OCT 24 2011
LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS
BRANCH

PUBLIC SUBMISSION

As of: October 24, 2011
Received: October 21, 2011
Status: Posted
Posted: October 24, 2011
Tracking No. 80f585da
Comments Due: October 21, 2011
Submission Type: Web

Docket: IRS-2011-0026
Summary of Benefits and Coverage and Uniform Glossary

Comment On: IRS-2011-0026-0001
Summary of Benefits and Coverage and Uniform Glossary

Document: IRS-2011-0026-0017
Comment on FR Doc # 2011-21193

Submitter Information

Name: Rene Cabral-Daniels
Address:
725 15th Street, NW
10th Floor
Washington, DC, 20005
Email: rene.cabral-daniels@npaf.org
Phone: 202.347.8009
Fax: 202.247.5579
Organization: National Patient Advocate Foundation

General Comment

See attached file(s)

Attachments

IRS Benefits and Coverage andthe Uniform Glossary _2_

NPAF National Patient Advocate Foundation

The Patient's Voice | *since* 1996

EXECUTIVE BOARD

Nancy Davenport-Ennis
CEO, President
National Patient Advocate Foundation
Dennis A. Gastineau, MD
Board President
Director, Human Cell Therapy Laboratory
Divisions of Transfusion Medicine & Hematology
Mayo Clinic
Christian Downs, MHA, JD, MHA
Immediate Past President
Executive Director
Association of Community Cancer Centers
Leah Locke-Arnett, RN, BSN, MHCA
Board Secretary
John L. Murphy
Board Financial Officer
Taguenay Capital, LLC
Bruce Avery, MD
Hematology Oncology Knoxville
Alan J. Balch, PhD
Vice President
Preventive Health Partnership
Martha E. "Meg" Gaines, JD, LLM
Clinical Professor of Law,
University of Wisconsin Law School
Lovell A. Jones, MD, PhD
Director, Center for Research on Minority Health
Department of Health Disparities Research
University of Texas
MD Anderson Cancer Center
Pearl Moore, RN, MN, FAAN
Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI
President, Clinical Services & Chief Medical Officer
HCA - Hospital Corporation of America
Roy Ramthun, MSPH
President
HSA Consulting Services
Reed V. Tuckson, MD, FACP
Executive Vice President and
Chief of Medical Affairs
UnitedHealth Group

SCIENTIFIC ADVISORY COMMITTEE

Robert M. Rifkin, MD, FACP
Chair, Science Advisory Committee
Director, NMDP Collection;
Rocky Mountain Blood & Marrow Transplant Program
Rocky Mountain Cancer Centers
Charles Balch, MD, FACS
Professor of Surgery and Oncology and Dermatology
Deputy Director, Johns Hopkins Institute for Clinical
and Translational Research
Johns Hopkins
Pamela S. Becker, MD, PhD
Associate Professor of Medicine/Hematology
Institute for Stem Cell and Regenerative Medicine
University of Washington
Al Benson III, MD, FACP
GI Medical Oncology, Professor of Medicine
Northwestern University, Feinberg School of Medicine
David Brizel, MD
Professor of Radiation Oncology
Associate Professor of Head and Neck Surgery
Duke University Medical Center
Nicholas J. Petrelli, MD, FACS
Medical Director
Helen F. Graham Cancer Center
F. Marc Stewart, MD
Professor of Medicine, University of Washington
Fred Hutchinson Cancer Research Center
Lori Williams, PhD, RN, AOCN
University of Texas
MD Anderson Cancer Center

October 13, 2011

Douglas H. Shulman
Commissioner
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Summary of Benefits and Coverage and the Uniform Glossary

Dear Commissioner Shulman:

National Patient Advocate Foundation (NPAF) would like to thank you for the opportunity to comment on proposed regulations which summarize benefits and coverage and the uniform glossary for group health plans and health insurance coverage in the group and individual markets. In an effort to assist consumers when they compare health insurance coverage options, the Patient Protection and Affordable Care Act (PPACA)[1] requires private individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. NPAF understands the regulations seek to provide health consumers with new, standardized summary information about private health insurance coverage.

NPAF is a non-profit organization dedicated to improving patient access to healthcare services through both federal and state policy reform. Its mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. NPAF has a fifteen year history of serving as the trusted patient voice. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained case management services from our companion organization, Patient Advocate Foundation (PAF). PAF is the nation's oldest direct patient services access organization and is staffed by professional case managers who resolve access to healthcare issues and collect and meticulously document data across 260 primary data fields for each case. In 2010, PAF resolved 82,963 cases nationally and provided information to almost 4 million online contacts.

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

725 15th St. NW, 10th Floor | Washington, DC 20005 | Phone (202) 347-8009 | Fax (202) 347-5579 | www.npaf.org

The comments in this letter reflect NPAF's long history of addressing the impact of federal policy on patients. This experience allows us to anticipate the unintended consequences of new policies on the patient population. While the statutory language directs the agency to consider the importance of providing information to health consumers, NPAF takes this responsibility one step further by suggesting improvements that assure the information is translated into language that identifies the consequences of the SBD should the health consumers become patients.

It is clear the regulations closely mirror the recommendations of the National Association of Insurance Commissioners (NAIC) workgroup. The workgroup was comprised of consumer advocates, insurers, health care providers, advocates for individuals with limited English proficiency, and others. PAF was a member of the NAIC workgroup and is pleased workgroup recommendations requirements for the SBD were adopted. The regulations require it to be limited to 4 double-side pages and cannot contain "fine print." It must describe the plan's premium, coverage features, patient cost-sharing and rules regarding use of network providers.

The NAIC also drafted "standards for definitions" of insurance-related and medical terms used in health coverage. The proposed regulation directs health plans to make the NAIC workgroup glossary of insurance terms available to applicants and enrollees. These definitions were drafted in a manner that not only helped consumers to understand the meaning of the terms, but more important, helped them to understand their operational significance. For example, the definition of "out-of-pocket limit" informs consumers that some health insurance plans will not count all of consumer co-payments and deductibles of other expenses toward this limit. To assure consumer understanding of terms most likely to affect costs, NPAF recommends the term "coordination of benefits" be added to the glossary and defined.

The aforementioned adopted workgroup recommendations all identify important enhancements to the ability of health consumers to make informed decisions regarding the purchase of health insurance. The workgroup is to be commended for its efforts to provide health consumers with new, standardized summary information about private health insurance coverage. NPAF offers suggestions that builds off of and improves the caliber of the proposed regulations so that they are indeed "patient-centric." The first recommendation NPAF offers is an over-arching one. The proposed regulation assumes communication of the above information should be the exclusive responsibility of group health plans and their administrators as well as health insurance issuers offering group or individual health insurance coverage. Health insurance reform requirements for the group and individual health insurance markets should encourage these entities to partner with nonprofits trusted by the patient community in their efforts to educate health consumers about the health insurance products. An article from the journal *Health Affairs* analyzed data from two surveys to explore Americans' understanding of their health insurance. The study revealed the majority of people when asked to explain their coverage did not fully understand how their managed care plans operate, despite serious efforts by providers to inform them.[2] NPAF reminds health policymakers that the responsibility of educating consumers should rest with those who have already gained their trust- the nonprofit community in general and patient advocate organizations in particular.

NPAF's second recommendation is likewise overarching. Consumers will have difficulty in understanding health insurance terms and that difficulty is likely to increase as market reforms are implemented. Efforts to reduce variation in the insurance market will succeed only if consumer comprehension is sufficient and expands commensurate with reform implementation. The first important area that consumers will have to understand well is that of actuarial value. Consumers have difficulty in understanding this concept[3] and that difficulty may result in unrealistic expectations regarding the health insurance products they choose. The

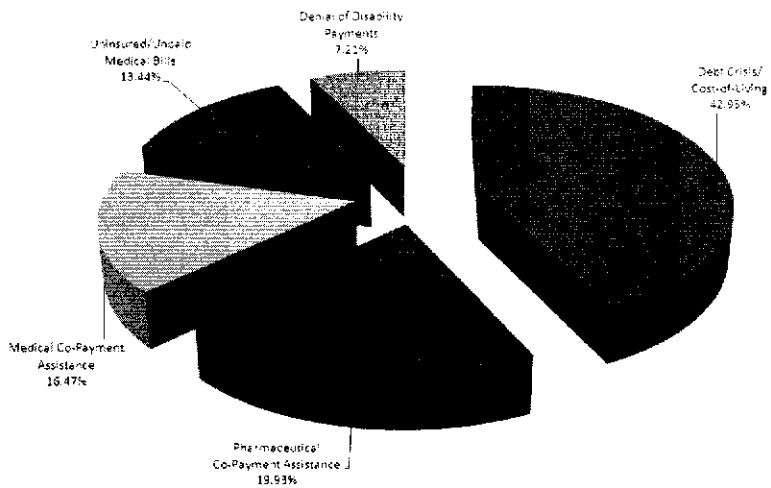
[2] Garnick, DW, et. al., " How Well Do Americans Understand their Health Coverage" *Health Affairs*, Vol. 12, Issue 3, 204-212
[3] See http://www.kff.org/healthreform/8177.cfm

tiering of plans offered through exchanges according to their actuarial value may lead consumers to the incorrect assumption that each tier represents a precise measure of health plan coverage comprehension. Consumers need to be made aware that the health plan rankings are based upon aggregate actuarial value and that individual health service utilization could result in different costs for plans that have the same actuarial value. A 2009 Georgetown University Health Policy Institute study that compared two separate bronze-level plans Massachusetts' Commonwealth Connector revealed a breast cancer patient receiving the same coverage might pay $7,600 for care under one plan but more than $12,000 for the other.[4]

The study also points out that consumers who have never been very sick may not appreciate the extent and type of medical care necessary to treat a serious illness nor the resultant expense. Research has documented the inability of consumers confused by their health plan options to correctly estimate the value of coverage compared to its cost and to select a plan that is most closely aligned to their needs and preferences.[5] PAF understands this fact and has data to quantify its importance to the proposed regulations which are designed to implement disclosure requirements to help individuals better understand health coverage as well as other coverage options. As noted above, PAF professional case managers resolve access to healthcare issues and document data across 260 primary data fields for each case which is compiled into a PDAR. The 2010 PDAR reveals Medical debt crisis was the largest mission category- 63% of case management patient issues fell into this category, which includes all forms of financial hardship resulting from a patient's illness.

The PDAR data suggest the types of medical debt issues faced by patients are directly related to the costs for which they are responsible under their health plan. About twenty percent of patients who reported medical debt crisis had difficulties managing their pharmaceutical co-payments. Another seventeen percent of patients had difficulties managing their co-payments for other medical services. Unpaid medical bills remained a problem for about fourteen percent of patients who reported medical debt crisis. A chart depicting these results is found on the next page. Clearly, the ability of health consumers to accurately predict the coverage they may need in the future when they becomes patients and to estimate resultant personal costs is a skill in need of considerable refinement. In essence, health consumers are simply not able to choose health plans that can protect them from financial peril when faced with a serious illness. Health consumers need assistance in choosing health plans from entities which understand this important dynamic- the patient advocacy community.

Exhibit 2: PAF Medical Debt Crisis Issues in 2010



[4] Georgetown University Health Policy Institute, 2009 "Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?" Available at http://hpi.georgetown.edu/pdfs/Georgetown%20Coverage%20When%2Dit%20Counts%20MA%20FINAL.pdf

[5] Melinda Beeuwkes Buntin, et. al., Trends and Variability in Individual Insurance Products *Health Affairs*, no. (2003):

Patient costs responsibilities across plans within a tier must be clearly understood by patients as the Georgetown University Health Policy Institute study observed the most significant health policy variation was the level of cost sharing imposed and rules for counting cost sharing expenses toward the policy's annual out-of-pocket maximum. One benefit to consumers in their quest to become well-informed about a plan's terms is to have adequate time to review the summary the SBC. NPAF applauds the regulatory language that requires a SBC to be provided when a plan or individual is comparing health coverage options. If the information in the SBC changes between the time of application and when the policy is issued, an updated SBC must be provided. The regulation text queries how best to communicate information regarding a change that is only a final premium quote. Rather than require the health insurance issuer to send a new, full SBC under such circumstances, the cost of which may be passed on to the enrollees or insured, NPAF recommends this information be permitted to be sent alone with reference to SBC information. Collectively, this provides the consumer with the totality of information necessary to make an informed decision. One final note regarding SBC dissemination concerns informing consumers in bold print and in multiple venues that they are entitled to receive the SBC free of charge.

Health insurance coverage will only make a difference to consumers if they are able to avail themselves of a plan's coverage. Therefore, plan information must be transparent at all levels. The NAIC workgroup suggested all plans must include an Internet address that may be used to obtain a copy of the uniform glossary. NPAF applauds this approach and builds on it to further promote transparency for consumers by suggesting the Internet site include a hyperlink that consumer may use to review their individual subscriber information. This approach has worked successfully in educating consumers about Medicare. The site MyMedicare.gov allows a subscriber to access individual records, ask for individual updates or seek documents for printing. To assure confidentiality, such individual accounts should be password-protected.

Consumer ability to understand health insurance plans will be as varied as there are consumers. The proposed regulation text requests comments regarding whether the SBC should include premium or cost information and if so, the extent which such information should reflect the actual cost to an individual net of any employer contribution, as well as the extent to which the cost information should include costs for different types of coverage. NPAF encourages federal policymakers to consider the merit of developing two types of SBCs- one focused on premium and the other on cost. This approach is in the best interest of consumers because it recognizes health consumers are not a monolithic group. Their ability to understand the complexity of health insurance runs a broad spectrum. Their interests are likewise varied and may not be limited to cost but may include social responsibility. For example, although premium information, such as increases are subject to a number of variables outside of the consumer's control, the information can be combined with other publicly available information to evaluate issuers' social responsibility standing. NPAF encourages the development of two sets of SBCs, one based on premiums and the other on cost to satisfy the diverse need for different types of information that health consumers are likely to require.

While there will certainly be variability in consumer comprehension of health plan terms and coverage, one fact that is well documented is the difficulty consumers have understanding health insurance information. A study by the Employee Benefit Research Institute (EBRI) found that the primary reference source document for consumers who participate in employment-based health care plans to review is the health insurance summary plan description (which can also be referred to as an SBC)[6]. However, the information contained in SBCs is written at a reading level too high for the average plan participant. The EBRI study found that crucial information was written at a reading level that is likely too high for the average health consumer. Eligibility,

---

[6] See http://www.ebri.org/pdf/notespdf/ebri_notes_10-20061.pdf

benefits, and participant rights and responsibilities was higher than the recommended reading level for technical material. While some language was written at a junior high school level, (9th grade), other material used language written at nearly a college graduate (16th grade) level.[7]

Employers will play an important role in the provision of uniform SBC to all applicants and enrollees. The regulation text astutely points out that correctly establishing whether an employer is offering affordable minimum essential coverage is important to individuals, employers, and Exchanges and necessitates the verification of certain information about employer coverage, including the information in the minimum essential coverage statement. NPAF agrees that responsible agencies should determine how information about employer-sponsored coverage can be provided and verified in a manner that limits the burden on individuals, employees and Exchanges. However, NPAF cautions these agencies to remember that expedient and burdenless yet incorrect information about employer health insurance coverage may result in harm to the consumer, particularly if it renders him or her unable to participate in an array of quality health insurance products. Certainly, the benefit to consumers is worth the burden of accurately categorizing employer health benefits.

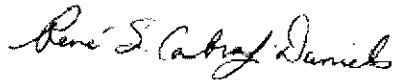
NPAF applauds the development of illustrative claims and cost scenarios for different conditions. Health plans and insurers will run these simulated claims against the policies they offer and estimate not only the total costs that consumer would have to pay in deductibles but includes other cost sharing. The ability to provide simulated claim information to consumers effectively empowers them to make informed decisions. Consumers will be able to compare different health plans against static cost illustrations to get a tangible idea of the relative protection plans offer. The segments that identify information entitled, "Why this is important" represents a wonderful first step in assuring health consumers can make well-informed decisions and the next logical step should be to provide actual patient advocates that consumers can contact for any other related questions which cannot reasonably be captured within a four-page document.

NPAF once again thanks you for the opportunity to comment on this rule. We would be pleased to respond to any questions about our recommendations that may arise in the future. We are also available to discuss, in

greater detail, our suggestions regarding a role for the nonprofit community in the implementation of the rule.

Sincerely,

Nancy Davenport-Ennis
Chief Executive Officer



Rene Cabral-Daniels
Executive Vice President of Regulatory Affairs

[7] Ibid