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March 2, 2015

**VIA ELECTRONIC SUBMISSION**

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

**Attention: RIN 0938-AS54**
**Summary of Benefits and Coverage and the Uniform Glossary**

**Dear Sir/Madam:**

Thank you for opportunity to comment on the Notice of Proposed Rulemaking regarding the Summary of Benefits and Coverage and the Uniform Glossary. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Our comments to the proposed regulation use the regulatory citations of the Department of Health and Human Services.

**§ 147.200(a)(1)(i)**

In both the 2012 final regulations and these proposed rules, if there has been a change in information required to be on an SBC between the time of application and the time of coverage, the issuer must provide an updated SBC by the *first day of coverage*. While we appreciate the prompt updating of information, the scenario raises concerns for us that a consumer or plan sponsor may have enrolled in a product without advance information that the plan's terms were changing. Applicants and enrollees in both the group and non-group markets need to know of pending plan changes during open and special enrollment periods so that they can make informed decisions about their plan options.

1444 I Street NW, Suite 1105 · Washington, DC 20005 · (202) 289-7661 · Fax (202) 289-7724
3701 Wilshire Boulevard, Suite 750 · Los Angeles, CA 90010 · (310) 204-6010 · Fax (213) 368-0774
101 East Weaver Street, Suite G-7 · Carrboro, NC 27510 · (919) 968-6308 · Fax (919) 968-8855
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We disagree with the proposed clarification that once the terms of coverage are finalized, the plan is not required to provide an updated SBC until the first day of coverage. At that point, it may be too late for a person who is dissatisfied with the change in terms to change plans.

> **<u>RECOMMENDATION</u>: When insurers are in the process of changing their offerings, any SBCs that they mail or display should include a statement such as:**
>
> **"Notice: This plan is changing. Check back on xxxx for an updated summary of benefits and coverage or call xxx for information."**
> **Once a change is finalized, the plan should be required to furnish a new SBC to applicants as well as enrollees.**

In the preamble, the Departments seek comment about whether to codify a policy allowing a group health plan administrator to either synthesize the information provided by more than one issuer into a single SBC or provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. We are concerned about enrollee confusion if benefits are carved up among several issuers in ways that enrollees have not come to expect. (For example, what if a plan uses a different vendor to deliver mental health services? Since there has been a history of disparities in mental health coverage that have only recently been addressed by parity laws, consumers could easily misunderstand their coverage for mental health if it was omitted from an SBC and the mental health plan SBC was delivered later.) Further, participants should not have to search through multiple websites or await multiple mailings to view all relevant SBCs for a group plan. Multiple mailings increase the likelihood that a consumer will miss vital information about their coverage.

> **<u>RECOMMENDATION</u>: At a minimum, enrollees and applicants should be able to obtain synthesized, comparable information about coverage of essential health benefits. The plan administrator should be required to ensure that any separate SBCs are delivered as a package rather than as separately mailed or emailed documents.**

**§ 147.200(a)(1)(ii)(B)**

As this section currently reads, if a plan or issuer does not distribute written application materials for enrollment, the SBC is not required until the first date on which the participant is "eligible to enroll" in coverage. It would be helpful to add an example to this section to clarify that this date may be *earlier* than the actual enrollment date. That is, if an employee must sign a paper authorizing premium deductions from his or her paycheck, does that constitute an "application for enrollment"? Is the employee eligible to enroll once he has worked for the requisite number of days, not to exceed 90, and is that what triggers the date the SBC will be furnished? Employees and their dependents may need SBCs to compare offers of coverage from an employer, a spouse or parent's

employer, the marketplace, and public programs so it is important for them to receive SBCs in advance of when they must make their coverage decision.

> **<u>RECOMMENDATION</u>: Add examples to clarify that for a new employee, the SBC must be furnished when the employee has worked at a job long enough to be eligible for coverage, when the employee authorizes premium deductions, or when the employee applies for coverage whichever is earlier.**

**§ 147.200(a)(1)(ii)(D)**

As drafted, this section would allow the issuer to wait until 90 days post-enrollment to furnish the SBC to special enrollees. This is too late and should be changed to require furnishing of the SBC to special enrollees by the first day of coverage. Like other enrollees, special enrollees need to understand their coverage upon enrollment, and they may wish to request the SBC earlier when they are comparing coverage options. The referenced section of ERISA allows the *summary plan description* to be provided up to 90 days post-enrollment, but that is a different document which contains additional information.

> **<u>RECOMMENDATION</u>: Require that the plan sponsor or issuer provide the SBC to special enrollees upon enrollment, by the first day of coverage, or earlier on request.**

The preamble and FAQ VIII clarified that COBRA qualified beneficiaries do not have to receive SBCs at the time of a qualifying event; but they must be given SBCs at the time that similarly situated non-COBRA beneficiaries would receive SBCs. Of course, rules do allow all enrollees to receive an SBC on request. Since SBCs are a useful document for people to use in comparing their coverage options through COBRA, marketplace plans, and other alternatives, if SBCs are not automatically provided to people experiencing a qualifying event, they should be prominently referenced in educational materials.

People leaving jobs lose easy access to an HR department whom they can consult about their plan's coverage.

The following paragraph of the preamble says that if a plan or issuer distributes written application materials for enrollment, the issuer must provide the SBC as part of those materials. We understand this to mean that a person applying for COBRA coverage would receive an SBC at that point. We recommend clearly stating that in the rule.

> **<u>RECOMMENDATIONS</u>: COBRA model notices and educational materials on DOLs website such as this http://www.dol.gov/ebsa/pdf/oncobracontinuationcoverage.pdf should mention the right to receive SBCs on request and their usefulness in**

**comparing coverage options. Clarify that a person electing COBRA must be given an SBC as part of their COBRA election materials.**

**§ 147.200(a)(1)(iii)**

We support required monitoring and timely corrective action if an entity has contracted with another party to provide SBCs and the other party fails to do so. We recommend clarification that corrective action must include prompt provision of the SBCs.
The preamble proposes that if another party such as an issuer provides timely and complete SBCs to each individual applying for or enrolled in a student health plan, an institution of higher education's obligation to provide SBCs will be satisfied. The Departments solicit comments on whether a requirement to monitor the provisions of SBCs should be added.

We support adding a requirement that entities (such as institutions of higher education) monitor the provision of SBCs by another party (such as an issuer). Such a provision helps to ensure accountability. Rules should require that if the issuer is not complying, the institution of higher education must step it to correct the noncompliance and provide applicants and beneficiaries the required information until such time as the issuer or other party remedies the problem.

**§ 147.200(a)(2)**

***Important Questions/Answers/Why This Matters Chart***

The current and proposed instructions to plans for completing the SBC are inadequate to ensure plans provide clear information about family deductibles. Without better information on family deductibles, consumers could face thousands of dollars in unexpected medical costs.

There are two types of family deductibles: embedded and aggregate. An embedded family deductible embeds the individual deductible with each member of the family, so that once a member of the family pays total covered costs equaling the individual deductible, that member has met her deductible for the plan year. Once any combination of family members pays total covered costs equaling the family deductible, the entire family has met the deductible for the plan year. In contrast, the individual deductible is completely irrelevant to a family enrolled in a plan with an aggregate deductible. An aggregate deductible functions as a single family deductible, so that none of the family members meet the deductible until the family has paid total covered costs equal to the family deductible.

The current instructions require plans to show both the individual and family deductible if "there is a separate deductible amount for each individual and the family."[1] These instructions do not provide any guidance for differentiating between an embedded deductible and an aggregate deductible. The instructions must require health plans to explain how deductibles apply to family coverage. Without such a requirement, women and families may not understand key differences in their health plan choices and could face thousands of dollars in unexpected costs because they expect that each member of the family only needs to meet the individual deductible.

The following changes to the SBC would clarify how the deductible applies in family coverage and establish consistency for when the deductible applies to services.

- The instructions should provide language that plans must include in the Why This Matters column for "What is the overall deductible?" The language must explain, in simple terms, whether the individual deductible applies for enrollees in family coverage (embedded deductible) or if a family must meet the family deductible before the plan pays claims for covered services (aggregate deductible). For example:

  If aggregate: *If you are enrolled in family coverage, once the family has met the family deductible ($ZZZZ), the plan pays claims for covered services. The individual deductible does not apply in family coverage.*
  If embedded: *If you are enrolled in single/individual coverage, you must meet the individual deductible ($XXXX) before the plan pays claims for covered services. If you are enrolled in family coverage, the plan begins paying claims for an individual family member once he/she meets the individual deductible ($XXXX). Once the family has met the family deductible ($ZZZZ), the plan pays claims for all members of the family for covered services.*

***Common Medical Event, Services, Cost Sharing, Limitations & Exceptions***

**a) Preventive Services**

The current structure of the SBC is misleading because it suggests that preventive services are restricted to a provider's office or clinic. Many preventive services do not occur at a provider's office. For example, a woman receiving breastfeeding support might receive lactation consultations at her home or in a hospital.[2] In addition, women

[1] U.S. Department of Labor, What This Plan Covers and What it Costs: Instruction Guide for Group Coverage (proposed Dec. 2014), *available at:* http://www.dol.gov/ebsa/pdf/sbcinstructionsgroupproposed.pdf; U.S. Department of Labor, What This Plan Covers and What it Costs: Instruction Guide for Individual Health Insurance Coverage (proposed Dec. 2014), *available at*: http://www.dol.gov/ebsa/pdf/sbcinstructionsindividualproposed.pdf.
[2] The CDC defines professional breastfeeding support as occurring in many settings: "Professional support can be given in many different ways and settings—in person, online, over

usually access the most commonly used contraceptive, birth control pills, through pharmacies, not a provider's office.[3] In both examples, the woman may not understand from the SBC that she can access her preventive service without cost-sharing, despite receiving the service outside of a provider's office. In addition, many preventive services fit into other common medical events on the SBC, which furthers the confusion that may occur by the category. Women may expect cost sharing for services such as preventive blood tests and mammograms to be addressed as "Diagnostic test" and "Imaging" services under "If you have a test" and cost sharing for contraceptives to be detailed under "If you need drugs."

The Departments should create a new category under "Common Medical Event" to explain coverage of preventive services.

| **Common Medical Event** | **Services You May Need** | **Your Cost If You Use an In-network Provider** | **Your Cost If You Use an Out-of-network Provider** | **Limitations & Exceptions** |
|---|---|---|---|---|
| **If you need a preventive service** | Listed preventive screenings, check-ups, patient counseling, and services | No cost for listed services; deductible does not apply | [provide cost-sharing information] | See full list of preventive services covered without cost-sharing at [website]. |

In addition, plans should note in the "Limitations and Exceptions" column under additional categories, e.g., "If you need drugs" or "If you have a test," that there are preventive services without cost sharing.

Further, the SBC should include a web address that has a comprehensive, up-to-date list of all required preventive services, including United States Preventive Services Task Force A and B recommendations, HRSA Women's Preventive Services Guidelines, Bright Futures recommendations, and the ACIP recommendations for vaccines. A comprehensive list allows consumers to know which preventive services their plan must cover. Ideally, plans should include this web address with the new category specifying coverage of preventive services. However, if the Departments do not create a new

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the telephone, in a group, or individually. Some women receive individual in-home visits from health care professionals, while others visit breastfeeding clinics at hospitals, health departments, or women's health clinics." Centers for Disease Control and Prevention, Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies (2013), *available at:* http://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF.

[3] In 2011-2013, oral contraception was the most commonly used form of contraception. Centers for Disease Control and Prevention, National Center for Health Statistics, Brief No. 173, Current Contraceptive Status Among Women Aged 15-44: United States, 2011-2013 (Dec. 2013), *available at*: http://www.cdc.gov/nchs/data/databriefs/db173.pdf.

category, they should still require plans to include a web address for a comprehensive list on the SBC to ensure consumers know how to find the full extent of preventive services they are entitled to without cost-sharing.

The final rule should include additional directions for grandfathered plans to ensure consumers can clearly understand their plan's coverage of preventive services. Grandfathered plans that provide some, but not all, preventive services without cost sharing should include a web address that provides a description of the preventive services the plan covers without cost-sharing. The final rule should also include the following language for grandfathered plans to include under "Limitations & Exceptions": "Your plan may not include certain preventive coverage the law requires other plans to cover." This will make it clear that the plan does not cover all of the preventive services without cost sharing that new plans must cover.

### b) If You Are Pregnant

The Departments should change the description of services under "If you are pregnant" to more accurately reflect the way insurance companies and women pay for maternity services. Specifically, the two rows in the column "Services You May Need" should read: (1) Physician/midwife fees (prenatal, labor and birth, postnatal) and (2) Labor/birth center fee.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you are pregnant** | Physician/midwife fees (prenatal, labor and birth, postnatal) | | | |
| | Hospital/birth center fee | | | |

With this change, the "If you are pregnant" section would be more consistent with the outpatient surgery and hospital stay portions of the SBC, which separate the cost of the facility from the cost of professional services. If this approach is adopted, the instructions should direct plans that have separate cost sharing amounts for the labor and birth compared to the prenatal and postnatal fees to detail all the cost sharing in the cost column.

As currently written, the SBC estimates in-network and out-of-network cost-sharing responsibilities for births and inpatient services that happen in a hospital. However, cost-sharing responsibilities associated with maternal and newborn care, as well as maternity-related care, can vary significantly based on where a woman chooses to give

birth and depends on a plan's specific limitations and exclusions. Charges and payments for care in freestanding birth centers are typically considerably lower than hospital costs for vaginal birth.[4] Thus, the Departments should include a subheading that reflects all birth facilities, not just hospitals, and require plans to provide details on how cost-sharing for birth and related services varies depending on the facility where the birth occurs. Our recommended language above includes references to birth centers to reflect this suggestion.

We commend the Departments for allowing issuers to collapse the two lines under the "if you are pregnant" section if a plan uses a global maternity fee. This will make the cost-sharing for maternity services clearer to women and align with a common industry practice.

### c) Facility Charges and Facility Fees

Patients face two types of costs that are not reflected in the existing or proposed SBC regulations and accompanying guidance. These costs can result in patients facing unexpected cost sharing or charges. The first cost is a type of cost sharing charged by the health insurance plan, sometimes called a facility charge, for services received at a higher cost facility such as outpatient services provided at a hospital, hospital campus, or hospital owned facility. An individual relying on an SBC may receive care from a physician on a hospital campus and incur an additional unexpected cost. Plans must disclose patient cost-sharing responsibilities for facility charges, or similar cost sharing for medical services provided at certain facilities, in the "Limitations and Exceptions" column by stating "Additional $X per visit for services received [insert description of facilities].

The second cost is a facility fee the health care provider charges for the use of the health care facility. Facility fees are billed charges in addition to the health care service that a specific health insurance plan may or may not cover. These provider charges can undermine the preventive services benefits in plans that do not cover facility fees billed by in-network providers for preventive services. The proposed SBC regulations and proposed instructions do not require plans to disclose whether or not they cover facility fees for preventive services (or other services). The Departments must require plans to state, in the "Limitations and Exceptions" columns for preventive services, office visits, and outpatient surgery, if the plan does not cover facility fees or has different cost sharing requirements for these costs.

### d) Information on Deductibles

The proposed instructions do not provide a strong enough standard for the Common Medical Event table when deductibles do or do not apply to services. As a result, consumers do not always have all the information about cost sharing and may be

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[4] Childbirth Connection, Facility Labor and Delivery Charges by Site and Mode of Birth, United States, 2009-2011 (2013), *available at*: http://transform.childbirthconnection.org/resources/datacenter/chargeschart/.

comparing SBCs with different levels of detail. This could lead to misunderstandings about how the deductible applies to services. As a result, a consumer may enroll her family in a plan because it has a low deductible, but not understand that an alternative plan applies the deductible to fewer services. The Departments should require plans to use consistent language to explain plan deductibles. The language should simply state whether or not the deductible applies; plans should include “after deductible” or “deductible does not apply” either in each row under the cost columns for both in-network and out-of-network providers or in the “Limitations and Exceptions” column.

**e) Additional Benefits in “Other Covered Services” or “Excluded Services”**

We oppose allowing plans to include benefits, in addition to those required in the regulations and guidance, under “other covered services” or “excluded services.” As we stated previously in this comment letter, the SBC is intended to allow consumers to make apples to apples comparisons. Allowing plans to pick and choose additional benefits to include in these sections may appear to increase transparency of health coverage but actually increase confusion and misunderstanding of plan coverage. This is because consumers will be comparing documents with different scopes of information. For example, one plan may list the inclusion of a common medical service, such as cesarean delivery. A consumer who sees that a cesarean delivery is listed in one plan’s SBC may incorrectly assume that another plan that has no information about cesarean delivery in the SBC does not cover such deliveries. Therefore, all plans should be limited to the standardized set of services required to be listed under these sections. In addition, plans should be required to provide a web address to the coverage policy or group certificate of coverage following the statement “Check your policy or plan document for other excluded services.” The proposed regulations already propose that such a web address be provided on the SBC by issuers. Including the web address at this location will ensure women and other health care consumers know how to access the full list of excluded services, beyond those services listed on the SBC. The underlying plan documents may also provide further detail about exclusions that are included in the SBC, such as if services are excluded, or only covered, in limited circumstances. The inclusion of the web address at this location should not replace including the web address in another location that will be obvious to consumers looking for additional plan information unrelated to exclusions.

**§ 147.200(a)(2)(i)(G)**

The revised SBC provides more clarity about whether plans provide minimum value and minimum essential coverage. Information about whether plans provide minimum value and minimum essential coverage is crucial to consumers’ enrollment decisions, helps them determine if they could be eligible for subsidized coverage, and helps them determine if they will or won’t be subject to individual responsibility penalties under this plan. See our comment below, however, regarding absence of premium information that provides additional recommendations about how to make this information useful.

**§ 147.200(a)(2)(i)(K), (L)**

We support that SBCs must include an internet address for obtaining a list of providers, and an internet address for obtaining information on prescription drug coverage. However, as the rule is drafted, the standard could still allow plans to provide a link to an issuer's general web page, and searching through such a web page to find the applicable provider directory or formulary for a consumer can be a confusing process. (Here is one typical example, although some are worse: This SBC directs the consumer to the overall company webpage to find a formulary: https://www.marylandhealthconnection.gov/assets/CareFirst.pdf From the overall webpage, you can click through to prescription drug information which lands you here: https://member.carefirst.com/individuals/drug-pharmacy-information/drug-search.page?#?accordion=aca-drug-search-tool. The consumer must have some sophistication to decide if they might be in a grandfathered non-ACA plan or in an ACA plan, and pick the applicable formulary. It would be much simpler if the SBC linked directly to the correct formulary.)

> **RECOMMENDATION: Amend subsections (K) and (L) as follows:**
> (K) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) ~~for obtaining~~ ***that is a direct link to*** a list of network providers;
> (L) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) ~~for obtaining information on~~ ***that is a direct link to*** prescription drug coverage.

**§ 147.200(a)(2)(i)(N)**

Abortion is common and critical health care service. NHeLP opposes the ACA's "special rules" on abortion services, which treat abortion different form other health care services. Nevertheless, those rules should be implemented to ensure that individuals have timely and accurate information about a plan's coverage of abortion services. To this end, all plans, inside and outside of the Marketplace, should inform prospective (and current) enrollees of all covered and excluded services. The Departments should thus require plans to disclose coverage or exclusion of abortion services before (and after) a consumer enrolls in the plan. The SBC must contain all of the information a person needs to make an informed choice about her health plan. This includes whether abortion is covered (as well as whether it is excluded), cost-sharing amounts, and any limitations on coverage. Additionally, all plans should include a link to their plan documents where consumers can find more information about the coverage details.

The Departments request comments where coverage of abortion services should be included. We recommend that this information be listed under the "Common Medical Events" section of the SBC. Abortion is a common medical procedure, one that more

than one million U.S. women obtain every year.[5] Moreover, listing abortion under Common Medical Events will enable plans to disclose important limitations and exceptions. Abortion coverage should not be listed at the end of the SBC under "other" services. Enrollees are unlikely to look at that section for abortion coverage. The services listed there are ones that enrollees expect are more discretionary or those that are excluded from coverage, such as acupuncture or chiropractic services, when all other options for pregnancy are explicitly listed in the "Common Medical Events" section. Plans should explain their coverage of abortion under "Common Medical Events" in either the "If you are pregnant" row or on a separate row, immediately below the "If you are pregnant" row. The following chart contains our suggested language for each circumstance – when a plan covers abortion, only covers abortion in certain circumstances, or does not cover abortion at all. If a plan does not cover abortion at all, it should have to clearly indicate the exclusion of coverage in the "Limitations and Exceptions" column as well as in the row for "Services Your Plan Does NOT Cover" in the "Excluded Services & Other Covered Services" section of the SBC, as indicated below.
.
Finally, the Departments should ensure that plans use accurate, objective, and plain language terms when describing the plans' coverage (or lack thereof) of abortion services. Thus, for example, the SBC Instruction Guide changes "when the life of the mother is endangered" to "when the life of the woman is endangered."

| | In-network provider | Out-of-network provider | Limitations & Exceptions |
|---|---|---|---|
| If a plan covers Abortions | [provide cost-sharing information] | [provide cost-sharing information] | None.<br><br>See full plan information at www.###.com |
| If a plan covers abortion only in certain circumstances | [provide cost-sharing information] | [provide cost-sharing information] | Coverage excluded except when [the woman's life is endangered] [the pregnancy is the result of rape or incest] [explanation of other circumstances].<br><br>See full plan |

[5] Three in 10 women will have an abortion before the age of 45. Guttmacher Institute, *Induced Abortion in the United States* (July 2014), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

| | | | information at www.###.com |
|---|---|---|---|
| If a plan does not cover abortion at all | Not covered | Not covered | Abortion is not covered [The exclusion must also be listed in the Services Your Plan Does Not Cover] See full plan information at www.###.com |

**§ 147.200(a)(2)(ii)**

***Changes to the Pregnancy Coverage Example***

The Departments should improve the pregnancy coverage example on the SBC and provide women with clearer information on coverage and cost-sharing related to maternity and newborn care. The coverage examples are only useful if women and other health care consumers understand them. Further clarifying the pregnancy coverage example will ensure women have easily accessible information about their maternity coverage benefits and cost-sharing obligations.

Specifically, the Departments should improve the maternity coverage example in the following ways:

- Change the title of the coverage example from “Having a baby” to “Pregnancy and childbirth.” The current title, “Having a baby” is not a medical or insurance term. “Pregnancy and childbirth” more appropriately aligns with the medical terms used to describe the other coverage examples of “managing type 2 diabetes” and “simple fracture.” In addition, the title “Pregnancy and childbirth” more accurately reflects the types of services and care that childbearing women and newborns need, including prenatal care, intrapartum care (labor, birth, recovery, and immediate newborn services), and postpartum/newborn care.

- Change the subtitle of the coverage example from “normal delivery” to “uncomplicated vaginal birth” or “vaginal birth.” Either “uncomplicated vaginal birth” or “vaginal birth” could be used, depending on whichever term most accurately reflects the origin of the cost estimates – either the average cost of all vaginal births or the average cost of only uncomplicated vaginal births.

  Clarifying the coverage example to explicitly reflect vaginal birth ensures consumers understand that cost-sharing responsibilities and coverage may be different for birth by cesarean delivery or for complex/high-risk deliveries. Nearly

one-third of births are now cesarean deliveries, so for some women, this procedure may seem be considered "normal," but the cost-sharing obligations for the procedure would not be reflected in this example.[6] Furthermore, the current term "normal" is imprecise and subjective because it has a broad range of meanings to the general public, and "birth" is a more plain-language term than "delivery."

- Change the coverage example term "routine obstetric care" to "routine maternity care (prenatal, labor/birth, and postnatal)." "Routine obstetric care" is not a consumer-friendly term because it does not clearly reflect whether plan coverage includes prenatal, intrapartum, and postpartum care. Modifying the term to "routine maternity care (prenatal, labor/birth and postnatal)" explicitly indicates the range of services pregnant women can receive under the plan and their accompanying cost-sharing amounts. In addition, "maternity" is an everyday language term for pregnancy care that is also used by health care providers, as opposed to "obstetric," which is drawn from technical medical terminology.

- Modify the coverage example to capture provider/professional fees that are associated with the newborn. The most costly type of newborn service is the cost of the facility (included in the current SBC calculation), followed by the professional fee for newborn care (not included in the current SBC calculation).[7] The coverage example can be improved by adding a row in the coverage example table following the "Hospital charges (baby)" row. This new row would read "Routine newborn care" and would provide accurate baseline information for professional payments for routine newborn care.

- We commend the department for including a row in the coverage example for "education." However, it is unclear what this category of coverage refers to and the Departments should provide clarity on what is included in this coverage category.

[6] Joyce A. Martin, et al., Centers for Disease Control and Prevention, National Vital Statistic Report, Births: Final Data for 2012(Dec. 2013), *available at*: http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf#table21.

[7] 2010 payments for newborns with employer-provided Commercial insurance and vaginal births were for facility (71%) and professional (28%) fees, with less than 2% on average for combined radiology/imaging, pharmacy, and laboratory fees. Commercial payments for newborns with cesarean births were for facility (75%) and professional (23%) fees, with 1% for combined pharmacy, radiology/imaging, and laboratory fees." Truven Health Analytics, Prepared for: Childbirth Connection, Catalyst for Payment Reform, and Center for Healthcare Quality and Payment Reform, The Cost of Having a Baby in the United States (Jan. 2013), *available at*: http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf.

### *Family Deductible Information*

As mentioned above, a misunderstanding of how the deductible applies to family coverage can cause thousands of dollars in unexpected medical costs. The coverage examples provide a simple way to portray how both the individual and family deductible apply to the health plan. However, the coverage examples are inaccurate if a consumer is enrolled or enrolling in family coverage in a plan with an aggregate deductible because the coverage examples are based on an individual deductible. Health care consumers may assume from the examples that there is an individual deductible as part of their plan. The coverage examples should therefore include both the individual deductible and family deductible and show the total costs for both individual and family coverage, applying the entire family deductible for the family coverage total in plans with aggregate deductibles. It is important that the family deductible be included for plans that have embedded deductibles as well as aggregate deductibles so women and other health care consumers can compare apples to apples summaries.

### § 147.200(a)(5)

Section 2715(b)(2) of the Public Health Service Act provides that the summary of benefits and coverage (SBC) should be presented in a "culturally and linguistically appropriate manner." The Departments have attempted to satisfy this statutory mandate by incorporating the rules for providing appeals notices pursuant to section 2719 of the ACA (hereinafter "appeal rules"), 54 C.F.R. 2590.715-2719(e), 29 C.F.R. 2590.715-2719(e), 45 C.F.R. 147.136(e).[8] These appeal rules provide that, in counties in which at least ten percent of the population residing in the county is literate in only the same non-English language, both translation and interpretation services must be provided upon request.[9] In the preamble to both the current and prior SBC rules, the Departments expressly state, though, that nothing in the proposed regulations should be construed to limit rights conferred by Federal or State civil rights laws, including Tittle VI of the Civil Rights Act of 1964, which prohibits recipients of Federal financial assistance from discriminating on the basis of race, color, or national origin. 76 Fed. Reg. 52450 (Aug. 22, 2011); 79 Fed. Reg. 78587 (Dec. 30, 2015). This requires recipients of Federal financial assistance to take "reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons." *Id.*

As we have stated in our prior comments on the SBC, as well as other regulations that outline language access provisions (such as the appeals rules), we strongly oppose applying this 10% standard to the Summary of Benefits and Coverage. The Departments propose to severely limit limited English proficient (LEP) persons' access to arguably the most important document regarding their health insurance to which they will have access, the document that allows them to compare plans, shop for plans, and understand the terms and limitations of the plan in which they enroll. We contend not

[8] 26 C.F.R. § 54.9815-2715(a)(5); 29 C.F.R. § 2590.715-2715(a)(5); 45 C.F.R. § 147.200(a)(5).
[9] 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136(e).

only that this is unwise, but also that it violates PHSA § 2715, Title VI and Section 1557 of the ACA.

***Title VI and Section 1557 of the ACA Require Broader Access for LEP Individuals***

Unlike the appeals rules, the proposed SBC rules expressly state that the intention is to meet the requirements of Title VI, 42 U.S.C. § 2000d *et seq*., which prohibits discrimination by any entity receiving Federal financial assistance. In addition, Section 1557 of the ACA prohibits discrimination in any "health program or activity, any part of which is receiving Federal financial assistance, "including credits, subsidies, or contracts of insurance . . . ." Every health plan that participates in an Exchange will receive Federal financial assistance, at least in the form of advanced payment tax credits. Thus, every one of those plans is obligated under both Title VI and Section 1557 not to discriminate, and that means that they must provide culturally and linguistically appropriate services, independent of the appeal or SBC rules. Further, the language of § 2715 itself requires that the SBC be provided in a culturally and linguistically appropriate manner. We do not believe that a 10 percent threshold for translation and provision of oral language assistance would ensure the provision of culturally and linguistically appropriate services as that standard is much higher than standards currently adopted by the Departments of Justice and Health and Human Services in their "LEP Guidances" (see www.lep.gov) and the Department of Labor in its regulations governing group plans for the provision of notices of appeals.

It is well documented that language barriers affect access to health care. The Institute of Medicine has stated that:

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.[10]

It is, thus, critical that consumers have access to vital information about their insurance plan in a language in which they are conversant.

The Departments acknowledge the complexity of selecting and understanding a health plan. For example, the Departments have required that a copy of the uniform glossary be made available to all individuals to whom a SBC is provided in recognition of the fact that even English-proficient consumers may have difficulty fully understanding the terms of art contained in the SBC. If insurance is complicated enough so as to require a uniform glossary even for those for whom English is not a challenge, there can be no

[10] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002)(citations omitted).

question that understanding the SBC is likely to pose an even greater challenge to those who are LEP.

Thus, the Departments recognize the importance of the SBC as is at the crux of ensuring access as it is the most basic document that is focused on providing individuals information to understand what services are or are not covered by different plans and helping individuals make informed decisions about what plan to select. Yet somehow it is not viewed as critical for LEP individuals since the requirements to translate this document are so high that it will only be translated into Spanish for a small segment of Spanish-speakers and virtually no other languages. As noted in the preamble, only 268 counties (78 of which are in Puerto Rico) meet the 10% threshold. If this critical information is not accessible to LEP individuals, it will only further affect LEP individuals' access to care as they will be unable to make informed decisions about selecting a plan.

This is exactly the kind of discrimination that Title VI and Section 1557 are supposed to prohibit. Although the Departments have not yet issued proposed or final regulations interpreting Section 1557, the Department of Health and Human Services has, over the years, issued guidance on LEP under Title VI.[11] This Guidance built upon Executive Order 13166, which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons.[12] In that Guidance, HHS recognized that "[t]he more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed."[13] The Guidance provided two "safe harbors" or rules recipients of Federal funds could follow and be sure they were in compliance with Title VI: first, the HHS recipient provides written translation of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served; and second, if there are fewer than 50 people in a language group that reaches the five percent threshold, the recipient can provide written notice of the right to receive competent oral interpretation of the written materials, free of cost. If these criteria were practicable for all recipients of Federal financial assistance – which included many insurers participating in Medicare and Medicaid – for more than eight years, why are they impracticable for insurers participating in an Exchange? Further, the LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed. The proposed regulations adopt a 10 percent per county threshold for the provision of oral communication assistance, again ignoring longstanding interpretations of Title VI.

In the LEP Guidance, HHS took great pains to consider the cost of compliance to recipients of Federal financial assistance. Indeed, there was recognition that large documents such as enrollment handbooks might not have to be translated *as long as*

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[11] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," 68 Fed. Reg. 47311 (August 8, 2003).
[12] This Executive Order was reaffirmed on June 28, 2010 and again on February 17, 2011.
[13] 68 Fed. Reg. 47314.

*the vital information contained in such documents is translated*.[14] Surely, a double-sided four-page SBC that contains basic plan information is both vital and short. Indeed, it may be the most vital information a consumer receives from and/or about their health plan. If HHS believes that its own LEP guidance is necessary and appropriate to implement Title VI in other contexts, those same thresholds should apply to the SBC (and to appeal notices, as well). The failure of a plan to comply with these rules violates Title VI and Section 1557 of the ACA.

***Public Policy Concerns Militate in Favor of Stronger Rules for LEP Individuals***

The adoption of a 10 percent per county threshold is not useful for determining thresholds for translation. First, as a practical matter, county demographics may not be reflective of a plan's demographics because a plan may market specifically to particular ethnic/cultural/language groups in a county, a region or nationally, or may serve employers that have high LEP populations, and thus have greater numbers of LEP enrollees than a given county in which the plan operates. We strongly believe that a plan must track data on its LEP enrollees and provide translated notices when the thresholds that we recommend below are met for *plan* enrollees.
Second, the appeal rules omitted a numeric threshold for plans participating in the group market and merely require translation of notices when 10% of a county's population is LEP. Again, this fails to recognize that plan demographics may differ from a county. As recognized in the appeal rules, very few counties meet the 10% threshold generally, and only a few counties meet the threshold for any language other than Spanish (including Chinese, Navajo and Tagalog). 79 Fed. Reg. 78587. Existing DOL regulations (29 C.F.R. 2520.102-2(c)(2)) and the LEP Guidances from the Department of Justice and HHS (see <http://www.lep.gov/guidance/guidance_index.html>) all recognize the need for a dual standard for translating documents and include both numeric and percentage thresholds. We believe that the statutory requirement for providing notices in a culturally and linguistically appropriate manner must have some meaning; indeed, it provides a strong rationale for enhancing current guidelines rather than weakening them. By deleting the numeric threshold, the standard for providing translated notices is now weaker after enactment of the ACA than before and will provide fewer covered individuals with language assistance.

We, thus, recommend that the Departments adopt a combined threshold utilizing the existing DOL regulations and DOJ/HHS LEP Guidances. We suggest that the threshold should be 500 LEP individuals or 5% of a plan's enrollees, whichever is less. The 5% is utilized in both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans. The 500 is utilized in the DOL regulations.

Further, the Departments must ensure that the translation is competent and not done through machine translation which does not produce competent translations. "Machine translation" refers to the use of a computer program to automatically translate information from one language to another. At this point in time, neither free nor

[14] 68 Fed. Reg. 47319.

commercial machine translation programs provide sufficiently accurate translations to rely upon for use with LEP patients. Thus Exchanges, QHPs, and others should be prohibited from using machine translation to develop translated materials and instead utilize best practices as recognized by the American Translators Association (ATA) for translating documents. ATA offers a guide called "Getting it Right" that offers advice on what to look for when evaluating translation services. The Guide is available at https://www.atanet.org/docs/Getting_it_right.pdf.

As some plans may undertake specific marketing and outreach activities to particular ethnic/cultural/language groups, we also recommend that the Departments adopt a secondary requirement to provide language services to any language group to which the plan specifically markets. This must be *in addition to* the basic thresholds. This standard would recognize that a plan could not conduct marketing and outreach to enroll LEP members and then fail to provide assistance when those members need additional information.

We also strongly believe that the Department should require plans and insurers to provide taglines in at least 15 languages with the SBC, informing LEP enrollees of how to access language services. The request for 15 languages is based on existing government practice. The Social Security Administration, through its Multilanguage Gateway (http://www.ssa.gov/multilanguage/), translates many of its documents into 15 languages and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish (CMS Language Access Plan, http://www.cms.gov/About-CMS/Agency-Information/OEOCRInfo/index.html). For example, CMS currently provides some vital documents in Arabic, Armenian, Chinese, Farsi, German, Greek, Haitian Creole, Italian, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, and Vietnamese (CMS Language Access Plan report at p. 9). Further, plans that operate in California are already required to do so and have adapted to this. As one example, Standard Insurance Company sends an insert with all Coverage of Benefits documentation that includes taglines. The tagline used by this insurer states:

> "No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or xxx-xxx-xxxx. For more help, call the CA Department of Insurance at xxx-xxx-xxxx."

Taglines by themselves are an effective and cost-efficient manner of informing LEP individuals and will help assist plans in determining in which languages additional materials should be provided. And to reduce costs to plans, the Departments can provide tagline language and translations for plan usage if plans did not wish to develop their own.

We do want to emphasize, however, that taglines must be accompanied by an English SBC so that individuals have a record of communication and may be able to obtain

information from advocates or others about its content. Providing oral information or a tagline is insufficient to meet the requirement of providing enrollees with SBCs.
We also recommend that the Departments require that, once a consumer has requested materials in another language, all subsequent communications with that consumer should be in the non-English language." For a variety of reasons, plans should be collecting data on their enrollees' language needs, both to ensure services are available as well as providing culturally and linguistically appropriate information. As one example, Standard Insurance Company has sent enrollees a Language Assistance Survey to gather data on enrollees' language needs. Once an LEP enrollee identifies his language needs, the plan should track this information and not require the enrollee to continue to request information in that language.

Finally, we strongly believe that ***regardless of whether a plan is required to provide written translations*** of SBCs, the Department must ensure that oral assistance – through competent interpreters or bilingual staff – is provided to ***all*** LEP enrollees. The current appeal rules only require plans to provide language services when the thresholds are met. We do not believe this meets the letter or spirit of PHSA § 2715, Title VI or the nondiscrimination provision of the ACA since this would leave millions of LEP individuals without any assistance from their plans when trying to understand information about services that are and are not covered and to make an educated decision about which plan in which to enroll. It is hard to understand how the statutory requirement in PHSA § 2715 to provide the SBC in a culturally and linguistically appropriate manner is upheld if plans can ignore the most basic communication needs of LEP individuals. In addition, it has been a longstanding recognition under Title VI of the Civil Rights Act of 1964, reiterated with the enactment of the nondiscrimination provision in Section 1557 of the ACA, that oral communication with LEP enrollees must be provided to every individual, regardless of whether thresholds to provide written materials are met. Thus, no less should be required here.

In sum, the SBC is one of the most vital of all documents that will be issued by a plan. To provide anything less than the same language access that is required of other recipients of Federal financial assistance would be to undermine the intent of the ACA's requirement of linguistic and cultural appropriateness, as well as Title VI and Section 1557's promise of non-discrimination. The rule should be amended to bring it into compliance with the HHS Guidance, at the very least.

**RECOMMENDATIONS**: **Our specific recommendations are:**

1. **Require plans to competently translate the SBC into any language which comprises 5 percent or 500 LEP individuals in the plan;**
2. **Require plans to provide oral language services – through competent bilingual staff or interpreters – for all LEP individuals with questions about the SBC; and**
3. **Require plans to provide taglines in at least 15 languages with all SBCs.**

## Additional Comments

### *Absence of Premium Information*

We are disappointed that rules will not require SBCs to provide premium information. While we understand the complexity of providing this information, knowing the full premium and employee or individual share of premium is crucial to consumers making coverage choices. Consumers must understand the employee cost of all available options under an employer sponsored plan to determine if they can afford the coverage, and also to determine if they might be eligible to buy a qualified health plan with premium assistance on the marketplace. Currently, consumers are encouraged to take an employer coverage tool to their employers to complete marketplace application questions about their eligibility for premium assistance. However, since there is no requirement that employers *complete* an employee coverage tool on request, consumers now shopping on the marketplace frequently have difficulty obtaining the information that they need.

The preamble refers to FAQ 16, which states that carriers that choose to provide premium information can do so at the bottom of the SBC. However, the template does not include an optional line for this, and so does not encourage carriers to provide the information. Further, this footnote in the preamble is confusing: "…it must display only the total premium for the plan, inclusive of all covered benefits and services." The referenced rule seems to mean that the display cannot segregate how much of the premium is for one benefit vs. another. We suggest clarification that an SBC *can* include the full premium as well as, for example, the employee share for self-only coverage. Automatic receipt of that information would be helpful to consumers who want to apply for marketplace coverage and who now face difficulties getting their employers to complete employer coverage tools.

Although section 2719 of the ACA is silent on whether SBCs must include premium information, it is clear in other parts of the ACA that premium information must be furnished to consumers to allow them to compare plans. For example, Section 1103 requires display of premium information for small group and individual coverage. Section 1311 (e)(3)(A) requires qualified health plans to make various elements transparent to consumers including "other information as determined appropriate by the Secretary and 1311 (e)(3)(D) requires that for group health plans, "The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A)." If the Departments determine that they cannot require SBCs to include premium information, the Departments should use this statutory authority to ensure that for individual coverage, premium information is readily available and that for group coverage, written and oral information is readily available and required to be furnished regarding the full premium, the employee share of self-only coverage, and whether a plan is the lowest cost minimum value plan offered to the employee.

We recommend providing a line at the bottom of the SBC template for premium information and model language to explain if this is the full premium before assistance (in a marketplace plan), and to provide the employer and employee self-only and, if applicable, family share (in a job-based plan.) If, contrary to our recommendation, the Departments determine that they cannot require this information on the SBC itself, at a minimum, the SBC template should include this as an optional line and should require a phone number and internet address where applicants, enrollees, and others can request this premium information and receive it promptly in writing. (For employer based plans, this phone number may be different than the issuer's phone number.)

**RECOMMENDATIONS: Require employers to furnish plain language written information during enrollment periods and on request providing the full premium, the enrollee's share of premiums for self-only and family coverage, and whether a plan is the lowest cost available plan providing minimum value. Below is suggested language, but it should be consumer tested:**

- "Employees pay $___ per ___ for single coverage premiums. Employees pay $___ per ___for family coverage premiums.
  If the cost for single coverage in the lowest-cost plan your employer offers you is more than 9.5% of your annual household income, you could be eligible for premium assistance in the Marketplace."
  (Instructions to plan administrators should explain that plans should follow the tax credit rule on treatment of wellness programs in completing the employee share of premiums.)
- This plan is available to dependents YES/NO (include check boxes for spouse, children, domestic partner)
- One of the following statements as it applies to the plan:
  *This plan is the lowest cost plan offered by this employer. You can use this form to answer questions about employer coverage if you are applying for health insurance through the Marketplace with premium assistance.* OR
  *This plan is NOT the lowest cost plan offered by this employer. You need the form for a different plan to answer questions about employer coverage if you are applying for health insurance through the Marketplace with premium assistance. Contact XXX to get the SBC for the lowest cost plan.*
- One of the following as it applies to the plan:
  - This plan is designed to pay at least 60 percent of the total costs of certain essential services; or
  - This plan does *not* pay at least 60 percent of the total costs of certain essential services.

  If the plan(s) offered by your employer do not pay at least 60 percent of the costs of essential services, you could be eligible for premium assistance in the Marketplace.

### *Single and family coverage deductibles*

Many plans are not issuing separate SBCs for individual and for family coverage. As an example: https://api.centene.com/SBC/2015/68432IL0010012-01.pdf. This same SBC comes up on healthcare.gov when browsing plans for an individual and when browsing plans for a parent and child. Since it indicates both an individual and a family deductible, it is not clear what deductible applies to a person with family coverage: is each member of the family covered when they meet an individual deductible, or does the family have to meet the family deductible before anyone is covered?
Another example of an SBC that indicates it is used for a number of different individual and family configurations is here:
http://info.kaiserpermanente.org/healthplans/virginia/individual/pdfs/2015/KP%20VA%20Silver_1750_25.pdf. Under IRS rules, the deductible for each person in a family in an HSA-qualified plan must be at least $2,500. The name of this plan indicates that it is HSA qualified, so since the individual deductible is less than that, we assume that only the family deductible applies to families. However, the summary plan description lists the overall deductible as "$1,750/person, 3,500/family." The SBC is misleading: It would not be clear to most families buying this plan that they must meet the family deductible before any person in the family is covered.

Misinformation about deductibles can literally cost families thousands of dollars, and it is of utmost importance that this problem be corrected.
Rules and instructions should clearly state that in family plans that do not use a per-person deductible, the plan must issue a separate SBC for family coverage tiers. In plans that do not use a per-person deductible for family members, the SBC should not refer to a per-person or individual deductible but should only list the relevant family deductible.

> **RECOMMENDATIONS: The uniform glossary definition of "deductible" should include information about how family deductibles work. The plan should use the glossary explanation that fits their plan, which might be *one* of the following:**
>
> a. **Deductible: The amount you or your family could owe before during a coverage period (usually one year) for health care services your health insurance or plan covers before your health insurance begins to pay. This plan has a "family deductible" as well as a "per-person deductible." When any individual in your family who is covered under this plan meets the per-person deductible, your health insurance will begin to pay for that person's covered services. When the family meets the family deductible, your health insurance will begin to pay for every family member's covered services.**
> b. **Deductible: The amount you or your family could owe before during a coverage period (usually one year) for health care services your health insurance or plan covers before your health insurance begins to pay. This plan has a "family deductible." This is the amount your family could owe during a coverage period (usually one year) for health care**

**services your health insurance or plan covers before your health insurance begins to pay. When any member or members of your family meet the family deductible, your health insurance will begin to pay for covered services for everyone in your family covered under this plan.**

The drawing in the uniform glossary that explains costs is helpful, but we recommend similar drawings for family plans that do and do not use aggregated deductibles. Again, the plan should display only the drawing that is relevant to the applicant or enrollee's type of plan and household unit.

Further, many consumers will not understand what it means that "the deductible does not apply." So it needs to be very clear that when the deductible does not apply, the person *only* has to pay the applicable copay or coinsurance, if any, even if they have not yet met their deductible.

In the Glossary, the definition of "deductible" correctly states that "The deductible may not apply to all services." We are concerned, however, that many consumers will not understand what this sentence means. Evidence from studies of high deductible employer plans consistently shows high proportions of enrollees do not know their plan will cover some services even before the deductible is met. We recommend adding an additional sentence to the deductible definition stating that: "When the deductible does not apply, the plan will pay its share of that service's cost even if the deductible has not been met."

***Additional Comments on the Summary of Benefits and Coverage (SBC) Template***

We recommend that the SBC cost-sharing example (pg. 4) include a reference to Jane using a preventive service where the deductible does not apply, to show that she could access that service free of cost sharing even *before* she meets the deductible.

***Children's Networks.*** Specifically with regard to children, we recommend the SBC list Pediatric Services as a "Common Medical Event." We urge the agencies to create a new category under "Common Medical Event" to specify a plan's coverage of pediatric services. The SBC Pediatric Services category should include a basic description of services and link to a more comprehensive listing of the full array of pediatric primary, tertiary and specialty services covered by the plan. Families must have access to clear and concise information regarding pediatric services that are covered and not covered by their plan. This information is particularly important for families of a child with a serious, complex or chronic health care condition who may need pediatric specialty and ancillary services that may not be covered or may be subject to certain limitations and exceptions. Therefore, we strongly urge the departments to add information regarding pediatric services to the SBC, which, as proposed, does not include any references to pediatric benefits and services, except for dental and vision care.

To further clarify a plan's coverage of pediatric services, the final rule should include specific directions for plans regarding the type of information that should be included in

the SBC to enable consumers to clearly understand the limits of their plan's pediatric services coverage. For example, the plans should be required to provide a direct link to a description of those pediatric services that are covered without cost-sharing (such as well-baby and well-child services). The final rule should also include the specific language that plans must include under "Limitations & Exceptions" to clearly explain that the plan's coverage of pediatric services requires cost-sharing for some services, limits on the number of visits, prior authorizations to see a specialist, etc.

***Prior authorization requirements and appeals processes to see a specialist or access necessary out-of-network care.*** We urge the agencies to require in the final rule that plans include information that describes the circumstances that warrant prior approval, including referrals to some specialists or procedures and the need to seek care out-of-network under rare circumstances. Individuals who need specialty care must have a seamless process to access that care in a timely manner. Prior authorization procedures can delay that care if they are overly burdensome, complex, or are not appropriately delineated for enrollees. Delays in needed care are particularly problematic for many individuals, including children who may suffer long-term developmental and health consequences as a result of those delays.

**RECOMMENDATIONS:** We suggest the following specific changes to the proposed SBC and Glossary:

- On page 1, under "Important Questions," add the following question: "Do I need prior authorization if I have been referred to a specialist, need a special procedure/service or need to go out-of-network for my care?" The answer to this question should link to information about these processes and remind enrollees to confirm that specialists are in the plan's provider network.
- On page 3, under "Your Grievance and Appeals Rights," clarify that a consumer may appeal a denial of coverage for out-of-network care
- Add a definition of "prior authorization" to the Glossary. We suggest the following: "Prior authorizations are for certain services and/or procedures that require plan review and approval, prior to being provided. Some services and/or procedures that may require prior authorization include hospitalization, surgical, and therapeutic procedures."

***Changes in Networks.*** We recommend the SBC include language to remind families that their provider network may change during the plan year. It is critical that children, particularly those with serious, complex, or chronic conditions, have access to uninterrupted, medically necessary services and to a stable provider network, to the extent possible. Our recommendations can help ensure that families can work to identify a new provider or make other arrangements so their child can experience a seamless transition of care when a provider network is modified. Thus in addition to the request to include a direct link to their provider directory in the SBC, we recommend that the following language be added to page 3 of the SBC under "Your Rights to Coverage":

- “A given provider network may change during a coverage period”
- “Enrollees should regularly refer to the provider directory for a current list of participating providers.”

***Minimum Essential Coverage and Minimum Value.*** The SBC template includes two questions on page four about "Minimum essential Coverage" and "Minimum Value." We support the inclusion of these questions to help consumers make informed decisions about their coverage. However, many consumers will not understand what these terms mean, and they are not defined in the SBC glossary. The essential consumer information about the MV standard is not that it has a 60% AV, but rather that employees whose employer does not offer an MV plan can qualify for tax credits on the Marketplace. We recommend adding language to the explanation of each question, such as:

- **On MEC:** (pg. 4) "The ACA requires most people to have health care coverage that qualifies as ‘minimum essential coverage’ **or pay a penalty.** This plan or policy does/does not provide minimum essential coverage."
- **On MV** (pg. 4): "The ACA establishes a minimum value standard of benefits of a health plan. If an employer-sponsored plan does not meet the minimum value standard, employees may be eligible to receive federal support to purchase an individual plan through the Marketplace. This health coverage does/does not meet the Minimum Valued Standard for the benefits it provides. **Note:** Minimum value plans must meet 60% actuarial value **<u>and</u>** cover at least inpatient hospital and physician services.”

***Additional Comments.*** We also have additional comments to revise the proposed Summary of Benefits and Coverage (SBC) template:[15]

- On page 1, in comparing the proposed SBC template to the currently applicable SBC template,[16] the proposed template does not contain two “Important Questions” from the currently applicable template: “Are there services this plan doesn’t cover?” We recommend including this question in the final SBC template.

- On page 1, given the primary importance of the applicability of the deductible (in addition to the monthly premium) for consumers when shopping for a QHP, we recommend including an “Important Question” in the final SBC template which asks “Are there any services to which the deductible does not apply?”;

- On page 3, the “Habilitation services” and “Rehabilitation services” items under “Services You May Need” should be renamed “Habilitation services and devices” and “Rehabilitation services and devices,” respectively;

[15] See http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.
[16] See http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

- On page 3, “Services You May Need” under “If you need help recovering or have other special health needs” should include “Orthotics and prosthetics” right below “Durable medical equipment”;

- On pages 2-3, and especially for the sections regarding rehabilitation services and devices, habilitation services and devices, durable medical equipment, and orthotics and prosthetics, any quantitative limits for covered services (e.g. number of hours, days, visits covered) should be clearly specified in the SBC in the “Limitations & Exceptions” column;

- On page 3, rehabilitation services and devices, habilitative services and devices, durable medical equipment, and orthotics and prosthetics that are not covered should be explicitly enumerated in the “Services Your Plan Does NOT Cover” section of the SBC;

- Covered habilitative and rehabilitative services and devices should be listed somewhere in the SBC with specificity to provide optimal clarity to consumers;

- On pages 3-4, the proposed SBC template no longer contains the questions “Does this Coverage Provide Minimum Essential Coverage” and “Does this Coverage Meet the Minimum Value Standard” as the current SBC template does, and the proposed Sample Competed SBC contains the question “Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?” while the proposed SBC template does not. We recommend including the questions “Does this Coverage Provide Minimum Essential Coverage” and “Does this Coverage Meet the Minimum Value Standard” in both the proposed SBC template and the proposed Sample Completed SBC; and

- On page 4, add a heading “Your Right to a Tax Credit” with text underneath it to read: “Use this page to learn if you might be eligible for premium assistance if you buy coverage through the Marketplace instead of through your employer. Only individuals who meet certain income guidelines can get premium assistance.”

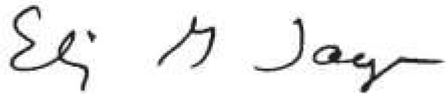
### *Applicability Date*

We support the proposed applicability date of September 1, 2015. The proposed regulations and accompanying guidance, with our recommendations, make improvements to the SBC that will improve women’s access to information about their health insurance plans. These changes should be instituted as quickly as possible. Requiring an applicability date of September 1, 2015 will ensure health care consumers have SBCs meeting the new requirements for plans with plan years starting in 2016. We also encourage the Departments to continue to review the implementation of the SBC requirements and work to improve the SBC after these proposed rules are finalized.

## Conclusion

Thank you for considering these comments. If you have questions, please contact Mara Youdelman, Managing Attorney (DC Office), 202-289-7661 or Youdelman@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director