individual participants of that group. We respectfully ask that the Agencies clarify in the final rule that a group sponsor can agree to distribute SBCs directly to its participants on behalf of carriers and, accordingly, to assume responsibility for any penalties assessed for a failure to do so.

E. Coverage Examples

We fully support the Agencies for their efforts to draft documents designed to make coverage more understandable to consumers. We are concerned, however, that the coverage examples as proposed may lead to more confusion than clarity. First, absent a more prominent and easily understandable disclaimer, consumers and plan members may incorrectly conclude that the coverage documents represent actual costs and/or cost-sharing requirements. For this reason, we ask that the coverage examples be accompanied by bold-faced, large-type disclaimers, which clearly indicate that the information presented is "for informational purposes

only" and that "costs and cost-sharing may not be representative of actual costs and cost-sharing." We then ask that consumers be directed to their own member materials and/or to member service departments for plan-specific information.

Additionally, we understand that the ACA requires that coverage documents illustrate common benefit scenarios, including pregnancy. These documents will be most helpful to consumers to the extent that they are not ambiguous or vague. First, we recommend that "Having a baby; normal delivery" be replaced with "Pregnancy and uncomplicated, vaginal delivery." Amending the proposed document in this manner will more clearly identify the "situation" at issue. Similarly, we recommend that the other serious or chronic medical conditions chosen be identified in ample detail. "Managing diabetes; routine maintenance of existing condition" is arguably vague, broad and open to multiple interpretations; additional specificity would better assist consumers in making informed coverage decisions. Finally, we recommend the coverage examples also clearly set forth the periodicity of the costs at issue; for example, whether costs are per episode of care, per month or otherwise. Such modifications will make these documents most helpful to consumers.

Finally, in the Proposed Rule the Agencies specifically ask whether the coverage document requirement should be phased-in over time. We respectfully assert that it should. Creating these documents for multiple conditions for each product will be a time intensive process. Requiring carriers and plans to produce these documents for one (or at most two) conditions at the outset will allow carriers and plans to implement and perfect necessary systems and processes. A phase-in will additionally allow carriers and plans (and the Agencies) to more fully evaluate the continued usefulness of these documents.

F. Non-English Language Requirements

We, of course, support and commend the Agencies for their ongoing sensitivity to the needs of those for whom English is not a primary language. None of the counties that meet the requisite non-English speaking thresholds are within our service area. We nonetheless will make these materials available in languages other than English upon request. Translating the requested materials within the 7-day window provided in the Proposed Rule, however, will be difficult. Accordingly, we ask that the Agencies replace the 7-day window with an "as soon as reasonably practical" timeframe and monitor compliance thereafter.

G. 30-Day Advance Notice Requirement

Likewise, while we appreciate the Agencies' desire to get the SBC in the hands of members as soon as possible, requiring carriers and plans to do so within 30-days of an automatic renewal may not be practical in application. As a matter of course, the majority of our small group business is subject to automatic renewal. Our underwriting department sends new rate information to these small groups 60 days in advance of the end of each 12-month period. These groups, however, often do not formally commit to such renewal until shortly before (and even sometimes after) the end of the 12-month period, often times with last minute changes to premiums and/or benefit designs. Requiring UPMC (and other carriers) to send the SBCs 30-days in advance will too often result in a second, updated SBC being sent thereafter. As stated

elsewhere, any administrative duplication at this point is undesirable. As such, we ask that in all instances carriers and plans be required to provide SBCs *after* a plan design has been unequivocally chosen by each group.

H. Tiered Network and other Value Based Design

Additionally, we have concerns as to how the proposed template SBC will translate and/or be useful in cases where a plan utilizes either tiered network pricing or some other value-based benefit design. The documents as proposed do not easily lend themselves to these types of plan designs. We ask that the Agencies' release guidance setting forth the manner in which carriers and plans can modify the proposed documents and remain in compliance with the necessary requirements. Second, in drafting such guidance, we ask that the final rule afford carriers and plans maximum flexibility in tailoring these documents to accommodate non-traditional benefit designs.

I. Summary Plan Descriptions

The Agencies specifically ask in the Proposed Rule whether carriers and plans should be permitted to include the SBC in summary plan descriptions provided the SBC is prominently displayed. We respectfully and enthusiastically assert that they should be permitted to do so. Controlling administrative costs has never been more important; affording carriers and plans the opportunity to meet their regulatory obligations without unnecessary duplication is essential.

Thank you for providing us the opportunity to offer input into the Proposed Rule regarding the Summary of Benefits and Coverage and the Uniform Glossary. We appreciate your consideration of these comments and look forward to working with the Agencies in the future.

Sincerely,

Sheryl Kashuba, Esq.
Senior Director Health Policy
UPMC Health Plan