ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

March 2, 2015

Secretary Sylvia Matthews Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Secretary Tom Perez
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20201

Secretary Jack Lew
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: **CMS-9938-P: Summary of Benefits and Coverage and Uniform Glossary**

Submitted via www.regulations.gov

Dear Secretary Perez, Secretary Lew, and Secretary Burwell,

Consumers Union, the policy and advocacy division of Consumer Reports,[1] submits these comments regarding the proposed rules governing the Summary of Benefits and Coverage and the Uniform Glossary.

Consumers Union is a strong proponent of the Summary of Benefits and Coverage (SBC) form. Shopping for health insurance is one of consumers' most dreaded tasks. Myriad variations in cost-sharing, complicated terms and exceptions, and service and coverage limitations make it extremely difficult for consumers to compare plans and to understand their coverage (and limitations) once they enroll in a plan. Consumers' new right to an SBC under the Affordable Care Act (ACA) means they finally have a uniform document that can be used to reliably compare private health plans and provide important coverage information.

In our comments to proposed rules governing "Benefit and Payment Parameters," Consumers Union applauded the provisions §156.420(h) and §156.425(c) requiring issuers to create and make publicly available SBCs for the cost-sharing reduction variations for Silver plans. The final rules, released February

[1] Founded in 1936, *Consumer Reports* is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using more than 50 labs, its auto test center, and survey research center, the non-profit organization rates thousands of products and services annually, Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace. This division employs a dedicated staff of policy analysts, lobbyists, grassroots organizers, and outreach specialists who work with the organization's more than 1million online activists to change legislation and the marketplace in favor of the consumer interest.

20, 2015, require SBCs for all plans, including Silver 73, Silver 87 and Silver 94 plans. The new rules will enhance a consumer's shopping experience and help ensure that those eligible for cost-sharing reductions understand the benefits of choosing a Silver level plan.

We now turn our attention to your proposed revisions to the rules that govern the SBCs for private health insurance products, including those offered on Marketplaces, in the private market outside Marketplaces, and by employers. The SBCs have been in circulation during three open enrollment periods. Consumers have been able to use them to shop for, enroll in, and use their health insurance. Yet, there are ways that the SBCs can be improved to make them more accessible and user-friendly. We strongly support improvements to the SBC, including the proposed added coverage example and revised glossary information, about which we provide specific suggestions below. We urge the changes be implemented as soon as possible, but no later than the proposed September 1, 2015.

§147.200(a)(1)(ii)(D), §54.9815-2715(a)(1)(ii)(D), § 2590.715-2715(a)(1)(ii)(D) - Requirement to provide SBC to Special Enrollees

Consumers Union is concerned that, as proposed, Special Enrollment Period (SEP) enrollees may not get an SBC for three full months (90 days) from the time they have enrolled. That means that individuals who apply outside of the open enrollment period will not have SBCs available to them in the same manner as consumers who enroll during the regular enrollment process. Under the proposed rules, individuals enrolling under a special enrollment period would have to know to request an SBC if they wish to have the plain language description of the plan sooner than three months after enrolling.

For the SBC to be a meaningful tool for consumers choosing and using insurance, we believe insurers and/or plan sponsors should be required to provide an SBC to SEP enrollees in the same manner as they are provided to other enrollees.

We recommend that the Departments require that group health plans treat SEP enrollees as applicants for coverage, which would mean the plan sponsor would have to provide an SBC as soon as practicable following receipt of an application, but in no event later than seven business days following receipt of the application. Consumers' need for a standardized health plan comparison document remains the same, whether they enroll in a plan via a special enrollment period or during the regular open enrollment period.

§147.200(a)(1)(iii) & (a)(3)(ii), §54.9815-2715(a)(1)(iii) & (a)(3)(ii), §2590.715-2715(a)(1)(iii) & (a)(3)(ii) - Rules When An Employer Carves Out Insurance Coverage

During the first year of ACA open enrollment, as an interim measure, the Department of Labor issued guidance that allowed employers who carve out insurance coverage (for example, a separate drug plan) to provide two separate SBCs. We strongly recommend against extending this temporary measure and do not want to see it codified, as proposed in the preamble of the NPRM.

While employers should be free to meet the comprehensive coverage requirements by contracting with separate vendors, consumers have the right to one comprehensive SBC that reflects their full range of health coverage. Consumers are entitled to a full set of ACA benefits and it is important for them to have a single source of information - one SBC - that provides a clear and understandable overview of what that coverage entails.

By providing the flexibility to employers to determine whether one comprehensive SBC is preferable than two separate ones, the Departments would be creating an obstacle to consumers, who would not be able to make apples-to-apples comparisons. Some employers may provide a comprehensive single SBC for one plan, while providing two separate SBCs for another plan, undermining the fundamental rationale of providing uniform, easily comparable information that consumers can understand.

We recommend that the Departments require health plan administrators, usually employers, to provide their employees with one consolidated SBC, which provides the consumer with a single document detailing the full range of coverage, regardless of whether the employer obtains that coverage from multiple vendors.

§147.200(a)(v)(B) and the preamble to §54.9815-2715(a)(1)(iii), §2590.715-2715(a)(1)(iii) - Monitoring the provision of SBCs in school-based coverage.

The Departments seek comment on monitoring the provision of the SBC through school-based insurance. Consumers Union supports active monitoring from the Departments to ensure all responsible parties are adhering to the SBC requirements, not just in the context of school-based insurance. The Departments could undertake a number of different measures to ensure that SBCs are being provided to consumers - through selective audits, secret shoppers, monitoring and following up on complaints data, and/or other strategies. Monitoring should occur across employer-based coverage, Marketplace coverage, and other private non-group coverage. We believe the Departments need to actively monitor to ensure that insurers, Marketplaces, employers, schools, and others are providing SBCs to consumers in an appropriate manner as outlined by the regulations.

§147.200(a)(2), §54.9815-2715(a)(2), §2590.715-2715(a)(2) - Include premium information on the SBC

Consumers Union asserts that premium data must be included as an important reported element on the SBC. As part of the NAIC template development in 2010, the draft SBC forms that CU and AHIP consumer-tested included a row for premium information on the 1st page.[2] Based on that testing, the NAIC recommended that a row for premium information be included on the SBC template form.[3]

Consumer testing shows that to make effective comparisons, consumers need premium information, alongside the other data on the SBC, including cost-sharing information (such as co-payments, co-insurance and deductibles), provider network details, and other primary information.[4] Most consumers can't meaningfully shop or use their health plans unless they understand the total cost of coverage. Though we want consumers to rely on the full cost of a policy, not just the premium, premium information is a significant part of the total cost of coverage and thus the SBC should include it.

We urge the Departments to support the inclusion of premium information in the SBC and to actually put a place for it on the top of the first page (not just allow insurers to add it on the last page, as

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[2] http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_soc_populated.pdf Instructions described how to populate the premium field. http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_inst_ind.pdf. See also report from AHIP here: http://www.naic.org/documents/committees_b_consumer_information_101012_ahip_focus_group_summary.pdf

[3] http://www.naic.org/committees_b_consumer_information_2011.htm

[4] Consumers Union and People Talk Research, Early Consumer Testing of New Health Insurance Disclosure Forms, December 2010.

suggested in the preamble). We understand that it may be difficult for plans to fill out the premium information to reflect an applicant's customized final rate. As an alternative, to help consumers make the apples-to-apples comparison, the premium amount could be completed on all SBCs for a standard person (e.g., "Standard rate for 40 year old non-smoker") in the initial row, thereby allowing the consumer to rank order plans based on their relative premium cost. To avoid confusion, the row would have to be clearly labeled as "Standard Rate for 40 year old non-smoker." The "Why this matters" should explain: "You can use this rate to compare plans, but the amount you are charged may be different. There are additional elements to total cost, such as deductibles and co-pays. Contact {xxx} to learn your individual premium amount."

Adding a premium row to the SBC would make the form more complete and useful to consumers, allowing them to conveniently line up two or more SBCs side-by-side, ensuring key information is on top.

If specific information cannot be included, an alternative would be to include the designated row at the top of page 1 (as was tested) labeled "Premium" to remind consumers of this important cost dimension, even if the "Answer" box is blank. Employers, brokers, navigators and others could help the consumer fill in the amount, once known. Finally, we urge the Departments to consumer-test the options to ensure they are understandable and actionable for consumers.

§147.200(a)(2), §54.9815-2715(a)(2), §2590.715-2715(a)(2) - Helping employees determine whether they may qualify for Marketplace tax credits

Employees seeking to learn if they might qualify for premium tax credits to purchase coverage in the Marketplaces need to know what their contribution would be relative to the lowest cost plan offered by their employer (that qualifies as minimum value coverage). In keeping with the goal of the law, which is to allow consumers to "compare health insurance coverage and understand the terms of that coverage," the SBCs should be designed so that consumers can easily use the form to complete Marketplace questions about available employer-sponsored coverage.

To accomplish this, **for group plans, the Departments should require the SBC to include "lowest cost employer plan" information**, as there is no other place where consumers will be able to find this data. Specifically, the Departments should require a check-box in the same general area as the minimum value disclaimer (approximately page 4) that requires an employer to indicate whether the plan is the "lowest cost plan" among the employers' plans meeting the minimum value requirement. The box will only require a small amount of space and will make it easy for consumers to quickly learn if this is the plan that should be used for the tax credit eligibility determination

Furthermore, for group plans, we urge the Departments to require introductory sentences to better help consumers understand the implications of their employer-sponsored coverage. For example, the following language should be added to page 4 of the SBC: "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 and for whom the cost of employer coverage is more than specific pre-defined amounts can get premium assistance."

§147.200(a)(2), §54.9815-2715(a)(2), §2590.715-2715(a)(2) - Include more information on deductibles

Consumers Union is concerned that the SBC does not currently present sufficient information about how plan deductibles work. We know from the insurance market that variation in types of deductibles

appears to be increasing as insurers experiment with new and different benefit designs. A health plan's annual deductible is one of the most important cost-sharing features that consumers need to consider when shopping for and using a health plan.

We urge the Departments to require that the SBC provide additional, important information about deductibles, including the following:

- **Require plans to show, in a consistent manner, which items or services the deductible does or does not apply to.** Even in California, where the Marketplace requires a standard benefits package for QHP products, there is wide variety amongst metal tiers as to when the deductible applies. If the SBC does not indicate when the deductible applies and when it does not, consumers are likely to be misled and not fully understand the cost-sharing associated with a plan. For example, many plans cover outpatient physician services, without requiring an enrollee to first pay the annual deductible amount (an "exception" to the deductible). Sometimes, a limited number of physician visits are exempted from the deductible each year, in order to encourage consumers to have access to at least some needed services without the burden of first paying what can be very large deductibles. Insurers have at times attempted to communicate this information in the SBCs, but not in a standardized way. Since it is not currently required, in most cases, the information is not stated on the SBC at all.

  We recommend adding a new second row (on page 1) with the "Important Question" listed as "Can I get services without paying the deductible first?" The "answer" column would indicate the exceptions to the deductible and the explanation in the "Why This Matters" column could say, "You do not need to pay any of the deductible to get coverage for some services. But a copayment or coinsurance may apply. See the list of common medical events."

- **Require plans to be more clear in "Why this Matters" when there is more than one deductible (e.g, a separate prescription drug deductible and an overall medical deductible).** It is important that not only does the SBC indicate to consumers when there is more than one deductible, but it must also explain the impact of the different deductibles. For example, a separate (smaller) deductible that is "nested" within the medical deductible, allows an enrollee to reach copayments or coinsurance sooner for the items or services to which the separate deductible applies. A separate deductible that is not nested, on the other hand, might apply totally separately from the deductible that applies to other covered benefits. In the case of a separate drug deductible, a plan might apply it to only to some drug "tiers" and not others. While the SBC template does specify the amount of any separate deductible and to what items or services it applies, the information in the "Why this Matters" column should be expanded to explain how any separate deductible amounts interact with the main annual deductible. It could be as simple as "You have a lower, separate deductible for prescription drugs, which means your insurance will start paying sooner for your medications."

§147.200(a)(2), §54.9815-2715(a)(2), §2590.715-2715(a)(2) - Clarifying how deductibles apply in family plans.

Family deductibles in plans covering more than one individual can be either "embedded" or "aggregate." This is often opaque and confusing to consumers, yet important for those with family coverage to understand. Under current SBC rules, there is no signal to the consumer that allows them to determine whether the deductible is embedded or aggregate. Further, there is nothing in the "Why this Matters"

that describes the consequences associated with each of the two options. Consumers Union urges the Departments to require separate SBCs – one for individual and one for family coverage – ensuring that enrollees have accurate information that helps them understand the differences between the two types of coverage and, more specifically, between the differences in the cost-sharing.

The new "Important Question" could be, "Does each family member have to pay a portion of the deductible?" Under "Why this matters" on page 1, row: "What is the overall deductible?" using the proposed language as follows:

- *If embedded*: "If you are enrolled in individual coverage, you must meet the individual deductible ($XXXX) before the plan pays claims for covered services. If you are enrolled in family coverage, the plan begins paying claims for an individual family member once he/she met the individual deductible ($XXXX). Once the family has met the whole family deductible ($ZZZZ), the plan pays claims for all members of the family for covered services."

- *If aggregate:* "If you are enrolled in family coverage, once the family has met the family deductible, the plan pays for covered services. The individual deductible does not apply in family coverage."

§147.200(a)(2), §54.9815-2715(a)(2), §2590.715-2715(a)(2) – Clarifying exclusions

The Departments propose to eliminate two rows from page 1 of the SBC template – "annual limits" and "services the plan doesn't cover."

Consumers Union proposes to replace those two rows with a single row that reminds consumers of exclusions and the remaining, permitted limitations to coverage. This might be entitled, "Does this coverage have limits?" and the "Why this Matters" section could say "This plan limits visits for certain services (see Chart on page 2). This plan also does NOT cover any of the services listed on page 5." The instructions should include alternate standard phrases for when scripts are limited and for other types of limitations.

When the NAIC consumer-tested the draft SBC form, consumers appreciated the reminder about exclusions.[5] Further, providing this information at the outset helps the consumer navigate the interior pages of the SBC.

§147.200(a)(2), §54.9815-2715(a)(2), §2590.715-2715(a)(2)- Information about drug cost-sharing

Consumers Union is concerned that in their current state, SBCs do not allow for helpful, consumer-friendly comparisons of drug costs. This is an especially important issue for consumers who take multiple prescription drugs and who need to compare plans based on their expected out-of-pocket cost for these drugs.

The current and proposed SBC needs several changes to allow consumers to more effectively compare their prescription drug costs under the various plan scenarios.

[5] Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, December 2010.

- **The language used in drug formularies to describe drug tiers should be identical to the language used in the SBC.** In most formularies, the drugs are described as "Tier 1, 2, 3" and etc. Moreover, plans' placement of drugs does not fit consistently into the current SBC captions: "Generic", "Preferred Brand", "Non-Preferred Brand" and "Specialty." For example, not all generic drugs will be in Tier 1 across every plan. Specialty drugs may be split across several tiers. Given that there is no consistency in tier naming conventions across plans, it is important that the SBC template provide a standard designation – we would suggest to use the numeric language, Tier 1, Tier 2, and Tier 3 (and more if there are further tiers). The template should then leave room in a parens and require the plans to insert the language they use in their formulary, so the SBC and any other of their public education materials are consistent.
- **A link to the specific product's formulary online should be provided directly on the SBC.** SBC instructions to insurers for completing the "If you Need Drugs" box in the "Common Medical Events" section must specify that the URL goes directly to the drug formulary for that specific health benefit plan.
- One of the most significant barriers for consumers to calculate their projected drug costs is that preferred brands and specialty **drugs are often subject to coinsurance rather than a specific copayment.** This makes it nearly impossible for consumers to anticipate their potential costs as they do not know the specific prices that coinsurance will be applied to. This could be addressed by requiring the plans' formulary website, to which the SBC already links, to display a column of the average cost-sharing paid by the plan members in the previous year, excluding silver plan members who got cost-sharing assistance.

§147.200(a)(2)(ii), §54.9815-2715(a)(2)(ii), §2590.715-2715(a)(2)(ii) - Coverage examples.

The Departments seek comment on the content of the coverage examples found on the SBC. During consumer testing, Coverage Examples were found by two studies to be one of the most helpful aspects of the SBC.[6] They provide an overall cost estimate to consumers and illustrate how cost-sharing works in a way that is much more informative and accessible than the discrete information included in the *Common Medical Events* table. They are the only SBC feature that allows consumers to understand their plan options based on an overall measure of cost-sharing.[7]

That said, we know there are consumer advocacy organizations with deep expertise about maternity coverage and diabetes care who have critiques of the current coverage examples' format and recommendations on how to improve those examples. We support these organizational efforts to make accurate and more meaningful the two original coverage examples.

We also applaud the Departments for adding an additional coverage example and updating the costs underlying all coverage examples to be a more accurate reflection of prices negotiated in the Marketplace.

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[6] Consumers Union and Kleimann Communications, *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance*, Consumers Union, August 2011, http://yourhealthsecurity.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance2.pdf and http://www.naic.org/documents/committees_b_consumer_information_110603_ahip_bcbsa_consumer_testing.pdf

[7] A few health plan comparison tools use claims data to calculate a "typical" amount of costs-sharing a consumer might face under the provisions of a plan (sometimes called total estimated cost) but most consumers don't have this summary measure available to them. As the Departments contemplate future revisions to the SBC, they should consider requiring plans to use claims data in this manner.

Consumers Union would urge the Departments to include a high cost example as one of the coverage examples. A very high cost example (breast cancer) included in consumer testing was the most motivational to consumers in terms of communicating the value of insurance. We strongly urge the Departments to add this type of example as soon as possible.

We also recommend using consumer testing to revisit the decision to allow insurers to include a wellness variation within the coverage examples. This was not included in the original consumer testing, nor was it included in the 2012 NAIC recommendations. This variation appears to make it harder for consumers to compare plans on an apples-to-apples basis. (As well, a coverage example that requires participation in a wellness program would not be applicable in a QHP, since wellness programs cannot be required in Marketplace plans at this time.) The coverage example needs to be revised to reflect the cost-sharing a consumer would pay if he or she did NOT participate in a wellness program, with a disclaimer at the bottom of the example that says "Lower costs may be possible if the enrollee successfully completes our wellness program" - when applicable.

§147.200(a)(2)(ii), §54.9815-2715(a)(2)(ii), §2590.715-2715(a)(2)(ii) - Use of the temporary calculator

In the preamble, the Departments seek comment on the continued use of the coverage examples calculator.

We strongly recommend that the Departments prohibit insurers from continuing to use the temporary calculator. The issues long associated with the temporary calculator have not been resolved, even two years after initiating its use. At the time, it was deemed a necessary, but ***temporary*** tool, and stakeholders questioned its efficacy. While insurers were under a great deal of pressure to provide specific costs for coverage examples in time for the statutory Sept 23, 2012 start date, the exigency no longer exists. Rather, by September 1, 2015, insurers should have experience with all three coverage examples to be able to complete SBCs by using actual cost-sharing provisions from their plans.

In addition, the temporary calculator allows plans to take shortcuts by using simplified assumptions that, at best, mislead consumers and, at worst, misstate the costs of treatment to the detriment of the enrollee. The temporary calculator can mask cost-sharing differences between plans and does not capture the unique coverage issues associated with the specific services identified in the examples. A particular concern with the temporary calculator is that the cost-sharing calculations rely exclusively on generic drug costs for all prescription drugs. For diabetes care, however, there is no generic form of insulin, a primary and essential medication for most diabetes sufferers. As a result of relying on generic drugs that are not available in this treatment regime, the diabetes coverage example populated by using the temporary calculator will almost always understate the cost of care. And since diabetes is one of only three coverage examples, use of the calculator ensures that at least 1/3 of the coverage examples are inaccurate.

In another diabetes coverage example, the temporary calculator treats all diabetes equipment and supplies as covered under the durable medical equipment (DME) benefit. But in practice, plans often cover these supplies under the prescription drug benefit - a line item that would be listed on the SBC coverage example with different cost sharing.

Given that the calculator has many flaws,[8] including significant inaccuracies or misrepresentations that relate to the actual coverage examples mandated to be included in the SBC, use of the temporary calculator should no longer be allowed. Insurers should be required to populate the coverage examples portion of the SBC by applying actual cost-sharing data to the template that is provided by the Departments.

The Departments seek comment on the updated pricing data used for the coverage examples. While we are concerned about the use of the calculator, we appreciate that *if* it is used completing the coverage examples will reflect recent, private claims data, rather than Medicare prices. This is a huge improvement over earlier years. Still, we strongly oppose continued use of the temporary calculator.

§147.200(a)(5), §2590.715-2715(a)(5), §54.9815-2715(a)(5) - Language Standards and Thresholds

The Departments seek comment on the thresholds and standards for providing the SBC in a linguistically and culturally acceptable manner. As proposed, Consumers Union is concerned that the regulations require the insurers to use a demographic standard based on county statistics and that only a percentage of the population is used as the threshold to determine whether an SBC must be translated into another language.

Consumers Union believes the standards for translating the SBC should align with existing DOL regulations and DOJ/HHS guidance and include both *numeric* and percentage thresholds. We are troubled that the proposed language removes the numeric threshold, in contrast with DOL regulations.[9] Moreover, we do not believe that the proposed 10 percent standard for translation and provision of oral language assistance will guarantee the delivery of culturally and linguistically appropriate services to the broad population the ACA was meant to protect. We would strongly encourage the Departments to lower the percent threshold in order to ensure that issuers and others are not discriminating on the basis of race, color or national origin.

The ACA was crafted to ensure that SBCs are provided in a "culturally and linguistically appropriate manner." The SBC is one of the most important documents that consumers will have access to; it is short, formatted in a standard fashion, provides basic summary information about the costs associated with health insurance coverage, and provides a glossary of complicated but relevant health insurance terms. Most recently, HHS affirmed that Marketplace QHPs have an obligation to provide meaningful access to any documents necessary for obtaining health insurance coverage or access to health care services.[10] It is necessary for limited-English proficient individuals to have access to the SBC.

In effect, the 10 percent standard proposed by the Departments will ensure that most language minorities will not have information in the SBC available to them in their native language. In the preamble, the Departments acknowledge that few counties in the country will reach the 10% threshold (with close to 1/3 of those in Puerto Rico), effectively meaning that in more than 90% of the counties in the U.S., insurers will not be obligated to translate the SBC.

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[8] Flaws were first documented over two years ago: "Transparency and Complexity," Kaiser Health Reform Source, August 13, 2012. http://healthreform.kff.org/notes-on-health-insurance-and-reform/2012/august/transparency-and-complexity.aspx.

[9] 29 C.F.R. §2520.102-2(c)(2).

[10] 45 CFR §156.250.

The Departments state that they would like to provide consistency in the establishment of the percent language threshold, but ignore some of their own guidance when proposing the standard at 10%. In fact, Guidance from the Department of Health and Human Services for Title VI requires written translation for LEP language groups that constitute 5% or 1,000 (whichever is less).[11] These criteria have been in effect for issuers participating in Medicare and Medicaid for more than eight years. While the guidance provides exceptions for translation of long documents, the SBC does not fit into that category. The SBC is specifically intended to be a short, comprehensive summary to help all speakers, whether they use English or any other language, to understand complicated and confusing insurance coverage. It is this very type of document that was intended to be accessible to limited-English proficient enrollees.

We are also concerned that the threshold uses county demographics as the measure for meeting the threshold. The demographics of the individuals participating in a particular plan may include more individuals with limited English proficiency (LEP), particularly in certain industries or, in situations where a plan markets to a specific population, than county data demonstrates. Rather, the threshold should be the languages spoken in the plan's service area.

Furthermore, the rules should be enhanced to require that when a health plan markets to a specific cultural or ethnic population, it must provide a translated SBC in the languages used by that population, even if the population otherwise does not meet the numeric or percentage threshold. If plans are trying to get consumers from these populations to enroll in their plans, they must be required to support them by providing information through the SBC in a culturally and linguistically appropriate manner.

We urge the Departments to require the competent translation of the SBC into any language spoken by 500 individuals or 5 percent of a specific non-English language in the plan's service area or an employer's workforce, whichever is less. DOJ/HHS LEP Guidances and the CMMS rules governing Medicare Part C & D plans use the 5% threshold for cultural and linguistic access. The 500 individuals numeric threshold arises from the Department of Labor's existing regulations. Taken together, these numeric and percentage thresholds should be adopted in order to ensure that access to the SBC is not a cause for discrimination against non-English speakers.

In addition, we urge the Departments to require the SBC include "taglines" in other languages when the 500 or 5% threshold has not been met, so that there is a sentence of information in a person's native language that lets her know that the document is important and she needs to get someone to help her read it in her own language. At a minimum, we recommend including a separate required document, in addition to the SBC, for taglines for any languages that don't meet the threshold. As an example, HHS has been including taglines on federally-facilitated Marketplace eligibility determination notices and the same information is critical to inform LEP individuals that the SBC information is available in their languages. The tagline language could read: "This is an important document that tells you what this plan covers and how much you might pay. You can call the Service Center at 1-800-???-??? and ask to have this form read to you in your language or sent in another format such as large print. For TTY call 1-???-???-????."

[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).

§147.200(a)(3)(i), §54.9815-2715(a)(3)(i), §2590.715-2715(a)(3)(i)- Format of the SBC

The Departments seek comment on whether the modifications to the SBC maintain critical information while shortening it enough to ensure that SBCs do not extend beyond the statutory limit. While we support compliance with the statutory limitation and believe consumers would welcome a shortened form, we believe the paramount question should be whether the design and content are crafted in the best way to communicate accurately, clearly, and in the most consumer-friendly format.[12]

We support some of the paring and other revisions, but as noted throughout these comments, there is critical information we urge be added or retained. For example, adding a "yes" or "no" check box that tells the consumer whether the plan is the "lowest cost plan," and therefore ineligible for financial help, would be critical. Similarly, Consumers Union believes that the current footer on each page of the SBC – containing a link to the glossary and the 1-800 phone number – should be retained. The proposed new version contains this information only once, on the top of the first page, blending into other information at the top of the page and less visible to consumers.

§147.200(c), §54.9815-2715(c), §2590.715-2715(c) - Uniform Glossary

Consumers Union appreciates the proposed updates to the uniform glossary, which provides consumers with access to plain language definitions of some of the hard-to-understand concepts associated with the purchase and use of health insurance. We make the following recommendations to the Department:

- The definitions proposed in the Uniform Glossary should match the definitions available on www.healthcare.gov (currently, many of the definitions on www.healthcare.gov reflect the 2014 version of the glossary and will need to be updated to reflect the revisions suggested in these proposed regulations.)

- Most importantly, new definitions should be evaluated for health literacy and should be consumer-tested before being made publicly available for the 2016 open enrollment period (proposed for September 1, 2015).

- In addition, we have the following comments:

    a. *Introduction to the glossary:* The introduction currently states that when there are conflicts in the definitions between the SBC glossary and plan documents, that the policy or plan governs. This seems overbroad since there are clear legal definitions from the ACA statute and regulations that would pre-empt issuer-generated variations. This language should be revised to reflect legal requirements.
    b. *Vague language:* Throughout the glossary, there are references to ambiguous concepts that are not readily understandable to a consumer, e.g., "sufficient" "reasonable" and "accepted." We propose that those definitions use more concrete language, or provide specific examples to illustrate a concept when ambiguous or undefined terms are used.
    c. *Added definitions:* We believe that proposed new terms including important definitions for "specialty drug" "minimum essential coverage" and "premium tax credits," are important additions and provide valuable information to consumers.

[12] http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf

d. *Definitions that need revisions:* A number of the definitions are confusing or problematic. Set forth below are some suggested wording changes, which we note are neither comprehensive nor consumer-tested yet:

1. Appeal: "A request that your health insurer, plan, or an independent organization ~~third party~~ review a decision that denies a benefit, payment, or part of a payment." ~~(either in whole or in part in whole or in part).~~

2. Claim: We prefer the more simple definition that is currently used on healthcare.gov: "A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered."

3. Cost-sharing Reductions: This definition is very long. Suggested edit: "... You can get these discounts if your income is below a certain level and you choose a Silver level health plan, or you are a member of a federally recognized tribe. ~~, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for cost-sharing reductions on certain services covered by a Marketplace policy of any metal level and may qualify for additional cost-sharing reductions depending on income.~~ To learn more about cost-sharing reductions, go to healthcare.gov."

4. Deductible: Point to the graphic example on the last page.

5. Formulary: The language in the definition should be more similar to what the consumer might see in her plan or policy - for example, often you will see plans identifying the levels of drug coverage by Tier 1, Tier 2, etc. In addition to adding a definition of "tier/s" to the glossary, suggested edits include: "A list of drugs your health insurance or plan covers. ~~A formulary may include how much you pay for each drug.~~ If your drug is not listed on the formulary, you may request an exception, or you may have to pay the full cost. Some plans use formularies with ~~If the plan uses~~ "**tiers**" for example, Tier 1, Tier 2, Tier 3. The tiers represent how much the plan will cover for your drugs. The higher the tier number, the more ***you*** will have to pay when you buy the drug." ~~the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.~~

6. Marketplace: This definition is too long: "A state or federal entity that serves as a gateway for individuals, families, and small businesses to learn about, ~~their health coverage options;~~ compare, ~~health insurance plans based on costs, benefits, and other important features; choose a plan;~~ and enroll in health insurance coverage. The Marketplace also provides information on programs that help people with low- to moderate-income ~~and resources~~ pay for coverage, like **premium tax credits, cost-sharing reductions**, ~~This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace (see premium tax credits and cost-sharing reductions), and~~ ~~information about~~ and other programs, including Medicaid and the Children's Health Insurance Program (CHIP). ~~The Marketplace is accessible through websites, call centers, and in-person assistance.~~ In some states, the Marketplace is run by the state. In others it is run by the federal

government. For those who qualify, it is the only place to get federal financial assistance to reduce premiums and other costs on commercial plans."

7. Minimum Value: This definition should be less technical and more clear to a consumer."~~Federal law establishes certain value standards for plans and health insurance.~~ The minimum value is the standard that health insurance you get through your job has to meet, covering 60% of the expected costs for an average population. This is a technical term to measure if the insurance you get through your job covers the bare minimum. If it does not meet the standard, you may be eligible to buy a plan with premium tax credits from a Marketplace. If it does meet the standard, you will not be able to get premium tax credits. ~~The measure If the insurance you get through a job does not cover 60% of the costs expected, on average, it doesn't meet the minimum value. For example, "bronze level" individual insurance is designed to pay about 60% of the total cost of certain essential medical services, on average, for a standard population. Plans are subject to a minimum value standard that is similar to that 60% standard, although the benefits covered by the plan may differ from those covered under individual insurance.~~"

8. Non-Preferred Provider: Concepts involving out-of-network and in-network providers and cost-sharing are among the most confusing for consumers. The common nomenclature since enactment of the Affordable Care Act is "in-network" and "out-of-network," which are both absent from the uniform glossary. It is not clear how "non-preferred" and "preferred" differ from those other terms. Many non-preferred providers do have contracts to provide services to enrollees, but may not be "in-network" for a particular plan. We strongly urge you to create separate glossary entries for" participating provider," as well as "in-network provider" and "out-of-network provider." Suggested edits to this definition: "A doctor, hospital or other provider who doesn't have a contract with your health ~~insurer or~~ plan to provide services to you. You'll generally pay more to see a non-preferred provider. ~~Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.~~ Your policy may use the term "out-of-network" or "non-participating" instead of "non-preferred."

9. Out-of-pocket limit: Needs to be revised to reflect accurately that the exception only applies to grandfathered plans, otherwise it is very misleading: "...This limit never includes your premium and ~~balance-billed~~ charges or health care services that your health insurance or plan doesn't cover. ~~Some health insurance or plans~~ A small number of plans that existed before the Affordable Care Act passed don't have to count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit. These plans are the exception."

10. Preferred provider: Same comments as above. Also, suggested edits: "A provider who has a contract with your health ~~insurer or~~ plan to provide services to you at a discount to the health plan. Your policy may use the term "in-network" instead of "preferred." Check ~~your policy~~ to see if your ~~can see go to all preferred providers or if your health insurance or~~ plan has a "**tiered**" network. That means you might have to ~~and you must~~ pay extra to see some providers. Your health insurance or plan may

have preferred providers who are also **participating providers**. Participating providers also contract with your health insurer or plan, but the discount may not be as great, ~~and be smaller,~~ so you may have to pay more.

11. Premium: The definition as currently drafted fails to mention premium tax credits. Since advance tax credits will pay part of a consumer's premium, we think they should be included in this definition: "The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. If you get **premium tax credits,** they will be paid directly to the plan, in advance if you wish, to reduce what premium you pay."
12. Preventive Care: Since preventive care is at no cost to the consumer, you should add the following to the definition: "Preventive care is available at no cost to you - no copayment or coinsurance, in most plans."

e. Definitions that need to be added: There are several complicated terms that are relevant to the SBC that are missing from the Uniform Glossary and should be added. Some suggested language is provided below:

1. Tier or tiered network**: "**Some plans organize their providers in different tiers or levels**.** The amount that you have to pay to see a provider may be different, depending on the tier the provider is in. For example, you may have to pay more to see an orthopedist in Tier 2 than one who is in Tier 1. If your health plan has tiers or a tiered network, be sure you know which tier your hospital, doctor or other provider is in, so you know how much you will be expected to pay. "

2. In-network provider**: "**Doctors, hospitals and other providers who accept an agreed upon rate as "payment in full" for services. They can charge you for **copayments** or **coinsurance**, but they cannot charge you more than the allowed amount."

3. Out-of-network provider**: "**Doctors, hospitals and other providers who have not agreed on a set rate with your health plan. This means they can charge you more than an in-network provider might. Most plans will pay less or not pay anything if you use out-of-network providers. If you use these providers anyway, you will have to pay more, and in some cases the full cost of services.**"**

4. Participating provider**: "**Like preferred providers, participating providers have agreements with your plan, but the discount may not be as much as for doctors, hospitals or other providers who are "preferred providers," so you may have to pay more. Check to see if your plan has a "**tiered**" network. That means you might have to pay extra to see some providers."

Applicability Date for Changes to the SBC

The Departments seek comment on the proposed applicability date of September 1, 2015 for the changes of the current requirements to provide an SBC, notice of modification, and uniform glossary. As noted throughout these comments, Consumers Union strongly supports the proposed date of September 1, 2015 as the date of applicability and opposes any delay in the adoption of these rules. Consumers have waited long enough to see the proposed changes enacted and for further changes to make the document more understandable.

However, in the event that a Sept. 1, 2015 effective date is not adopted, we urge that any additional time be used to further refine the design and formatting and to engage in more rigorous consumer-testing and stakeholder review.

Regulatory Flexibility

In Section C of Part VI, Economic Impact and Paperwork Burden, of the Preamble to the proposed regulations, the Departments seek comment on the appropriateness of the size standard used in evaluating the impact of these proposed regulations on small entities.

While we understand that it may be more difficult for small insurers to comply with these rules than it is for larger companies, we believe exceptions to the requirement that employers and insurers provide an SBC to consumers would create an uneven playing field for all stakeholders. A consumer who works for a small entity should still have the right to obtain an SBC to better shop for and understand health plan choices. It is virtually impossible for a consumer to assemble the key information to be presented in the SBC and needed to make the decision of which plans to buy to comply with legal requirements under the ACA and avoid a hefty financial penalty. Any challenges that health plans and large employers may face in populating the forms, pale by comparison. We thus urge that all insurers, plans and employers, regardless of size, be held responsible for populating and providing an SBC to consumers.

Conclusion

During the Congressional work crafting the ACA, researchers, policymakers, journalists, and consumer advocates agreed that consumers would be most helped by the ability to make apples-to-apples comparisons, including through the provision of coverage examples. Surveys and polling data identified the consistent and widespread confusion amongst consumers about health insurance and health insurance concepts and reaffirmed the desire to use the ACA to help simplify the provision of health insurance. This is the promise that was ultimately adopted by the ACA via the Summary of Benefits and Coverage.

Consumers Union urges the Departments to resist any efforts to delay its improvement or limit its distribution. Only by widespread use of this tool, will we start to chip away at the longstanding dread and confusion consumers face when shopping for and using health insurance. We urge the Departments to move forward with plans to improve the SBC, with particular emphasis on the issues we have identified in this letter.

On behalf of Consumers Union, we thank you for the opportunity to comment on this important rule making and would be happy to answer any questions.

Sincerely,

DeAnn Friedholm
Director
Health Care Reform