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Summary of Benefits and Coverage and Uniform Glossary

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General Comment

See attached file(s)

Attachments

SBC Comment Letter with Appendices 10.21.2011

America's Health
Insurance Plans

October 21, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Summary of Benefits and Coverage and the Uniform Glossary (CMS–9982–P)
Templates, Instructions, and Related Materials (CMS–9982–NC)

Submitted electronically: www.regulations.gov

Dear Sir or Madam:

America's Health Insurance Plans (AHIP) is writing to provide comments in response to the Notice of Proposed Rulemaking on the Summary of Benefits and Coverage and Uniform Glossary (the "proposed rule") and the Templates, Instructions, and Related Materials (the "related materials") published in the *Federal Register* on August 22, 2011. The proposed rule and the related materials implement provisions of the Affordable Care Act (ACA), which require health insurers and group health plans to provide information to enrollees and policy or certificate holders about their benefits and coverage.

AHIP and its members have long supported efforts to provide consumers with clear information about their health coverage options – such disclosures empower consumers to make informed decisions about their health coverage. In fact, health insurance plans today employ a wide range of user-friendly information disclosures, including coverage brochures, premium and cost-sharing comparison, and online tools, to help consumers understand the benefits and costs of their health care coverage. These materials are designed to provide individuals and businesses with clearly communicated and actionable information.

The benefits of providing a new summary of coverage document, in addition to what is already provided to consumers, must be balanced against the increased administrative burden that drives up costs to consumers and employers. For example, since most large employers customize the benefit packages they provide to their employees, some health insurance plans could be required to create tens of thousands of different versions of this new document – which would add significant administrative costs without providing meaningful help to employees.

Our comments in this letter and the attached detailed recommendations document (Appendix A) are intended to promote better and more efficient disclosure of insurance policy and health plan information to consumers.

I. Establish a Realistic and Efficient Implementation Time Frame

Recommendations: We strongly recommend that health insurers and employers be given 18 months after the issuance of a final rule to implement the SBC requirements. In addition, compliance should be required for plan or policy years on or after the effective implementation date. In considering this time frame, it is also critical that any decision permitting additional time to comply be announced as soon as possible to provide certainty moving forward and allow health insurance plans and employers sufficient time to adjust compliance efforts accordingly.

Rationale: The March 23, 2012 effective date for compliance in the proposed rule presents major challenges. The proposed rule requires an almost *complete redesign* of how information is provided to consumers today, and it will be difficult and costly to fully implement in the short time frame, which is significantly less than the compliance deadline clearly specified in Section 2715 of the Public Health Service Act (PHSA), as amended by the ACA. In developing the standards in the proposed rule, the ACA directs the Secretary of Health and Human Services (HHS) to consult with the National Association of Insurance Commissioners (NAIC). The NAIC began its work in June of 2010 and did not submit its final report to HHS until July 27, 2011, more than three months after the implementing rule should have been published. Following the late submission of the NAIC report, the proposed rule was subsequently issued on August 21, 2011. We believe an explanation of the complex circumstances HHS faced in issuing a final rule by the deadline should be made. We think that such an understanding is relevant to, and supports the basis for, delaying implementation.[1]

This implementation challenge is exacerbated by the fact that we the nature and scope of changes to the Summary of Benefits and Coverage (SBC) requirements that may be made in the final rule and the subsequent guidance referenced in the proposed rule remain unknown. As a result, the proposed rule does not provide health insurers or group health plans with sufficient time for compliance.

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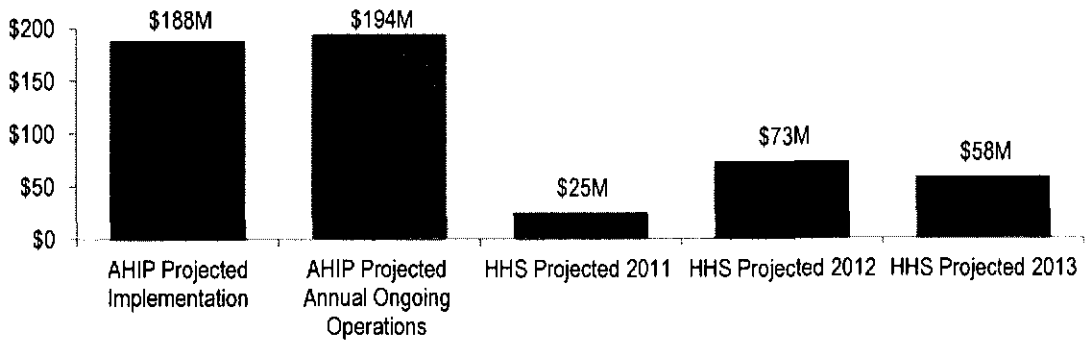
[1] The failure to meet the ACA deadline for issuing standards has been severely disruptive. Regulatory agencies have broad discretion to provide an enforcement delay or safe harbor to allow affected stakeholders enough time to implement new regulatory requirements. This approach has been followed previously with other ACA requirements, such as the rules for claims internal appeals and external review where it was recognized that strict compliance with the ACA deadlines was not possible given the delay in issuing regulations and clarifying guidance.

A. Ease Administrative Burden and Promote Efficiency. To determine the impact of the proposed rule and to inform these comments, we conducted a survey of our membership to determine the cost burden of the proposed rule and health plans, representing over two-thirds of the estimated universe of 180 million enrollees with private coverage (through individual and group insurance and self-funded plans), responded to the survey. The survey indicates that both the initial implementation costs ($188 million) and one year of ongoing operations costs ($194 million) are each higher than the three-year total cost estimate of $156 million that was included in the proposed rule. (See Figure 1. The full report is attached as Appendix B.) These higher costs reflect the expenditure of considerable resources, including extensive reliance on out-sourced services, to comply with the major changes for processes and systems to produce and distribute the SBCs.

Figure 1.

AHIP Member Survey vs. HHS Estimated Issuer Cost to Comply with Summary of Benefits and Coverage and Uniform Glossary Proposed Rule



Note: AHIP member survey results based on companies with 127 million enrollees and extrapolated to an estimated universe of 180 million enrollees.
Note: Estimated Costs are in 2011 Dollars. HHS estimates include both implementation and ongoing operations costs.

B. Allow Additional Time to Address "Workability" Challenges. In addition to the cost burden, we have identified a number of operational concerns or "workability" issues that must be addressed in a final rule. These issues are significant, and Appendix A contains a detailed description of and makes specific recommendations for these issues in four main categories:

- Time frames for producing SBCs;
- SBC delivery issues;
- Flexibility issues in completing the SBC; and
- Other workability issues.

Until these issues are resolved, it will be difficult for insurers and group health plans to fully implement all of the changes that will be necessary to provide meaningful and timely information to consumers.

C. Provide 18 Months after Issuance of Final Rule for Implementation. Given that the final regulation will be delayed significantly and will be beyond the timeframe included in the ACA, an implementation timeframe should be established that gives health insurers and employers sufficient time to make the operational and administrative changes needed to create the SBCs. Our members have indicated that 18 months following the issuance of the final rule would give them sufficient time create and distribute the new documents and, in the AHIP survey described above, they estimated significant reductions in implementation costs of 23 percent with an 18-month implementation time frame. (See Table 2.)

Table 2

AHIP Survey Results – Estimated Cost Savings with an 18-Month Implementation Timeline

	Implementation Cost at Deadline	Implementation Cost with 18-Month Extension	Percent Savings with Extension
Responding Plans*	$94,456,820*	$72,608,527*	23%

Source: AHIP Center for Policy and Research.
*Cost figures based only on plans responding with both estimated implementation costs at deadline and estimated implementation costs with an 18-month extension.

In addition, in establishing an effective date for implementation, we suggest that HHS adopt the compliance approach used for other ACA requirements, i.e., compliance is required for plan or policy years beginning on or after the effective date.[2] This approach addresses the significant operational disruptions that would occur if changes are required in the middle of a plan or policy year. Further, this time frame will allow for full consideration of open issues and resolution of operational challenges, as requested in this letter. We also note that during the implementation phase, individual consumers and small employers will have access to the federal health insurance Web portal (known as the Plan Finder at Healthcare.gov) that will allow them to shop and compare coverage.

D. Provide Immediate Guidance on the Implementation Schedule. Health insurers and employers are already expending considerable resources to meet the March 23, 2012 compliance deadline. These are costs that cannot be recovered if changes are made to the final rule. To minimize the administrative and financial burdens, it is critical that the agencies immediately provide clear guidance on the expected publication date of the final rule and when compliance will be required.

II. Allow Alternatives for Providing Information to "Shoppers"

Recommendations: Since the ACA does not require the SBCs to be provided to shoppers, AHIP recommends that the final rule not include this requirement. Instead, individuals and small businesses should be allowed to obtain information about coverage options through the federal health insurance Web portal, and the final rule should not require SBCs for large employer shoppers.

Rationale: We support the goal of providing information to consumers and employers about their coverage. Section 2715 of the PHSA requires that SBCs be provided to "(A) an applicant at the time of application; (B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and (C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate." The proposed rule, however, goes beyond the statutory provision by requiring that SBCs also be provided to consumer and business "shoppers" for coverage. In addition, the PHSA provision requires HHS to consult with the NAIC in formulating the content and format for the SBCs.

[2] Under this approach, for many employers sponsoring group coverage, this will mean an effective date of January 1, 2014, aligning the implementation of the SBC requirements with the opening of the Exchanges and implementation of other ACA requirements, such as essential benefits and certification of actuarial value.

In its deliberations, the NAIC discussed a requirement that SBCs be created for individual and employer shoppers. However, it was recognized that such disclosures were not required under the ACA and questions were raised about the document's usefulness where an individual or employer is "browsing" health coverage options. For example, it would be impossible for insurers to estimate premiums and include this information on the SBC, without a fuller understanding of the specific coverage provisions sought by the shopper with respect to a given benefit plan, as well as the demographic details regarding the individual consumer or an employer's population. As a result, the template and instructions that were recommended by the NAIC – and substantially adopted in the proposed rule – are not designed for shoppers and do not work well for individual consumers or businesses seeking coverage.

We believe that the requirement to provide SBCs to shoppers is not supported by the ACA and should not be included in the final rule. Further, if the goal is to provide information to consumers and businesses during the shopping phase, we suggest alternative approaches for the individual, small group, and large group insurance markets.

Individual Shoppers. The proposed rule provides that with respect to individual consumers, a health insurance issuer that complies with requirements for the federal health insurance Web portal will be deemed to comply with requirements to provide SBCs to individual shoppers. We strongly support this approach as it appropriately recognizes the need to streamline processes and avoid duplication of existing efforts to inform individuals about their coverage options.

Small Group Shoppers. We strongly recommend that the approach discussed above for individual consumers be extended to businesses shopping for insurance coverage in the small group market. Currently, HHS is requiring health insurers to submit information about their small group insurance market products for the Web portal and the information will be included on the Plan Finder beginning on November 15, 2011. We suggest small businesses can use the portal as a valuable resource to obtain information about all available small group insurance products.

Large Group Shoppers. As previously noted and pursuant to the statute, the SBCs were designed to provide information to individual consumers only. The template was not designed for businesses shopping for coverage, especially large employers, who typically have access to more internal and external information resources and frequently rely on brokers or health benefits consultants for assistance in designing health insurance benefits and procuring coverage. In almost all cases, large employers, or their brokers or consultants, ask health insurers to respond to a Request for Proposal (RFP) that specifies benefit design and administration standards and requires a tailored, detailed response. Requiring the insurer to provide an SBC to the employer, in addition to the RFP response or other submission is an unnecessary and costly

duplication of effort. Since the NAIC-recommended SBC template was not designed for shoppers, it does not consider the resources currently available to and used by large employers to obtain coverage.

III. Align ACA and ERISA Disclosure Obligations to Streamline Processes and Reduce Duplication

Recommendations: Group health plans and insurers providing coverage to group plans should be permitted to provide the information required under the SBC final rule by including the information in materials already provided to employees.

We also recommend that a uniform approach be established that permits health insurers and group health plans to provide coverage information electronically, if the individual has access to the internet or other electronic media such as e-mail.

Rationale: The proposed rule requires group health plans to provide SBCs to participants and beneficiaries and invites comments on ways that the ACA requirements might be coordinated with group health plan disclosures, such as summary plan descriptions (SPDs) and other materials required by other federal laws, such as the Employee Retirement Income Security Act (ERISA). The proposed rule, however, does not make any specific accommodations for currently-required ERISA disclosure materials. Additionally, the proposed rule does not recognize the extensive disclosures about cost and coverage already provided today by employers to their employees.

Consequently, the standards under the proposed rule are in many instances duplicative of information currently required by ERISA and provided by employers today, such as descriptions of benefits covered under the plan, information on network providers, processes for preauthorization or utilization review, and other information about the benefit plan.

More specifically, the SPD required under ERISA must provide the following information:

- Description or summary of benefits;
- Description of cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts;
- Any annual or lifetime caps or other limits on benefits;
- The extent to which preventive services are covered;
- Whether and under what circumstances existing and new drugs are covered;
- Whether and under what circumstances coverages are provided for medical tests, devices and procedures;

- Provisions governing the use of network providers;
- The composition of the provider network;
- Whether and under what circumstances out-of-network services are covered;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service; and
- Rights to continuation coverage (e.g., COBRA).

A chart showing the ERISA-required information for SPDs and comparing those to the requirements in the proposed rule for SBCs is attached to this letter as Appendix C. As noted above and shown in the chart, employers currently provide considerable information to their employees regarding their health care coverage. In addition, if employers offer more than one benefit plan, they typically provide enrollment packages to their employees that allow employees to compare the benefit plan options and premiums. These enrollment packages are provided in addition to the required SPDs, and employers expend considerable resources in making these materials understandable and informative and customizing them for their particular benefit plan options and employee populations.

As noted above, the proposed rule makes no specific accommodation for currently required documents and also does not acknowledge all of the materials employers currently provide to employees. Employers should have the flexibility to include the SBC information required by the ACA within currently-provided materials, in a manner consistent with the ERISA requirements for SPDs. This will allow group health plans to tailor the communication in a manner that best meets the needs of their employee populations, while achieving the overall goals of the ACA to provide more complete information to individuals about their benefits and coverage.

In addition, group health plans and insurers should be given flexibility to use electronic delivery to distribute SBCs or other disclosure materials with SBC-required information. The SBC is not an ERISA document that needs to comply with ERISA electronic delivery rules; rather the SBC is a PHSA disclosure document under an express statutory provision allowing SBCs to be delivered in "electronic form." We urge HHS to develop procedures that facilitate the electronic delivery of SBCs and other disclosure materials to consumers.

IV. Allow Greater Flexibility to Enable Issuance of Meaningful SBCs

Recommendations: We recognize that the ACA requires SBCs, however, given the workability issues with completing the template, we recommend that the final rule and template instructions should explicitly give health insurers and employers flexibility in completion of the form to allow them to provide more accurate and functional information.

Rationale: The proposed rule and related materials establish strict guidelines – based on NAIC recommendations – for the completion of SBC forms. These instructions include detailed font and format requirements, in addition to specific guidelines for the inclusion of required text that cannot be altered or deleted. This strict standard does not make practical sense and can result, under some circumstances, in the SBC providing misleading or incomplete information to consumers about their coverage.

Today, some insurers offer products which include, not just one provider network, but multiple provider networks, each with varying reimbursement levels based on a consumer's choice of a specific network for services. Although the SBC format allows for disclosures of multiple level products, such as three-tier point-of-service plans, there is no capability within the SBC template or in the instructions for an insurer or employer to provide information regarding multiple provider networks may be needed by consumers to either evaluate the product or the multi-provider network benefits.

The instructions and template also effectively prohibit the inclusion of additional statutorily-required language pertaining to required translations. The proposed rule requires SBCs to include notices in "applicable non-English languages" that translation services are available to consumers, who may have specific language needs. Notwithstanding this requirement, the SBC template provides no space to include the notice and no flexibility to rearrange the SBC to create space for the required information.

The proposed template is also inadequate in that it fails to reflect all of the benefit designs available in the market today. We are concerned that consumers and enrollees will receive insufficient information from the SBC template about innovative and creative products, such as those incorporating value-based design features and patient-centered medical homes that cannot be adequately described within the confines of the template. As an example, an AHIP member is piloting an innovative, three-tiered product – with different provider networks in each tier (including one with a patent-centered medical home) and different eligibility criteria (including participation in wellness activities) for the tiers. Enrollees would receive inadequate disclosure about this coverage if the information needed to explain the options is truncated and distorted to fit within the confines of the SBC template.

V. Provide Consumers with Meaningful Coverage Examples

Recommendations: We respectfully suggest that the coverage examples be removed from the SBC template at this time and HHS convene a work group of affected parties to further explore ways in which to provide consumers with meaningful information about benefits and cost sharing under their coverage. Such functionality might be provided through existing insurer Web sites, as part of health insurance exchange web portals available in 2014, or a new HHS-designed common tool.

Rationale: We have strong concerns that consumers could be misled by the coverage examples (CEs), as required under the proposed rule and SBC template. To complete the CEs, health insurance issuers will be required to use HHS-generated cost data for the common treatment scenarios on which all CEs will be based. These common treatment scenarios for breast cancer, normal delivery, and type-II diabetes will need to be based upon HHS assumptions for the course and cost of treatment, including the specific medical and or surgical services provided for the condition. This will not provide relevant or accurate information to consumers. In addition, HHS will need to provide a common methodology for calculating cost sharing that may not reflect the wide variation in the cost of services across the country and each health insurance issuer's or group health plan's reimbursement approaches.

AHIP and its members understand that the CEs are only presented as illustrations, but believe that there are more efficient and accurate alternatives for providing consumers with information about the benefits provided and the costs they may incur under their specific coverage. We note, for example, that many of our members today are providing consumers with cost calculators and other on-line tools to assist them with an understanding of coverage and provider options. Such on-line tools are a more effective way of providing information to individuals about the medical services that are available to them and the potential cost sharing involved. The CEs cannot provide this more accurate and actionable information.

VI. Ensure that the SBC Requirements are Workable

Recommendation: We recommend that HHS establish a technical work group with HHS staff and health plan representatives to identify solutions to these workability issues in advance of the issuance of the final rule.

Rationale: The proposed rule presents many issues with respect to the "workability" of its requirements. For example, during the NAIC process, many operational concerns were raised with respect to delivery of the SBCs and the SBC template. Because these operational issues were not taken up during the NAIC process, it was anticipated that they would be addressed in the proposed rule. Unfortunately, many of these workability issues were not addressed in the proposed rule, and Appendix A of this letter specifically identifies a number of these issues that we recommend be addressed in the final rule.

Issues are identified within four categories:

- Timeframes for producing SBCs;
- SBC delivery issues;
- Flexibility issues in completing the SBC; and
- Other workability issues.

Appendix A provides detail on issues within these four categories, with specific recommendations for identified issues.

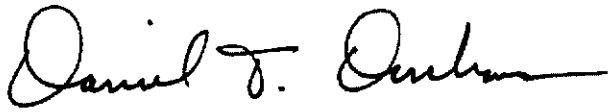
VII. Promote Uniform Approaches for the SBCs and Compliance

Recommendations: We recommend that the final rule encourage states to forego form filing requirements for the federally-required SBCs and – to promote uniformity and efficiency – not vary the rule's requirements for the SBCs. We also recommend that HHS, in conjunction with the states and other affected parties, establish standards that provide for the effective and efficient oversight of SBCs and reference these standards in the final rule.

Rationale: The proposed rule does not address the issues of state form filing requirements and market conduct examinations for compliance with the rule's requirements. While we recognize that the language within PHSA Section 2715 preempts state laws that "require a summary of benefits and coverage that provides less information to consumers" than that required through the SBCs, we believe it makes no sense to allow states to require different rules regarding SBCs, including with respect to any rules regarding the filing and approval of SBCs by state insurance departments. If both federal and state-specific SBCs are permitted, consumers would receive multiple disclosure documents providing different information in different formats and language for the same health insurance coverage. Further, since HHS will look to states to enforce compliance with the SBC requirements, we believe an approach should be adopted that promotes uniform enforcement of these uniform document requirements.

We appreciate the opportunity to provide comments on this important issue. AHIP and its members worked with the NAIC as the SBC and related materials were developed and we look forward to continuing our collaboration with HHS as it considers critical modifications before issuing the final rule.

Sincerely,



Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs

APPENDIX A

Detailed Comments on Summary of Benefits and Coverage Proposed Rule

A. Time Frames for Producing the Summary of Benefits and Coverage (SBC)

1. **Short Production Times.** The proposed rule requires health insurers and health plans to produce SBCs, under several circumstances, within seven days of a request. The production of an SBC requires the matching of specific health benefit coverage provisions to specific benefit coverage selections made by individual purchasers and group plan participants. The very large number of contract variations that health insurers and health plans will have to maintain for the completion of SBCs – some AHIP members estimate the number of variations to exceed 150,000 – when combined with the need to retrieve and assemble this information on an individual basis, calls for a longer period of time to produce an SBC to assure the preparation and delivery of a complete and accurate SBC.

   Recommendation: The final rule should provide for the production of SBCs within 15 business days of the receipt of a request to produce an SBC document.

2. **Timing of Employer Coverage Choice Decisions and Amendments.** Employers are not required to make coverage selection/purchasing decisions, including amending those choices, within a specific time frame, and may do so at any time, up to and even after the policy effective date. Health insurers recognize that employers, particularly small employers, may need additional time to make coverage decisions and prefer to accommodate their employer customers in this regard. The proposed rule, however, requires the delivery of an SBC upon enrollment and, if the coverage terms subsequently change, before the first day of coverage.

   Recommendation: In cases where employers communicate coverage selection decisions, including a decision to amend a previously selected coverage options, to health insurers less than 30 days in advance of the policy or plan effective date, health insurers should be required to produce SBCs as soon as practicable, but no later than 15 business days following receipt of the employer's final coverage decision.

3. **Timing of Employer Coverage Choice Decisions and Amendments for Health Plans Maintained Pursuant to Collective Bargaining Agreements (CBAs).** Because of the nature of the negotiation process between labor and management, changes to health plans maintained pursuant to CBAs are typically made without regard to plan year. As a result, coverage terms for such plans are often finalized after the beginning of a plan year and may require retroactive implementation of coverage changes. Given that the terms of coverage, including effective dates, are dictated by the CBA, it may not be possible in all cases to provide 60-days advance notice of a material modification.

Recommendation: In cases where a health plan is maintained pursuant to a CBA, the final rule should provide that existing disclosure requirements are deemed to provide sufficient notice of, and such plans are not required to provide 60 days advance notice with respect to any coverage changes, regardless the effective date agreed to within the CBA.

4. **Delivery of Material Modifications Due to Clerical Errors.** The proposed rule provides that where benefit plan changes require delivery of an updated SBC, a material modification notice must be delivered 60 days in advance of the benefit plan change, except in instances of coverage renewals. The rule makes no exceptions for situations involving clerical errors that do not affect the actual coverage – but which may require multiple mailings of modification notices and amended SBCs – increasing the possibility for consumer confusion concerning errors that make no modifications to actual coverage.

   Recommendation: The final rule should allow issuance of amended SBCs due to clerical errors, without triggering the 60-day advance material modification notice requirement.

B. SBC Delivery Issues

1. **Delivery of SBCs to Employers.** The proposed rule requires SBC delivery as part of enrollment packages and, if there are changes to previously issued SBCs, again before the first day of coverage. The proposed rule also contemplates the SBCs will be delivered to the home address of employees and certain beneficiaries. Further, it requires health insurance plans to produce SBCs for renewing enrollees as part of re-enrollment packages and health insurance plans and employers to be jointly responsible for delivery of the SBCs.

   While hearth insurers can produce enrollment and renewal packages (and do produce the certificates of coverage), the general practice is for health insurers to bulk deliver these materials to employers, who then provide copies to their employees during open enrollment periods, which most often occur at the workplace, or by permitted mail or electronic delivery. The most effective and efficient delivery method for delivery of SBCs would be to follow these existing practices.

   Recommendation: The final rule should establish that health insurer delivery of enrollment or re-enrollment SBCs to an employer constitutes delivery to the employee participant (and any beneficiaries of the employee) for the purpose of delivery compliance under the ACA. The final rule should also allow delivery by employers to employees at the employee's workplace.

2. **Delivery of SBCs to Employer's Broker or Benefit Consultant.** The proposed rule requires health plans to produce SBCs for renewing enrollees as part of re-enrollment packages, but is silent with regard to delivery through an employer's designated broker or benefits consultant. A common practice within the group marketplace is for health insurers to bulk deliver these materials to an employer's designated broker or benefits consultant, who then provides these materials to the employer or directly to the employees in instances where the broker or consultant conducts the open enrollment on behalf of the employer. The final rule should recognize this general business practice.

   Recommendation: The final rule should establish that in instances where an employer informs a health insurer that the employer has retained the services of a broker or benefits consultant, the delivery of enrollment or re-enrollment SBCs to an employer's designated broker or benefits consultant constitutes delivery to the employee and dependent for the purpose of delivery compliance under the ACA.

3. **SBC Preparation and Delivery in Certain New Sales Situations.** Often health insurers do not obtain detailed census information, such as names and addresses, for new group enrollments, including those for new hires and special enrollments, until the submission of enrollment forms. In these circumstances, quotes are provided to employers based on general employee census information. This practice reduces the burden for employers requesting premium quotes, by eliminating the need for employers to provide employee names and addresses to the health insurer, while also eliminating the need to disclose protected personal health information to insurers – which may never be needed if the employer does not purchase the coverage. To comply with the proposed rule, health insurers and employers must amend long-standing current business practices to ensure that employers produce the detailed health plan participant census information necessary to complete the SBCs in advance of enrollment and the effective date of coverage.

   Recommendation: In instances where employers do not provide detailed health plan participant census data sufficient to produce SBCs 30 days before enrollment, the final rule should permit health insurers to produce SBCs for delivery to the employer no later than 15 business days following receipt of the detailed health plan participant census information.

C. Flexibility Issues in Completing SBCs

1. **Presentation of Non-Network Coverage Products in the Individual Insurance Market.** AHIP's members are particularly concerned that the current SBC template is primarily designed to summarize and describe a provider network-based product. This presents substantial issues with respect to the ability of the SBC template to adequately

and accurately describe other types of products, which do not use provider networks. These include products that may no longer be marketed by a health insurer, but are regularly renewed by individual consumers. The template does not contemplate these types of products and they cannot adequately be described using the predetermined fields.

Recommendation: The final rule should recognize that the SBC template does not adequately provide for the summarization and description of non-network provider coverage products and allow health plans greater flexibility to remove inapplicable, predetermined fields and use that space to provide relevant information to non-group policyholders with those products.

2. **Link to Web Sites at Fulfillment.** Health insurers offer numerous web-based tools and disclosure materials designed to assist their customers in understanding and effectively utilizing their benefits. The prescriptive instructions prevent health insurers from providing their customers with links to these materials in the SBC, thereby denying consumers with easy and timely access to these tools and materials.

   Recommendation: The final rule should allow health insurers and health plans to amend the SBC template to provide links to their proprietary tools and disclosure materials, such as cost estimators, provider selection sites, and consumer education materials, in order to provide information beyond that provided by the SBC.

3. **Inclusion of Group Coverage Enrollee Premium Information.** The National Association of Insurance Commissioners (NAIC) recognized that employers, not health insurers, establish employee premium sharing levels that are necessary for completion of the SBCs. That recognition was not fully reflected in the proposed rule. Consequently, the group insurer instructions require employers to provide employee coverage cost information, while the premium field, which will not contain enrollee (employee specific) coverage cost information, continues to be part of the SBC template.

   Recommendation: The final rule should remove the premium field from the SBC template for group coverage and provide that employers disclose group coverage enrollee cost information to their employees in some other transparent manner.

4. **Inclusion of Non-group Coverage Enrollee Premium Information.** The proposed rule requires the creation of a separate SBC for each premium tier level (individual, two person, parent and child, family, etc) when an SBC is requested by individuals shopping for coverage. This is also the case for new non-group applicants, if the SBC information has changed from the information posted on the Plan Finder at HealthCare.gov. To satisfy this requirement, SBCs for each rating tier must be created, forcing consumers to

look through up to 30 pages of SBCs to find the information they need. Even with the production of all of these SBC forms, the premium information on each SBC remains at best a representative value based upon an insurer's manual rating values – the premium will only become fixed and valid upon the completion of the underwriting process. Health insurers provide accurate premium information to consumers and policyholders at various points in time, and requiring estimates to be included in the SBC could prove misleading.

Recommendation: The final rule should remove the premium field from the non-group SBC and allow insurers to present accurate premium information separately.

5. **HHS Coverage Examples Website.** The proposed rule calls for the HHS to create a website for the posting of data to assist health plans and health insurers in creating Coverage Examples (CE). Public access to this website may lead consumers to believe that the information is indicative of HHS preferred courses of treatment for the listed health conditions and appropriate fee amounts for those medical services.

   Recommendation: The HHS CEs data website should be designed as a limited access source, available only to health plans and health insurers for the purpose of creating CEs. Alternatively, if the website is public, the final rule should require that the website be clearly marked that:

   - it contains information provided solely for completion of the CE portion of the SBC document;
   - CEs are illustrative examples created to help consumers compare health coverage plans;
   - the terms and conditions of a consumer's or employee's actual medical experience will vary from the data within the template; and
   - claim payments will be based on submitted claims and the terms and conditions of a consumer's health coverage contract or plan.

   Further, the rule should require that this statement be prominently displayed on the website in a manner similar to other disclaimers required in the SBC document.

6. **SBC Disclosure Language.** AHIP members remain very concerned about the sufficiency of the disclosure language in the SBC. To prevent consumer overreliance on the SBC and further assist consumers with decisions regarding benefits and access to services, the SBC should contain additional language explaining the purpose and limitations of the information in the SBC and providing direction for how a consumer can obtain additional information.

Recommendation: The final rule should amend the SBC template to clearly indicate that the form was adopted by HHS for use by all health insurers and health plans and that consumers should contact their health insurer, plan administrator or employer for additional information about benefits and coverage.

7. **Out-of-Pocket Limits and Non-contracting Providers.** On page one of the SBC template, the explanation for the question "Is there an out-of-pocket limit on my expenses?" states that this answer is to show the most a consumer could pay during a policy period. This answer is only partially correct, as it is only true in the case of in-network charges and payments, and is clearly incorrect for consumers who use the services of out-of-network providers.

   Recommendation: The final rule should amend the SBC document to clearly indicate this statement is only true for in-network care.

8. **Out-of-Pocket Limits and Contractual Penalties.** The SBC document does not clearly indicate that penalties imposed on individual policyholders or group enrollees for failure to comply with benefit plan provisions, such as precertification requirements, are not applied against out-of-pocket limits. Consumers need to be aware that penalties imposed for failure to comply with the requirements of their coverage may cause higher out-of-pocket costs.

   Recommendation: The final rule should amend the SBC template and insurer instructions, so that the out-of-pocket row on the first page clearly discloses to consumers that penalties imposed for failure to comply with plan provisions, such as precertification requirements, are not applied against out-of-pocket limits. Accordingly, we recommend that the sentence "This limit never includes your premium, balance-billed charges or health care your plan doesn't cover" be amended to read "This limit never includes your premium, balance-billed charges, health care your plan doesn't cover, and penalties for not complying with plan provisions (e.g., non-notification penalties)."

9. **Carved-Out Benefits.** Employers often provide medical benefits through multiple health insurance issuers or third party administrators. For example, the medical benefits may be insured/administered by one entity and the behavioral health or pharmacy benefits insured/administered by another entity. Neither entity would be aware of the benefits insured/administered by the other. We recommend that separate SBCs be allowed in these "carved-out" situations.

   Recommendation: The final rule should clarify that the SBC provided by the issuer of a group insurance policy or group health plan administrator is required to describe only

the benefits it covers. Non-covered services should be represented in the SBC as not covered, with a comment to contact your employer for information on these services. This aligns with the NAIC instructions on coverage examples, whereby costs for non-covered services are reflected in the "you pay" table.

10. **Pre-enrollment Availability of Policies and Certificates.** The proposed rule requires the inclusion of a notice at the top of the first page of the ABC template warns the reader the SBC is "not a policy" in addition to language in the footer that the reader may obtain a copy of the policy by directing them to a website and phone number. In instances where the SBC is being provided to consumers applying for new non-group coverage or enrolling in newly established group coverage, there is no existing policy to review. Even in instances of purchases of new group coverage where an employer has purchased coverage plans, it is a common business practice for health insurers to create the policy and the related coverage certificates only after the enrollment process has been completed. There again, there is no existing coverage document for a consumer in the group market to review. Under the proposed rule, insurers are not permitted to delete this misleading text.

    In both instances of the purchase of individual insurance and the enrollment in group coverage, the consumers will receive their respective insurance policy or certificate of coverage shortly following the completion of the individual insurance application process and the group enrollment process.

    Recommendation: The final rule should permit insurers to remove the language that a policy or certificate is available to consumers making application for non-group coverage or enrolling in group coverage.

D. Other Workability Issues

1. **Health Savings Account and Health Reimbursement Arrangement Funds.** The SBC document does not provide space for important information concerning funds related to Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs) needed by group enrollees to perform a cost benefit analysis in the selection of a plan of coverage at open enrollment. These accounts or funds provide consumers with an important tool to manage health care costs in conjunction with their health coverage. Failure to provide this information may lead consumers to overlook the unique advantages provided by HSAs and HRAs. In addition, incorporating HSA and HRA information within the SBC template is important for individual purchasers of HSA and HRA coverage, so they can obtain adequate disclosures related to these arrangements.

Recommendation: The final rule should amend the SBC template to allow health insurers and employers to disclose information to consumers and employees about the existence of an account or fund related to HSAs and HRAs. This will ensure consumers have the information necessary to evaluate the important implications of such accounts when applying for or enrolling in coverage.

2. **Grievance and Appeals Rights.** The SBC template on page four requires contact information for consumers to learn about their grievance and appeal rights. This information is already provided to all consumers as part of the policy or certificate delivery process and is not required by the ACA to be included on the SBC. In addition, because the instructions require identification of "the proper state health insurance customer assistance program and include their website and phone number" for handling grievances and appeals, insured group health plans for multi-state employers would need to potentially list up to 50 different state regulatory agencies on the SBC or issue separate SBCs for each jurisdiction.

   Recommendation: The final rule should remove the grievance and appeals information requirements from the SBC template, since health insurers currently provide these disclosures in other documents.

3. **Separate SBCs Required for Every Non-Group Premium Tier Option.** The instructions for the SBC template require the creation of a separate SBC for each premium tier level (individual, two person, parent and child, family, etc) for new non-group applicants. This requirement will require health insurers to issue up to five or more separate SBCs to an applicant for individual coverage and was proposed by the NAIC as the only means to provide non-group applicants with complete pricing information for available coverage plans and products. With the creation of the HHS Plan Finder tool, this rating information is now readily available to shoppers though this web-site.

   Under the proposed rule, these multiple SBCs would still need to be provided upon request, forcing consumers to look through up to 30 pages of SBCs to find the information they need. As permitted for group coverage, insurers should be allowed to present the costs for the different rating levels – single person, two person, parent and child, family, etc. – on a separate rate disclosure sheet, and insurers should be permitted to provide all of the deductible and annual out-of-pocket maximum tier information for a coverage plan on one SBC, thereby significantly reducing the burden of production and significantly increasing the consumer's ability to quickly find the information they need.

   Recommendation: The final rule should remove the premium field from the non-group SBC and allow insurers to present premium information on a separate premium

disclosure form to be delivered with an SBC. The final rule should permit insurers to provide all of the deductible and annual out-of-pocket maximum tier information for a coverage plan on one SBC form.

4. **Rate Tables.** On page four of the instructions for group coverage, under the caption, ***What is The Premium?***, the instructions require the attachment of an insurer's complete rate table for small group plans that use such methods for determining premiums.

   Recommendation: The final rule should remove any reference to a "rate table" for coverage options on the SBC and require employers to separately provide information on employee cost-sharing to the employee.

5. **Need for Additional Space to Provide Information.** The format of the SBC template cannot accommodate many benefit plan structures and related information, offered by health insurers and health plans. The inclusion of an additional row, perhaps entitled "Other Important Information" would provide the opportunity for health insurers to identity significant coverage plan provisions related to covered services, cost sharing, limitations, and exceptions. By creating this row to provide additional, coverage plan specific information, enrollees would be better informed about these additional policy provisions.

   Recommendation: The final rule should create a section in the SBC template that allows health insurers and employers to provide additional coverage and benefits information to consumers.

6. **Preventive Care.** The SBC document does not clearly set forth that preventive care is available without cost sharing for non-grandfathered plans. This is important information for currently uninsured individuals, who may be unaware of the new ACA provisions concerning no cost sharing for preventive care.

   Recommendation: The final rule should amend the SBC template and insurer instructions to disclose that certain preventive care may be obtained without cost sharing.

7. **Expatriate Health Plans.** The preamble to the proposed rule acknowledges the unique characteristics of expatriate and international health plans and invites comment on these plans. Employers with globally-mobile workforces typically sponsor a single international plan to cover their expatriate employees. Accordingly, a comparison of plans at time of enrollment, a situation that fundamental to the concept of the SBC, is non-existent with expatriate or international coverage. The utility of the SBC in this context is highly questionable.

Recommendation: The final rule should recognize the unique characteristics of expatriate and international coverage and the limitations of the SBC template to adequately address those characteristics. Accordingly, expatriate and international plans should be exempted from the requirements of the final rule.

8. **HIPAA Excepted Benefits**. We appreciate the clarification regarding scope and applicability in the instructions for completing the SBC contained in Appendices B-1 and B-2. Specifically, the guidance to states and health plans regarding the continued exemption for products that are classified as HIPAA "excepted benefits" is very helpful and will assist stakeholders as we work collaboratively to implement the new federal requirements.

   Recommendation: The final rule should include the guidance found in the instructions in Appendices B-1 and B-2 of the proposed rule that HIPAA "excepted benefits" are exempt from the requirements of PHSA Section 2715.

9. **Stand-Alone HRAs.** The proposed rule does not provide an exception for stand-alone HRA's. However, if an SBC is required for a stand-alone HRA, all of the fill-ins for the various fields in the SBC template reflect "$0" or "No" or "None." The result will be the production of an SBC that is unnecessary and not at all useful to employees.

   Recommendation: The final rule should exempt stand-alone HRAs from any requirement for the completion of an SBC.

AHIP
Center for Policy and Research

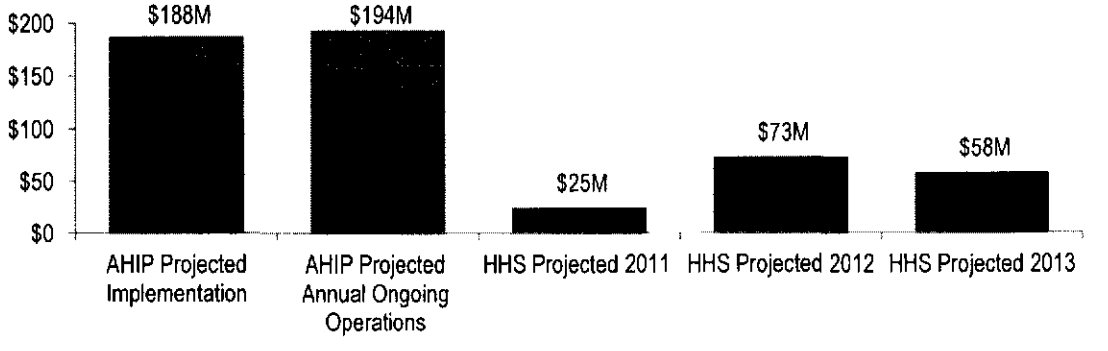
Summary of Benefits and Coverage and Uniform Glossary Proposed Rule: Implementation and Annual Ongoing Costs of Compliance

October 2011

In September 2011, AHIP conducted a survey of health insurance plans on costs of compliance with the new Summary of Benefits and Coverage (SBC) and the Uniform Glossary requirements detailed in a notice of proposed rulemaking (NPRM) issued by the Department of Health and Human Services (HHS), Department of Labor, and Department of Treasury on August 22, 2011.

The SBC and Uniform Glossary are required under the Affordable Care Act (ACA) and are intended to provide individuals and group health plan sponsors with a document that "accurately describes the benefits and coverage under the applicable plan or coverage," as well as definitions of health insurance terms. In addition, the SBC will include "coverage examples" of at least three common benefit scenarios – pregnancy, breast cancer, and diabetes.

Figure 1. AHIP Member Survey vs. HHS Estimated *Issuer Cost to Comply with Summary of Benefits and* Coverage and Uniform Glossary Proposed Rule



Source: AHIP Center for Policy and Research.
Notes: AHIP member survey results based on companies with 127 million enrollees and extrapolated to an estimated universe of 180 million enrollees. Estimated Costs are in 2011 Dollars. HHS estimates include both implementation and ongoing operations costs. M = millions.

The proposed rule requires health insurers to issue SBCs to individuals and employers in the shopping phase for health insurance ("shoppers"), at application, at enrollment, when a policy is issued, at renewal, or on request.

The proposed SBC template was developed by the National Association of Insurance Commissioners (NAIC), in conjunction with a working group of representatives of consumer advocacy groups, health insurers, health care professionals, and other stakeholders.[1]

Standardized, easy-to-understand information about health coverage allows consumers to make informed decisions and use their benefits in an optimal way. Health plans increasingly provide user-friendly online tools and clear materials to make sure that consumers understand the benefits and costs of their health insurance policies.

However, the deadline for the switch from health plans' current benefit materials to the proposed SBC is rapidly approaching, and the final rules are not yet published. The transition from health plans' current benefit descriptions to the new system could be difficult and costly to implement in such a narrow time frame. Likewise, some elements of the SBC, such as providing premium information on the benefit description or providing paper copies of documents, could add to the cost.

The AHIP survey indicates that the implementation and ongoing costs of the SBC requirement could be considerably higher than those estimated by HHS in the NPRM. The open-ended part of the survey allowed responding health plans to suggest other key issues that could affect costs:

- The March 23, 2012 implementation date
- Requirement to include premium information on initial SBC
- The number and complexity of coverage examples required
- Renewal process and timeframe to send SBC(s).
- The number of variations of SBCs to be delivered to each applicant or enrollee
- Duplication of materials already delivered to group health plan enrollees
- Paper delivery of SBCs to most group enrollees
- Requirement to provide SBCs to business "shoppers"
- Insufficient flexibility in the SBC template for explanation of benefit and rating tiers, especially for newly developing and innovative products

Health plans are only beginning to develop implementation strategies and estimate implementation and ongoing operations costs for the SBC rule. Furthermore, it is possible that the proposed rule will be modified and clarified when the final rule is published. Thus, the cost estimates in this survey should be regarded as preliminary.

SURVEY RESULTS

Survey results were compiled in two formats: *quantitative* estimates of implementation and annual ongoing operations costs, and *qualitative* or open-ended responses regarding operational changes and key implementation issues noted by health plans. The survey results were based on responses from health plans with about 127 million enrollees. The implementation and ongoing cost results were extrapolated to an estimated universe of 180 million

[1] *Summary of Coverage: What this Plan Covers & What it Costs.* (2012, August 22). Retrieved from U.S. Department of Health and Human Services: http://www.healthcare.gov/news/factsheets/2011/08/labels08172011b.pdf

Table 1. AHIP Survey Results and Extrapolated Results – Estimated Implementation and Annual Ongoing Operations Costs Related to Summary of Benefits and Coverage and the Uniform Glossary

Company Size	Enrollment	Total Implementation Costs	Total Annual Ongoing Operations Cost
		Survey Results	
Large (more than 5 million enrollees)	89,743,947	$87,809,000	$109,618,000
Medium (1 million to 5 million enrollees)	33,119,824	$37,431,000	$22,559,000
Small (fewer than 1 million enrollees)	4,437,027	$7,990,000	$5,266,000
All Companies in Survey	127,300,798	$133,229,000	$137,443,000
		Results Extrapolated to 180 Million Covered Lives	
Large (more than 5 million enrollees)	126,895,595	$124,159,000	$154,998,000
Medium (1 million to 5 million enrollees)	46,830,565	$52,927,000	$31,898,000
Small (fewer than 1 million enrollees)	6,273,840	$11,297,000	$7,445,000
All Companies in Survey	180,000,000	$188,383,000	$194,341,000

*Includes 4 plans reporting that they are unable to estimate costs for implementation by March 23, 2012.
Source: AHIP Center for Policy and Research.
Notes: AHIP member survey results based on companies with 127 million enrollees and extrapolated to an estimated universe of 180 million enrollees. Enrollment figures include fully-insured and self-funded covered lives provided by the 36 survey responding companies. Numbers may not sum to totals due to rounding.

Table 2. AHIP Survey Results – Estimated Cost Savings with an 18-Month Implementation Timeline

	Implementation Cost at Deadline	Implementation Cost with 18-Month Extension	Percent Savings with Extension
Responding Companies*	$94,457,000*	$72,609,000*	23%

Source: AHIP Center for Policy and Research.
Note: Survey assumed a hypothetical 18-month implementation period, assuming final rules were published in December 2011.
*Cost figures based only on companies responding with both estimated implementation costs at deadline and estimated implementation costs with an 18-month extension.

enrollees with private health insurance for comparison with the estimates provided in the proposed rule.

Figure 1 compares estimated health plan costs to comply with the SBC and the Uniform Glossary projected by HHS with the estimated costs identified in AHIP's member survey. HHS projected total costs (implementation and ongoing) for the years 2011, 2012, and 2013, while AHIP's survey estimated separate costs for implementation and annual ongoing operations. Estimated costs for both the HHS and AHIP survey are in 2011 dollars.

Table 1 shows total enrollment, estimated implementation costs, and annual ongoing operations costs for responding companies in the survey. The table shows the survey results as well as an extrapolation of the survey results to 180 million covered lives, a roughly estimated number of commercially-insured enrollees.

Large plans, which we defined as those with more than 5 million enrollees, reported estimated implementation costs of almost $88 million and annual ongoing operations costs of about $110 million. Medium-sized plans, defined as those with between 1 million and 5 million enrollees, reported $37 million in estimated implementation costs and almost $23 million in estimated annual ongoing operations costs. Smaller plans with fewer than 1 million enrollees reported estimates of almost $8 million in implementation costs and over $5 million in annual ongoing operations costs.

Table 2 shows estimated implementation cost savings with an 18-month extension of the implementation timeline, from the estimated publication date of the final rules to the date of implementation. Technically, to give responding plans a specific time frame, the costs were estimated based on the assumption that the final rule would be published in late December, 2011. Thus, the hypothetical implementation period would be the ensuing 18 month period. It is important to note that the total implementation cost at deadline takes into account *only* responding plans that estimated implementation costs at the deadline and with an 18-month extension. For plans responding with both cost figures, there was an estimated 23 percent savings on implementation costs with an 18-month implementation period.

Table 3 details the percentage of estimated annual ongoing operations cost that is attributed to the hiring of additional staff. For all responding companies in the survey, about 17 percent of annual ongoing operations costs are estimated to be attributed to the hiring of additional staff.

Table 3. Estimated Annual Ongoing Operations Cost Attributed to Hiring of Additional Staff

	Total Ongoing Operations Cost	Costs Attributed to Hiring Additional Staff	Staffing Costs as a Percent of Ongoing Cost
All Plans in Survey	$137,443,000	$23,801,000	17%

Source: AHIP Center for Policy and Research.

MAJOR ISSUES FROM HEALTH PLAN RESPONSES

The following sections provide summaries and selected quotations from the open-ended responses to the survey. The Appendix to this report provides additional direct quotations.

March 23, 2012 implementation date. Implementation costs are significant, and preliminary strategies and process developments are subject to change as final guidance is provided, increasing the complexity of compliance by March 23, 2012.

> *"In order to meet 3/23 [2012] effective date, we are having to rely on a large percent of contracting resources. A longer timeframe would allow employees who are currently working on HCR projects with an earlier effective date (i.e. 1/1/12) to become available and lower the development cost."*

Requirement to include premium information on initial SBC. Requiring the inclusion of premium information on SBC during the "shopping" phase will significantly increase complexity and costs for health insurers and cause confusion for consumers, especially in group markets. Premiums cannot be accurately provided without collection of detailed information from a shopper prior to application for coverage and could frequently change as the shopper considers options.

> *"The requirement to provide premium information in the SBCs distributed to applicants and enrollees of an employer group will have a cost impact. Carrier would be able to provide the gross premium information. However, carrier does not have access to records of employer group contributions toward their employees' premiums."*

Number and complexity of coverage examples required. The number of possible coverage examples, taking into account benefit, and plan designs will be very large, creating complexity for carriers and causing consumer confusion and increased cost.

> *"Requiring more than 3 benefit scenarios, and possibly as many as 6, potentially provided for all benefit packages offered, to be populated and incorporated into a template document...only serves to further increase the costs and complexity of producing the SBC, which is intended to be a 'Summary' of Benefits and Coverage."*

> *"We expect over 157,000 versions of the document to be developed initially and increasing as new plan designs are developed."*

Renewal process and timeframe to send SBC(s). The proposed rule requirement that health insurers must send SBCs to enrollees at least 30 days prior to renewal has the potential to significantly affect business practices regarding renewals.

> *"[The] automatic renewals [requirement to] deliver the SBC 30 days prior to the effective date is not in line with our current business practices. This requirement would cause a major change in our renewal process. In the case of automatic renewals, it would seem more appropriate that the SBC be sent within 30 days of the effective date, along with other coverage documents, rather than prior to the effective date."*

Number of variations of SBCs to be delivered to each applicant or enrollee. Throughout the shopping, application, and enrollment phases, the number of SBCs provided to applicants and enrollees may

cause increased confusion and complexity. By not allowing a single SBC to include different benefit levels and premium tiers for one person, two person and family coverage, multiple SBCs will need to be generated, thus significantly increasing the workload and development costs for carriers and potentially inundating consumers.

> *"Requiring issuers to provide SBCs to shoppers... [and] provide specific "coverage date" information, and provide multiple iterations for each product based upon coverage tier elected significantly increases compliance costs."*

Duplication of materials already delivered to group enrollees. Group plan enrollees receive summary plan documents (SPDs) and the challenge will be to minimize duplication of materials already sent to enrollees.

> *"The revised format and the specific delivery requirements for the SBC create complexity because they duplicate and completely revise an existing document and process."*

Paper delivery of SBCs to most group enrollees. Printing, mailing, and other costs related to delivering SBCs on paper may cause carriers to have to change their fulfillment processes, and will be a significant annual ongoing cost.

> *"By requiring that we provide the SBCs in paper would require us to completely redesign our fulfillment processes and costs."*

SBCs for employers and group sponsors. Allowing employers to request SBCs during "shopping" phase along with individuals significantly increases cost burden.

> *"Creating the SBC Pre-Sale for Employer Groups will increase complexity, given the high level of variations that have to be taken to account when creating the SBC."*

Insufficient flexibility in SBC template for explanation of benefit tiers. The inability for carriers to include additional more specific information, such as benefit tiers for certain plan designs, will cause confusion for consumers.

> *"HHS should consider allowing plans the option to modify the headings of the SBC template to reflect the appropriate tiered network benefits. We also recommend a field that would allow plans to include more specific information about the benefit plan. Currently we include disclaimers that outline the specific rules of the plan. The current SBC template does not include enough space to make these specifications clear to the members, which can cause confusion."*

ACKNOWLEDGEMENTS

The data for this report were compiled by Dan LaVallee of AHIP's Center for Policy and Research. For more information, please contact Jeff Lemieux, Senior Vice President, at 202.778.3200 or visit www.ahipresearch.org.

APPENDIX – Open-Ended Company Responses

The following are direct quotations from the open-ended responses to AHIP's SBC survey. The responses of multiple companies may be included in each section. The quotations were edited to eliminate redundancy, for clarity, and to de-identify the responding company.

March 23, 2012 Implementation Date

The SBC cost estimates were conservatively estimated by using only incremental costs to produce the plan design and Summary Plan Document (SPD) solutions in place today. Moreover, issuers must now invest resources (financial and personnel) to meet the effective date based upon a proposed rule that is likely to change before made final. In addition, further investment will be required to support state-specific mandated formats. Ongoing development costs will be incurred to support changes in mandates, product designs, etc.

These costs represent preliminary estimates to design, test, and implement capabilities to produce the SBC, Coverage Examples, and Uniform Glossary. The March 2012 costs reflect a 50 percent premium due to the short delivery timeframe. These estimates are subject to change as new guidance is provided regarding the final format and content of the SBC.

In order to meet 3/23 [2012] effective date, we are having to rely on a large percentage of contracting resources. A longer timeframe would allow employees who are currently working on HCR projects with an earlier effective date (i.e. 1/1/12) to become available and lower the development cost.

If we had an extension we would save on the administrative and operational costs and most likely reduce implementation costs by having the opportunity to implement more comprehensive and efficient delivery processes. Presumably, we would also have the advantage of final guidance which would allow us to pursue implementation with a greater measure of certainty that resources would not be wasted.

This project is going to require significant development effort. Solutions will need to be created that either duplicate the efforts for various systems and data mapping or a solution that presents a single source for data to feed to. Putting such a short time frame on the implementation forces health plans to choose the quickest solution (as opposed to the most appropriate), increasing the cost and inefficiency.

While we expect the financial impact to meet the March 23, 2012 deadline to be significant, our primary concern is the ability to fulfill the deadline requirement through outsourcing. The vast majority of the skills and tools needed can't be outsourced due to the complexity of the systems, lack of experience an outsourced resource would have of our with current work flow processes and IT architecture, in addition to the lack of final regulations to build a solution upon. Recent experience with the HCR Portal demonstrated the risk and additional costs that must be absorbed by pursuing a solution based on the preliminary regulations. Substantial rework was required on our HCR Portal solution to account for the variance in the final regulations.

Cost estimate assumes minimal automation due to the brief implementation timeline. Minimal automation would result in a large number of employees being hired to execute manual processes. Cost estimate assume[s] a greater level of automation (and therefore, increased initial development costs). This estimate also assumes fewer FTEs will need to be hired to complete manual tasks.

The shortened timeframe of the March 2012 deadline does affect the testing window and puts additional pressure on limited resources. [Our] estimate includes business analysis, project definition, systems development and online availability via public website.

Such a short implementation time frame means costs will be significantly greater due to:

- *Cost of additional staff resources, over and above what we would have allocated to this project if the implementation deadline were not 6 months away;*
- *Cost of temporaries to back fill for staff who will be needed on this project full time to make the deadline;*
- *Cost of inevitable rework because we have to begin implementation now before we have final requirements which will likely be changed from the NPRM;*
- *Cost of rushing a vendor to implement in a compressed time frame and having to populate 1500 SBC templates.*

If given extension, it will allow for proper/better planning of budgeting/allocation of resource[s]. Some costs may be deferred by working with vendors that have a responsibility to comply with the mandate as a market wide implementation, not specific to one entity; however, we will still be responsible for remediation of custom functionality.

To meet a 3/23/12 effective date, we will need to handle certain processes manually; therefore, staff will need to be hired until we can automate the processes.

Ongoing costs will depend on the implementation timeline and the amount of automation that can be developed.

We have not completely determined impact on all operational areas since clarification of regulations is still forthcoming through various government entity comment periods, and legal interpretations. It's imperative we get final rules and guidance, without which we cannot determine the necessary operational and system requirements. Under current assumptions, there is risk that the implementation date of 03/23/12 may not be met otherwise.

The complexity and cost of implementation is drastically increased with the requirement to provide this information down to the plan level. The strain of programming and development resources involved in creating the SBC could potentially be mitigated if this information were provided only down to the product level.

We will see rework as we need to begin to build now for a March 23, 2012 date and expect there will be changes once [the final rules] are released. The compressed timeframe will force less system and process testing, limited ability to effectively communicate with employers and brokers in advance of the changes, create confusion in the marketplace with employers and members in the initial launch period. The 03/23 date requires starting process/systems work to commence prior to [the final rules]. Additional adjustments defined in the [final rules] will create post effective date changes to our processes and systems further creating marketplace confusion.

Limited timeframe to implement, given the delay in final regulations, we are faced with an exceptionally short period of time to implement the SBC which has very complex IT requirements. An extension of the implementation date would alleviate unnecessary strain and expenditure of resources.

This single ACA provision represents significant administrative cost and should be more fully considered in light of on-going pressure for health plans to reduce these costs.

The volume of plans will make the implementation complex. That in combination with the need to essentially create individualized SBCs based on information to determine premium, makes this next to impossible. We, along with the rest of the industry, urge the need for additional time for sufficient development and testing.

Overall costs increase the longer carriers have to wait for final guidance as carriers are developing solutions based on assumptions that may not be correct and ultimately require re-work. The investments required to meet the timeline are not necessarily foundational to the long term solution. There are temporary manual solutions being developed in order to meet the compliance date, and may be revised upon release of the final regulation.

Requirement to Include Premium Information on Initial SBC

The requirements around providing "premiums" and "pharmacy" will significantly increase the complexity and cost of implementing this NPRM. It is not part of our standard business process to provide premium information at any of the "trigger" points laid out in the NPRM. We will have to completely redesign our quoting processes. Also, a decision was made by the plan to provide documentation online. Requiring that we provide the SBCs in paper would require us to completely redesign our fulfillment processes and costs.

The NPRM retains the NAIC direction to issuers regarding premium information relating to the group markets (issuers will answer "Please contact your employer for your share of the premium amount.") However, the request for comments in the NPRM on whether premium or cost information should be included in the SBC and how, raises concerns that issuers may be required under final rules to obtain this information from employers and include specific cost sharing information in the SBC. Premium and cost sharing information is particularly sensitive information for employers that issuers do not currently know. Managing significant volumes of new information across thousands of individuals would further add to the cost of implementation.

Having the Premium information on the SBC for both Group and Non-Group adds significant complexity as the SBC has to be customized. It requires data from our underwriting system to interface with our claims system to determine an employee's premium (i.e. share paid by employees, not employers). The level of specificity, including premium amount and exact benefit design, required to be included in summary of benefits and coverage (SBC) will result in the need to maintain an immense number of SBC versions.

The requirement to provide premium information in the SBCs distributed to applicants and enrollees of an employer group will have a cost impact. Carrier would be able to provide the gross premium information. However, carrier does not have access to records of employer group contributions toward their employees' premiums.

Number and Complexity of Coverage Examples Required

It will require major technical enhancements, as well as additional staffing, to provide coverage examples alone. Technical costs will be higher due to the short window of time given to implement, as will man hours for project implementation management.

Annual ongoing operations costs include printing, mailing and staffing costs for the SBC and Coverage Examples.

The requirement to produce the Coverage Examples has an obvious significant impact on the cost and complexity of producing the SBC. While the specific information necessary to simulate benefits covered under the plan or policy remains unavailable from HHS it is impossible to determine ease or difficulty of use and any associated unexpected costs or complexities. Nonetheless, populating the coverage examples will provide its own set of challenges. Requiring more than 3 benefit scenarios, and possibly as many as 6, potentially provided for all benefit packages offered, to be populated and incorporated into a template document that already challenges the provisions of Sec. 2715 (a)(1) and (a)(3)(A) of the Patient Protection and Affordable Care Act (uniform definitions are included in the 4-page limit) only serves to further increase the costs and complexity of producing the SBC, which is intended to be a 'Summary' of Benefits and Coverage

The creation of coverage examples that require simulating claims processing is burdensome. The suggestion in the NPRM for creating a portal for this purpose is something we support. If this is not feasible, a simpler approach, such as the use of uniform illustrative examples, should be used.

Coverage facts labels and other graphics increase the complexity of developing and printing/electronically publishing SBCs.

Coverage fact labels are of questionable benefit to consumers because they are potentially misleading due to wide variation between individuals' treatment costs for common conditions (for example, because of treatment complications).

Based on consumer demand, we offer a variety of plan designs, with various premiums, network structures, etc., in the marketplace. Unless comparisons are made between like plan designs, the comparison will not be meaningful and may be misleading.

The NPRM (Supplementary Information, Section I: Proposal pp 52477-78) states that HHS will update the national average payment data annually and that plans will need to modify the Coverage Examples and reprint SBCs for use 90 days after the update. The NPRM goes on to say that "these updates alone will not be considered a material modification under paragraph (b) of the 2011 proposed regulations." This means SBCs could reflect different payment data from health plan to health plan. This would render the comparisons invalid. Since the intent is to provide a comparison tool, then all plans should be required to make changes on the same cycle; otherwise the Coverage Examples are not comparable and a great deal of time, effort and cost will have been expended for a tool that is invalid.

The timing of HHS' release of national average payment data is critical. Certain times of the year, the fall for example, are extremely busy with renewals and open enrollments. HHS needs to avoid these critical times since printing is completed well in advance.

Renewal Process and Timeframe to Send SBC

The requirement to provide the SBC within 7 days of a request for information about the health coverage by a group health plan has a significant impact on the Large Group Proposal process, particularly in the case of an extensive RFP where employer groups seek information from multiple carriers to compare against current plans. Generally, information is gathered and returned to the Group within a specific time period of time and may include numerous benefit and rate options from which the Group can narrow down their selection(s). If the intent of the rule is to incorporate the SBC into the initial proposal process, the cost increase and complexity associated with the change in current process will be substantial.

The timeframes for delivery of SBC's after receipt of a request are not feasible in a group process. Seven days may be feasible in an individual, prepackaged plan market, but in a group setting, with complex and flexible benefit packages (approximately 70,000 currently) it can be as much as 60 days to respond to complex RFP's. In general, the delivery times and methods (electronic) need specific analysis given the current practices in the market which are driven by plan sponsor and producer needs.

60 day notice of material modification: many small and large groups request last minute benefit change or do not confirm renewal of coverage until a few days before the plan effective date or even request retrospective changes. It will be very difficult for our plan and our groups to comply with the 60 day requirement.

Automatic renewals require delivery of the SBC 30 days prior to the effective date – This requirement is not in line with our current business practices.

The requirement that applicants must receive SBCs by effective date of the contract can be problematic in instances where there is a retroactive effective date, or in cases where the request is received just days prior to the effective date (less than 7 days before the effective date).

Number of Variations of SBCs to be Delivered to Each Applicant or Enrollee and SBCs for Employers and Group Sponsors

The requirement to provide the SBC to group health plans or sponsors when they are shopping around will substantially increase the cost and complexity of compliance. Frequently, as many as 10-12 different plan options can be presented to employers or their brokers. Currently, those options are reflected in a one page spreadsheet. If SBCs are required, they will have to be continually modified to reflect all the different options being presented. In the group market, less than 10% of groups quoted will ultimately end up buying one of our plans. Therefore, a

significant cost will be incurred in providing multiple SBCs that contain low level information that most group purchasers will not find useful and which will not result in a sale. Once a plan is selected and a contract is entered into, it makes sense to provide the SBCs to employees at enrollment. The template content is geared toward a lay person, not to brokers and group purchasers.

"A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application or request for information about the health coverage as soon as practicable following the request, but in no event later than seven days following the request. If an SBC is provided upon request for information about health coverage and the plan (or its sponsor) subsequently applies for health coverage, a second SBC must be provided under this paragraph (a)(1)(i)(A) only if the information required to be in the SBC has changed." With respect to sentence 2, the 'Draft Instruction Guide for Group Policies' pg 3, bullet 2 (NPRM pg 52495) requires that "For final forms (provided to employees after selection), insurers should only include information for the relevant plan." Enrollees are capable of making this distinction providing the levels of cost sharing are appropriately labeled as to their applicability within each category. This requirement further adds to the increased cost and administrative burden, and the complexity of providing the SBC. This requirement appears to be in conflict with the intent of §(a)(1)(i)(A).

Preparing the documents for shoppers within the required timelines will be very time-consuming, expensive and difficult for our plan to implement.

The unique aspect of employer group coverage and coordinating all of this with employer groups adds an enormous amount of complexity to this requirement.

To require that issuers and employer groups follow the 2002 Department of Labor ("DOL") electronic distribution safe harbor is particularly burdensome in the current environment where most individuals have access to electronic information systems outside of work. To require compliance with the DOL safe harbor is likely result in paper delivery of at least initial and perhaps subsequent SBCs to group Participants and Beneficiaries, significantly increasing associated costs. Issuers do not currently know the universe of Participants or Beneficiaries nor do they know which Participants have electronic access to documents at any location where they can reasonably be expected to perform their duties and for whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Without this information, issuers are required to deem all Participants as not having such access; therefore, must build processes to obtain affirmative consent from all. A March 23, 2012 applicability date does not allow enough time for issuers to build and test such processes, educate plan sponsors on what information must be provided, and incorporate Participant and Beneficiary information into such processes.

Requiring issuers to provide SBCs to shoppers (meaning individuals who have not submitted an application) for any product they might be curious about, provide specific "coverage date" information, and provide multiple iterations for each product based upon coverage tier elected significantly increases compliance costs. Issuers do not acquire or maintain information on individuals who do not submit an application for coverage; therefore, requiring delivery of SBCs in the proposed from to "shoppers" creates the need to build an entirely new process for acquiring and maintaining such information. Furthermore, it is unlikely that many issuers will be able to track what version of which SBCs was delivered on what date to a shopper; therefore, issuers will likely be forced to resort to reissue new SBCs at the points in time identified in the NPRM under a presumption that something in most recently delivered SBC has changed.

Requiring the issuance of a new SBC iteration specific to the coverage tier elected by an individual creates the potential of multiple SBCs to an individual each time an individual adds or removes a dependent (e.g., self , self plus one, self plus two, self plus 3, family).

Currently we support almost 9,000 active benefit summaries for our existing business. To implement the mandate as currently defined would increase our volume by over 5-fold. Our existing summaries are "static" meaning the same summary is provided pre-sale and post-sale to all groups/members with the same benefit. The noted items above will cause the creation of "custom" summaries by member/group just so the items noted (policy period and coverage type, and deductible) are correctly listed when all the other data elements will be constant. This greatly increases our implementation costs and impacts our record retention abilities.

Creating the SBC Pre-Sale for Employer Groups will increase complexity, given the high level of variations that have to be taken to account when creating the SBC.

One requirement that will significantly increase the complexity and cost will be the requirement to track and provide updated versions of the SBC during the shopper/application/initial enrollment phases. This will require development of a cross-departmental distribution management solution.

The intent of the SBC is to "help individuals better understand their health coverage options so that they may make informed coverage selections". However, the instructions indicate that the SBC is to be issued pre-sale (prior to initial & annual enrollment/renewal, etc) and post-sale ("when an insurer issues a policy or delivers a certificate form" p 2 Instruction Guide). Requiring the SBC to function as both a "pre-sale" and "post-sale" document, i.e., providing the SBC twice annually will significantly increase cost and complexity.

The requirements regarding the timing of sending SBCs, particularly to shoppers, increase ongoing costs to produce and send. In addition, as proposed, we will need a method to track what versions were sent when, identify changes and send updated versions.

If we have to continue to provide for shoppers, then the safe harbor to publish on healthcare.gov does minimize some concerns. However, there is no way to track what version of an SBC a shopper receives, and as such we recommend not having to resend to shoppers if there are any changes. As with any purchase in any industry, while people are still just shopping, everything is still subject to change.

The requirement to send to multiple addresses is extremely complex. Today we do not collect additional addresses for dependents on the plan, but instead send plan materials to the subscriber. This would also be burdensome for employers. We recommend that the final rule be altered to only require SBCs be sent to the individual making the purchasing decision- the subscriber.

Paper Delivery of SBCs to Most Group Enrollees and Duplication of Materials Already Delivered to Group Enrollees

Also, the percentage of digital fulfillment versus print is difficult to predict unless we know how prominently the print alternative must be advertised. When consumers are given a choice they tend to choose print. Consider how difficult it has been to get consumers to move to online billing. Postage is around $2.50 per envelope.

Response is annual cost of printing and mailing SBCs and notices of material mod for shoppers, at open enrollment, and/or at renewal. Electronic delivery would be less ($0.00233 per e-mail) but is difficult to estimate due to uncertainty over which consumers or enrollees could or would elect electronic delivery.

The revised format and the specific delivery requirements for the SBC create complexity because they duplicate and completely revise an existing document and process.

Insufficient Flexibility in SBC Template for Explanation of Benefit Tiers

Currently, the guidelines do not allow us to add anything to the SBC. We believe that means we are prohibited from adding barcodes. Without barcodes, it is impractical to use automatic mail inserters. This will mean we have to develop a manual insertion strategy. If would also be helpful if we could print the prospect's name and address on the back page of the SBC. This would allow us to insert the SBC without creating a separate sheet to simply carry that information. Also, the guidelines do not explicitly cover binding options or simply state that insurance companies are free to bind in the most suitable way or not bind at all. Another point, we would like to add information such as creation date or a tracking number. The

federal government is encouraging a move to digital records, but the guidelines make digital tracking and record keeping difficult.

The SBC chart is not flexible enough to accommodate products with various levels of benefits/tiers. The only distinction the chart allows is Participating and Non-Participating Providers. However, there are some wellness plans that dictate what benefit the member receives based on program compliance (completing a health risk assessment etc.). The chart does not allow for this type of distinction which may lead to the issuance of a second SBC once final benefits are determined. We also have tiered provider plans specific to our hospital groups.

Currently we include disclaimers that outline the specific rules of the plan (e.g.: embedded deductible, HSA rules, etc.). The current SBC template does not include enough space to make these specifications clear to the members, which can cause confusion.

Appendix C
SBC Comment Letter

COMPARISON CHART
October 18, 2011

Comparison of group health plan disclosure requirements (content and format) under the Employee Income Retirement Security Act for Summary Plan Descriptions (SPDs) and under the Proposed Rule for the Summary of Benefits and Coverage (SBC) pursuant to the Affordable Care Act.

Requirement	Summary Plan Description (SPD)	Summary of Benefits and Coverage (SBC)
Content of Disclosures	29 CFR §2520.102-3 The SPD must include the following information: Specific Requirements for Health and Welfare Plans • Description or summary of benefits • Description of cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts • Any annual or lifetime caps or other limits on benefits. • The extent to which preventive services are covered. • Whether and under what circumstances existing and new drugs are covered. • Whether and under what circumstances coverages are provided for medical tests, devices and procedures. • Provisions governing the use of network providers. • The composition of the provider network (the list may be furnished as a separate document without charge). • Whether and under what circumstances out-of-	29 CFR §2590.715-2715 (Proposed Rule) The SBC must include the following information: • Uniform definitions of standard insurance and medical terms. • Description of the coverage including cost sharing, for each category of benefits identified by the [HHS] Secretary in guidance. • The exceptions, reductions, and limitations of coverage. • The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations. • The renewability and continuation of coverage provisions. • Coverage examples. • With respect to coverage beginning on or after January 1, 2014, whether the coverage provides minimum essential coverage. • 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

Requirement	Summary Plan Description (SPD)	Summary of Benefits and Coverage (SBC)
	network services are covered. • Any conditions or limits on the selection of primary care providers or providers of specialty medical care. • Any conditions or limits applicable to obtaining emergency medical care. • Any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service. • Rights to continuation coverage (e.g., COBRA). <u>General Requirements for All Plans (Group Health Plans and Pension Plans)</u> • Name and address of the employer or employee organization sponsoring the plan (in the case of a multi-employer plan you may indicate that the employers/employee organization information will be provided on request). • Employer identification number (EIN) for the plan. • Type of plan (e.g., group health plan). • Type of plan administration (e.g., contract administrator or insurer). • Name, business address and business telephone number of the plan administrator. • Name, title, and address of the agent for service of legal process. • Name, title, and address of the principal place of business of each trustee. • Rules regarding eligibility for participation and receipt of specific benefits. • Circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefits (e.g., plan rights to subrogation or reimbursement).	contractual provisions of the coverage. • Contact information for questions and obtaining a copy of the plan document or insurance policy, certification or contract (e.g., telephone number and Internet address). • For plans and issuers that maintain provider networks, an Internet address (or similar contact information) for obtaining a list of network providers. • For plans and issuers that maintain a prescription drug coverage formulary, an Internet address (or similar contact information) for obtaining information on prescription drug coverage. • An internet address for obtaining the uniform glossary. • Premiums or cost of coverage.

Requirement	Summary Plan Description (SPD)	Summary of Benefits and Coverage (SBC)
	• Identity of any funding mechanism for the plan (e.g., insurance). • Date of the end of the plan year. • Procedures governing claims for benefits (including procedures for obtaining preauthorization, approvals, or utilization review services). • Statement of ERISA rights (e.g., contact information for regional Department of Labor office). • Certain additional requirements apply to plans that are maintained pursuant to one or more collective bargaining agreements.	
Format	29 CFR §2520.102-2 The SPD must be: • Written in a manner calculated to be understood by the average plan participant; and • Sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. In satisfying the two above requirements, the regulations require the following: • The plan administrator must exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. • To this end, the regulations state that "[c]onsideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex	29 CFR §2590.715-2715 and 42 CFR §147.200 The Summary of Benefits and Coverage (SBC) must be provided as a stand-alone document in the form authorized by the HHS Secretary. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

Requirement	Summary Plan Description (SPD)	Summary of Benefits and Coverage (SBC)
	sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents." • The format of the summary plan description "must not have the effect to misleading, misinforming or failing to inform participants and beneficiaries." • Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Additionally, "such exceptions, limitations, reductions or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits." • The advantages and disadvantages of the plan must be presented "without either exaggerating the benefits or minimizing the limitations. "	