To: Chairwoman Angela Nelson, Consumer Information (B) Subgroup
From: Kathleen Gmeiner, JoAnn Volk, Bonnie Burns, Brenda Cude, Tim Jost, Kim Calder
Date: April 29, 2015
RE: Comments on Summary of Benefits and Coverage Template

Thank you for your continued efforts to ensure that consumers have access to accurate, easy-to-understand information about their health insurance options and for your long-standing commitment to using a public, multi-stakeholder process to inform NAIC decisions. In furtherance of this goal, the consumer members of the Advisory Working Group—representing millions of health care consumers—are pleased to offer comments on the Summary of Benefits and Coverage (SBC) template.

By enabling apples-to-apples comparisons among private health insurance options, the SBC is a critical tool to help consumers select the plan that best meets their personal needs, understand how their coverage works, and take advantage of the protections they are entitled to under the Affordable Care Act. Indeed, consumers that use the SBC often describe it as the most helpful source of health plan information.

Yet, awareness of the SBC remains low, and there are significant opportunities to refine the SBC template to the benefit of consumers. The attached comments address the ways that the current SBC template can be improved. Note that we do not address changes to the Uniform Glossary, which we understand will be addressed by the Advisory Working Group at a future date. As a result, these comments are limited to the content, format, layout, and use of the SBC template itself. The comments are organized in the order of the existing SBC template and color-coded to indicate a recommendation to add new content (blue), amend existing content (red), and provide additional feedback on the format and use of the SBC (purple).

In addition to our comments on the template, we have two additional, overarching recommendations for the Consumer Information (B) Subgroup to consider. First, more consumers would use the SBC if it were professionally designed to be more appealing and easy to use. We recommend that the NAIC, drawing on its experience with designing consumer disclosures, consider commissioning a redesign, or, failing that, urge the relevant federal agencies (the Centers for Medicare & Medicaid Services and the Department of Labor) to take on this task. Approximately 190 million consumers with private insurance coverage could potentially benefit from this form, so a modest investment in usability is surely merited. A professional redesign will be most successful if the key informational elements are retained but the designers are given significant latitude to rearrange them.

We also recommend consumer testing of the proposed changes to ensure both the content and the design are effective and helpful to the people who will use the SBCs. Testing should also examine the impact of modifications that were made to the template after the last round of consumer testing (such as the removal of a premium row on page 1 and the removal of the breast cancer coverage example). The testing should be done early enough that it does not delay needed revisions to the form. Further, it should be done by an experienced, independent third party. We recommend that the NAIC commission the testing itself, or, failing that, we urge that CMS and DOL take on this task.

We also recommend that a schedule be created for SBC revisions over time so that all stakeholders know what to expect. For example, we could plan to reconvene to revise every 2 or 3 years, using evidence to drive revisions.

We want to be clear that a number of improvements should be made to the SBC in time for the 2017 plan year, even if, for some reason, there is a delay in consumer testing or a limit to the elements of the template that can be tested. Similarly, we do not think changes to the SBC should be delayed if the professional redesign we recommend cannot be done in the near term. The breadth of experience and variety of perspectives found among the members of this Subgroup will generate important improvements to the SBC, even if it turns out that not every element can be formally tested or cannot be tested in the short timeframe that is available.

Thank you in advance for your consideration, and we look forward to continuing to work closely with the Consumer Information (B) Subgroup and the Advisory Working Group to address these issues and ensure that all consumers have equal access to accurate, easy-to-understand information about their health insurance benefits. If you have any questions, please contact JoAnn Volk (joann.volk@georgetown.edu).

Important Questions (Page 1)

- **Add a new row for premium information.** The SBC should include a new row on the first page with the question "What is the **premium**?" The "Answer" box can be left blank so employers, brokers, navigators, and others can help the consumer fill in the amount once known. When the NAIC tested the SBC, the draft forms included a row on the first page for premium, and consumer testing indicates that consumers appreciated this key piece of information in addition to cost-sharing requirements. 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 with key information on top.

Important Questions	Answers	Why this Matters:
What is the premium?	**$**	This is the amount you pay each month for your coverage.

- **Modify the SBC template or the requirement to provide the SBC to better illuminate the cost-sharing differences between individual and family coverage.** The SBC template should be streamlined so consumers can easily identify the differences between individual and family coverage. Issuers could, for instance, be required to provide separate SBCs for individual and family coverage for each plan where these variations are offered. Doing so will reduce the amount of information on each SBC and simplify comparisons for consumers. Currently, a family-plan SBC that lists both a per-person deductible and a family deductible is ambiguous. It could mean the per-person deductible is for an individual plan and is not pertinent to the family plan, or it could be for each member within the family in the family plan. This solution also allows more tailoring for coverage examples that could focus solely on individuals or, in the case of family coverage, elucidate cost-sharing implications when multiple family members receive care. While this change will require issuers to create two SBCs for each plan, issuers are already required to compile this information, and it may ease administrative burden by reducing difficulty in the creation of SBCs with conflicting content and length requirements.

- **Amend the existing row on the overall deductible in the "Why this Matters" box to note whether out-of-pocket costs are "embedded" or "aggregate."** The "Why this Matters" box on the first page with the question "What is the overall **deductible**?" should reflect whether a family deductible is embedded or aggregate with specified amounts. A health plan's annual deductible is one of the most important cost-sharing features for enrollees. Yet, the SBC does not currently present all of the information that consumers need to understand how deductibles work, particularly for those enrolled in family coverage. The SBC should easily allow families to understand how their coverage works and what it means if their deductible is embedded or aggregate.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$**	**For plans with an embedded deductible**: If you are enrolled in family coverage, the plan begins paying claims for an individual family member once he/she meets the individual deductible ($XXXX). Once the

		family has met the family deductible ($ZZZZ), the plan pays claims for all members of the family for covered services." **For plans with an aggregate deductible**: "If you are enrolled in family coverage, once the family has met the family deductible ($ZZZZ), the plan pays claims for covered services. The individual deductible does not apply in family coverage with an aggregate deductible."

- **Amend the existing row on other deductibles in the "Why this Matters" box to incorporate the possibility of separate deductibles.** The SBC should be amended on the first page with the question "Are there other **deductibles** for specific services?" Plans should clarify how any deductible that is separate from the overall medical deductible (i.e., a prescription drug deductible) interacts with the overall medical deductible. Although the SBC template specifies 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. A separate (smaller) deductible could, for example, be "nested" within the medical deductible, allowing a plan 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, would 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 some drug tiers and not others.

Important Questions	Answers	Why this Matters:
Are there other deductibles for specific services?	**$**	

- **Add a new row for services excluded from the deductible.** The SBC should include a new row on the first page with the question "Is there anything to which the **deductible** does **not** apply?" The "Why this Matters" box should read "The health insurance policy or plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply." A health plan's annual deductible is one of the most important cost-sharing features for enrollees. Yet, the SBC does not currently present all of the information that consumers might need to understand how deductibles work. Moreover, insurers increasingly vary the types of deductibles with, for instance, many plans covering prescription drugs or outpatient physician services without requiring an enrollee to first pay the annual deductible amount. Although some insurers have attempted to communicate this information in the SBCs, it is not required or reflected in a standardized way that would clearly communicate these differences to consumers.

Important Questions	Answers	Why this Matters:
Is there anything to which the deductible does not apply?		The health insurance policy or plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply.

- **Amend the existing row on limits on out-of-pocket expenses in the "Why this Matters" box to note whether the out-of-pocket maximum for family coverage is calculated as "embedded" or "aggregate."** The "Why this Matters" box on the first page with the question "Is there an **out-of-pocket limit** on my expenses?" should reflect whether the out-of-pocket maximum is embedded or aggregate with specified amounts.. The SBC does not currently present all of the information that consumers might need to understand how out-of-pocket limits work, particularly for those enrolled in family coverage. The SBC should easily allow families to understand how their coverage works and what it means if their out-of-pocket limit is embedded or aggregate.

Important Questions	Answers	Why this Matters:
Is there an out–of–pocket limit on my expenses?	**$**	**For plans with embedded out-of-pocket limits**: If you are enrolled in family coverage, once an individual family member has met the individual out-of-pocket maximum ($YYYY), the plan will pay 100% of the cost of covered services for that individual. Once the family meets the family out-of-pocket maximum ($WWWW), the plan will pay 100% of the cost of covered services for all members of the family." **For plans with an aggregate out-of-pocket limit**: "If you are enrolled in family coverage, once the family meets the family out of pocket maximum ($WWWW), the plan will pay 100% of the costs of covered services. The individual out of pocket maximum does not apply in family coverage with an aggregate deductible."

- **Add a new row on coverage limits to replace the two rows on annual limits and non-covered services.** The SBC should include a new row on the first page with the question "Does this coverage have **limits**?" The "Why this Matters" box should refer consumers to the rest of the SBC for additional information. The instructions could include alternate standard phrases when there are limits on other benefits, such as prescription drugs. This box would replace the existing questions on annual limits ("Is there an overall annual limit on what the plan pays?") and non-covered services ("Are there services this plan doesn't cover?"). By including this new question, the SBC will continue to alert consumers to the possibility that not all services will be covered. In testing, consumers appreciated the reminder about exclusions and other limitations on their coverage, and this sort of information provided on the first page can help the consumer navigate the interior pages of the SBC.

Important Questions	Answers	Why this Matters:
Does this coverage have limits?		This plan limits visits for certain services listed on page 2. This plan does not cover any of the services listed on page 5.

- **Add a new row for plans to link directly to the plan-specific prescription drug formulary.** The SBC should include a new row on the first page with the question "What **prescription drugs** are covered under this plan?" By including this new question, the SBC will directly link consumers to plan-specific information about their formulary while also alerting consumers to the possibility that not all drugs will be covered.

Important Questions	Answers	Why this Matters:
What prescription drugs are covered under this plan?	See full list at [direct link to website].	

- **Add a new row on prior authorization for specialists.** The first page of the SBC should include a new row with the question: **"**Do I need **prior authorization** to see a specialist, to get certain services, or go out-of-network for my care?" By adding this question, the SBC will alert consumers to the possibility that not all services or specialists will be covered and that they may need to get approval in advance. A description of 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, will help ensure that consumers who need specialty care 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.

Important Questions	Answers	Why this Matters:
Do I need prior authorization to see a specialist, to get certain services, or to go out-of-network for my care?		This plan requires you to get special approval before accessing certain services, such as seeing a specialist or going to an out-of-network provider. See full plan information at [website]."

Common Medical Event (Pages 2 and 3)

- **Add "X-ray" to the examples under "imaging."** The SBC should include an X-ray as an example of an imaging service on the second page. Consumers are very familiar with X-rays and likely more familiar with this service than MRIs or PET scans. The addition of this example will help consumers identify and understand the types of services that will be covered under this category.

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 have a test	Diagnostic test (x-ray, blood work)			
	Imaging (X-ray, CT/PET scans, MRIs)			

- **Add a new row for the coverage of preventive services.** The SBC should include a new row on the second page to highlight the benefits of preventive services without cost-sharing and let consumers know that the delivery of preventive services is not limited to a provider's office. Under "Limitations and Exceptions," plans can link to a web address with a comprehensive, up-to-date list of all preventive services available without cost-sharing, 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. The web address will help ensure that consumers know how to find the full extent of preventive services they are entitled to without cost-sharing.

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		No cost for listed services; deductible does not apply		See full list of preventive services covered without cost-sharing at [website].

- **Add new language on prescription drug tiering to reflect the way that plans describe their tiers and amend the language from "drugs" to "a prescription."** The SBC should amend its existing language to replace "drugs" with "a prescription" and add new language on the second page to the rows related to prescription drug coverage to align these tiers with the more common numeric tiers. In most formularies the drugs are described as "Tier 1, 2, 3, and 4" but the SBC's drug captions are "Generic, Preferred Brand, Non-Preferred Brand, and Specialty." Since most formularies identify their tiers numerically—rather than the descriptions provided in the SBC—the descriptions should also include a reference to the numeric tier system. Adding a cross-reference to the numeric tiers will assist consumers in matching this information to online formularies and minimize confusion.

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 prescription to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs (usually Tier 1)			
	Preferred brand drugs (usually Tier 2)			
	Non-preferred brand drugs (usually Tier 3)			
	Specialty drugs (usually Tier 4 or higher)			

- **Add cost-sharing information for plans with split formulary tiers.** The SBC should include cost-sharing information for each drug formulary tier on the second page of the template. Health plans are increasingly adopting additional drug formulary tiers where certain categories—such as "generic" or "specialty"—are split into more than one tier. The SBC instructions currently do not provide clear directions for plans that have split drug formulary tiers, which are an increasingly common plan design element. Clear instructions to list the cost-sharing for each drug formulary tier, including split tiers, will make it easier for consumers to understand how plans will apply cost-sharing.

- **Add medical services related to outpatient surgery that could be considered out-of-network.** On the second page, the SBC should include information about any out-of-network services that consumers might face when undergoing outpatient surgery—even if received at an in-network facility. This information should be reflected in the column on "Limitations and Exceptions" and may include examples such as anesthesia services.

- **Amend the language of the category related to mental health, behavioral health, and substance abuse.** The SBC should be amended to replace "If you have mental health, behavioral health, or substance abuse needs" with "If you need mental or behavioral health services or substance abuse services." Doing so will ensure consistency with the other categories and match the terminology used in the "Services You May Need" column.

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 mental/ behavioral health or substance abuse services	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			

- **Amend the description of services under "if you are pregnant."** The SBC should be amended on the third page to more accurately reflect the way insurance companies and women pay for maternity services by replacing "prenatal and postnatal care" with "physician/midwife fees (prenatal, labor and birth, postnatal)" and replacing "delivery and all inpatient services" with "hospital/birth center fee." These changes will ensure that the "If you are pregnant" section is 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. We also recommend that the instructions direct plans that have separate cost-sharing amounts for the labor and birth compared to the prenatal and postnatal fees to detail this cost-sharing information. By broadening the SBC category to "hospital/birth center fee," the SBC will better reflect the variation in maternal and newborn care based on where a woman chooses to give birth.

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			

- **Amend the description of services under "If you need help recovering or have other special health needs."** The SBC should be amended on the third page to more accurately reflect the services that consumers may need for recovery or other special needs by replacing "rehabilitation services" and "habilitation services" with "rehabilitation services and devices" and "habilitation services and devices," respectively. The SBC should also include

"wheelchair" as an example under the category for "durable medical equipment." These changes reflect the fact that both services and devices are often covered by a plan and help consumers understand the types of items that are included under the category of "durable medical equipment."

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 help recovering or have other special health needs	Home health care			
	Rehabilitation services and devices			
	Habilitation services and devices			
	Skilled nursing care			
	Durable medical equipment (e.g., wheelchair)			
	Hospice service			

- **Add a new row for the coverage of pediatric services.** The SBC should include a new row on the second or third page to highlight the pediatric services that are available under the plan. The "Limitations & Exceptions" should be used 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. The SBC does not currently include any references to pediatric benefits and services, except for dental and vision care. 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.

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 pediatric services				

- **Add a new row for the coverage of abortion.** The SBC should include a new row on the second or third page to clearly communicate the details related to whether and how abortion is covered under a plan. To contain all of the information a person needs to make an informed choice about her health plan, the SBC should include whether abortion is covered (as well as whether it is excluded), cost-sharing amounts, and any limitations on coverage under "Common Medical Event" to disclose these important limitations and exceptions. Additionally, the SBC should include a link to plan documents where consumers can find more information about the coverage details. It is also critical that the SBC reflects accurate, objective, and plain language terms when describing the plans' coverage (or lack thereof) of abortion services. For example, the SBC Instruction Guide should be changed to "when the life of the *mother* is endangered" to "when the life of the *woman* is endangered."

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 an abortion				**For plans that cover abortion**: "None. See full plan information at [website]." **For plans that cover abortion only in certain circumstances**: "Coverage excluded except when the woman's life is endangered, pregnancy is the result of rape or incest, [other exceptions]. See full plan information at [website]."

- **Add cost-sharing information for plans with tiered networks.** The SBC should include cost-sharing information for each network tier under "Your Cost if You Use an In-Network Provider" on the second and third pages of the template. The SBC instructions currently do not provide clear directions for plans that have tiered networks, which are an increasingly common plan design element. In 2014, about one-fifth of employers offering health benefits offered a plan with tiered network design. Yet, adequate information about the network structure is not available through the marketplaces. Clear instructions to list the cost-sharing for each network tier would make it easier for consumers to understand how plans will apply cost-sharing.

- **Add cost-sharing information for plans with facility charges and facility fees.** The SBC should reflect cost-sharing information for facility charges and facility fees under "Limitations and Exceptions" in the columns for preventive services, office visits, and outpatient surgery on the second and third pages of the template. The SBC currently does not reflect certain cost-sharing, sometimes called a facility charge or a facility fee, for services received at a higher cost facility such as outpatient services provided at a hospital, hospital campus, or hospital owned facility. In addition, some health care providers charge for the use of the health care

facility. These 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, for example, undermine the preventive services benefits in plans that do not cover facility fees billed by in-network providers for preventive services. While the additional cost-sharing is detailed in the summary of benefits, it is not included in the SBC, and an individual relying on the SBC may receive care from a physician on a hospital campus and incur an additional unexpected cost.

Your Rights, Minimum Essential Coverage, Minimum Value, and Language Access Services (Page 4)

- **Add two statements that provider networks can change and that enrollees have the right to continue coverage during an ongoing course of treatment under "Your Rights to Continue Coverage."** In the "Your Rights to Continue Coverage" section on the fourth page, the SBC should include 1) a statement that alerts consumers to the fact that their provider network may change during the year; and 2) a statement that individuals have a right to transitional treatment. It is critical that consumers, 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. Significant disruptions of care and provider relationships resulting from an unexpected plan change or plan termination could be catastrophic, and it is critically important that consumers undergoing active care understand their rights to care transition planning and coverage continuity.

> **Your Rights to Continue 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. An individual in active treatment may be able to continue coverage if required by state or federal law.

- **For group health plans, add a new introductory statement on Marketplace subsidies.** Above the questions on minimum essential coverage and minimum value, the SBC should include a new statement on the fourth page which lets consumers know that the information can be used to determine if they are eligible for premium assistance through the Marketplace. Employees seeking to learn if they might qualify for premium tax credits to purchase coverage in the Marketplaces need to know their contribution to the lowest cost plan offered by their employer (among plans that meet minimum value requirements). 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 in such a way that consumers can easily use this document for completing Marketplace questions about available employer-sponsored coverage.

> **Are You Eligible for Premium Assistance Through the Marketplace?**
> 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.

- **For group health plans, add a new check-box for employers to certify that the plan is the lowest cost plan.** After the question on minimum value, the SBC should include a new check-box on the fourth page so employers can indicate whether the plan is the lowest cost plan among plans that meet the minimum value requirement. The box will make it easy for consumers to quickly learn if a plan that meets the minimum value is the lowest cost plan offered. Consumers are currently unprotected, as they do not have a form where employers are required to report this information.

> **Is This Plan the Lowest Cost Plan among the Plans from this employer that Meet the Minimum Value Requirement?**
>
> ☐ Yes
>
> ☐ No

- **Add "taglines" in at least the same languages recognized by healthcare.gov on all SBCs.** The SBC should include taglines on the fourth page in at least the same languages recognized by healthcare.gov to indicate the availability of translated SBCs and oral language services. Doing so is consistent with the forms in the federally-facilitated marketplace where HHS has been including taglines on eligibility determination notices. The inclusion of taglines will inform individuals with limited English proficiency that the information is available in their languages.

Coverage Examples (Pages 5 and 6)

- **Amend the maternity coverage example to change the title from "having a baby" to "pregnancy and childbirth."** The SBC should reflect the title "Pregnancy and childbirth" rather than "Having a baby" for the maternity coverage example on the fifth page. 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.

- **Amend the maternity coverage example to change the description from "normal delivery" to "uncomplicated v*g***l birth" or "v*g***l birth."** The SBC should reflect the type of procedure—in this case, uncomplicated v*g***l birth—for the maternity coverage example on the fifth page. Clarifying the coverage example to explicitly reflect v*g***l 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 be considered "normal," but the cost-sharing obligations for the procedure would not be reflected in this example. 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."

- **Amend the maternity coverage example to reflect "routine maternity care" rather than "routine obstetric care."** The SBC should reference "routine maternity care (prenatal, labor/birth, and postnatal)" rather than "routine obstetric care" in the maternity coverage example on the fifth page. "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.

- **Add a new row to the maternity coverage example to reflect "routine newborn care."** The SBC should include an additional row on "routine newborn care" under the row for "Hospital charges (baby)" in the maternity coverage example on the fifth page. 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). This new row would read "Routine newborn care" and would provide accurate baseline information for professional payments for routine newborn care.

- **Amend the coverage example on diabetes to include the coverage of a statin drug.** The SBC should include a statin drug in its diabetes coverage example on the fifth page. The SBC should reflect coverage examples with the most accurate information and treatments possible. Both the American Heart Association's and the American Diabetes Association's guidelines recommend that, for patients with diabetes over age 40 without overt cardiovascular disease, clinicians should consider using statin therapy, in addition to emphasizing lifestyle modification. Thus, for the 52 year old patient with diabetes in the diabetes treatment scenario, use of a statin would be indicated and should be reflected on the SBC.

- **Amend the coverage example on diabetes to eliminate the assumption about participation in a wellness program and adopting a new disclaimer for plans that offer a wellness program option.** The SBC should not include an assumption in the diabetes coverage example on the fifth page that a consumer is participating in a wellness program; rather, the plan should include a new disclaimer if it offers a wellness program. This disclaimer could read "If you have diabetes and participate in our wellness program, your costs may be lower." Currently, the coverage example for managing type 2 diabetes includes a wellness program disclaimer for plans to use which notes "these numbers assume the patient is participating in the plan's diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher." However, for the consumer, this disclaimer adds a layer of confusion and ambiguity to the diabetes example. For individuals comparing plans who might have difficulty participating in or meeting any required outcomes for the diabetes wellness program, the out-of-pocket cost estimates assuming participation in the wellness program could provide consumers with an artificially low impression of out-of-pocket costs under the plan. It also confounds the goal of being able to make "apples to apples" comparisons between plans.

- **Add at least one new coverage example that reflects a common health problem that most individuals experience, such as a simple foot fracture with an emergency room visit, in the context of a family coverage scenario.** The SBC should include a new coverage example for a simple foot fracture in the context of a family coverage scenario on the fifth page. The categories of expenses should include an emergency room visit and physical therapy, among others. This coverage example will be particularly helpful as a health problem that most individuals could experience (whereas having a baby and type 2 diabetes affect a subset of the population). In particular, we recommend that the foot fracture be suffered by a dependent to help illustrate how cost-sharing works for family coverage.

- **Add at least one new coverage example that reflects an expensive, catastrophic event such as breast cancer.** The SBC should include a new coverage example for breast cancer on the fifth page. The categories of expenses should include high-cost items such as radiology, laboratory tests, and chemotherapy, among others. This coverage example will help consumers understand their bottom line and illustrate how cost-sharing works in a way that is much more accessible than the discrete information included in the Common Medical Events table. Indeed, during consumer testing, coverage examples were found by two studies to be one of the most helpful aspects of the SBC. Coverage examples are currently the only tool that allows consumers to rank order their choices based on an overall measure of cost-sharing. In addition, a very high cost example was included in consumer testing and was the most motivational in terms of making insurance seem valuable and encouraging its purchase.

- **Add a new coverage example to reflect the impact of receiving care from an out-of-network provider.** The SBC should include a coverage example that reflects the impact on cost-sharing when a consumer receives care from an out-of-network provider on the fifth page. Out-of-network care is relatively common, yet unexpected for many consumers. By reflecting this information in a coverage scenario, consumers will be better able to understand how they might be affected by the need for out-of-network care. This understanding can also spur them to better consider and assess their plan options by selecting a plan that meets their needs and includes their choice providers.

Additional Comments on Format and Use

- **Require the provision of the SBC within seven days of receipt of an application during special enrollment periods.** ERISA requires summary plan descriptions to be provided no later than 90 days after enrollment in a plan, which means that individuals enrolling under a special enrollment period would have to request an SBC if they wish to have the plain language description of his/her plan sooner than three months after enrolling in the plan. Given the importance of the SBC as a consumer tool, this document should be provided to consumers sooner than three months after the start of their coverage. Whether an individual enrolls in a plan via a special enrollment period or standard open enrollment, a consumer's need for standardized health plan comparison document remains the same.

- **Require all information to be consolidated within a single SBC even when employers carve out insurance coverage.** Currently, the Department of Labor has allowed employers who carve out insurance coverage (for example, a separate drug plan) to provide two SBCs

rather than create a consolidated SBC for their employees. We believe this temporary measure should be ended. While employers should be free to provide comprehensive coverage using separate vendors, employers should communicate the full range of coverage through one comprehensive SBC. We believe the two SBC documents will be potentially confusing to consumers. Employers should provide their employees with one consolidated SBC, which provides the consumer with a single document detailing the full range of coverage.

- **End the use of the coverage examples calculator.** Concerns associated with the coverage examples calculator are well-documented and have not been resolved, even two years after it was created. At the time, the calculator 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 September 2012 start date, this exigency no longer exists. Rather, by September 1, 2015, issuers should have sufficient experience with all three coverage examples to complete SBCs by using actual cost-sharing provisions from their plans. Actual cost-sharing estimates are far preferable to the temporary calculator, which allows plans to take shortcuts by using simplified assumptions that are less accurate, mask cost-sharing differences between plans, and make the coverage examples less useful for consumers. For example, a particular concern with the temporary calculator is that the cost-sharing calculations rely on generic drug costs for all prescription drugs. For people with diabetes, however, there is no generic form of insulin, a primary medication for most diabetes sufferers. Since diabetes is one of only three coverage examples, use of the calculator ensures that at least one-third of the coverage examples will be inaccurate. In another diabetes coverage example, the temporary calculator treats all diabetes equipment and supplies as covered under the durable medical equipment benefit. But in practice, plans often cover these supplies under the prescription drug benefit, with different cost-sharing. Given that the calculator has many flaws—including significant inaccuracies or misrepresentations that relate to one of the coverage examples—use of the temporary calculator should not be further extended.

- **Revise SBC language access requirements to comply with existing Department of Labor regulations and Department of Justice/Department of Health and Human Services guidance.** The standards for translating the SBC should align with existing DOL and HHS guidance and include both numeric and percentage thresholds. In particular, the SBC should be competently translated 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. We do not support a threshold based on county demographics (which is the current standard) since the make-up of a particular plan may include more individuals with limited English proficiency, particularly in certain industries or if a plan markets to them, than county data demonstrates.

- **Standardize the set of services required to be listed under "Other Covered Services" and "Excluded Services."** 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. To further address this issue and enable consumers to understand the additional services that may or may not be covered, 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."