February 3, 2015

To: Angela Nelson and members of the NAIC Consumer Information (B) Subgroup

Cc: Jennifer Cook, NAIC Staff

Re: Proposed NAIC Comments on the Summary of Benefits and Coverage (SBC), Notice of Proposed Rulemaking, due March 2, 2015 to DOL

Thank you for using a public, multi-stakeholder process to formulate your comments on the Summary of Benefits and Coverage (SBC), notice of proposed rulemaking (NPRM). We appreciate the opportunity to provide written comments on the highest priority changes the NAIC may want to consider including in their comments to the Department of Labor (DOL).

As this Subgroup knows, the SBC is a critical consumer benefit. It is the only document that allows consumers to compare private health plans – using a standardized display – across all venues: employer, exchange, and individual plans purchased outside the exchange. The law intended the SBC to be a consumer-friendly document, completed with reliable information and easily understandable by the average consumer.

While the current rule is an advance for consumers, there is also room for improvement. For the committee’s consideration, here are our highest priority items for future revisions:

Provision of the SBC

- **Requirement to provide SBC during Special Enrollment Period (SEP).** The proposed rule would allow group health plans to provide an SBC to individuals enrolling in coverage as a result of a special enrollment period no later than the date by which a summary plan description (SPD) is required to be provided (see §54.9815-2715(a)(1)(ii)(D)). ERISA requires SPDs to be provided no later than 90 days after enrollment in a plan, which means that, individuals enrolling under a SEP 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, we believe 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. We recommend the NAIC support a requirement 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.
• **Rules When An Employer Carves Out Insurance Coverage.** As an interim measure, 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, contrary to the suggestion in the proposed rules. 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. *We urge the NAIC to require employers to provide their employees with one consolidated SBC, which provides the consumer with a single document detailing the full range of coverage.*

**Information included in the SBC**

• **Include Premium Information On The SBC:** Premiums must be included in the SBC if it is to be considered consumer friendly. When the NAIC tested the SBC as part of the development process, the draft forms included a row on page 1 for premium.¹ Consumer testing indicated that consumers appreciated having this key piece of information alongside cost-sharing information (such as co-payments, co-insurance and deductibles), provider network details, and other primary information. Based on the consumer-testing, the 2012 NAIC recommendations included a premium row on the form. However, a requirement to display premium information was not included in the final rule, citing the difficulty of providing an accurate premium given that amounts vary for a given plan.

The new proposed rule does not require premium information to be displayed on the SBC, but rather leaves it as an option. Language in the preamble suggests if it is included, premium information should be posted at the end of the SBC.

*We urge the NAIC to support the inclusion of premium information in the SBC on the first page.* First, at a minimum, the SBC form should include a row at the top of page 1 (as was tested) labeled “Premium” to remind consumers of this important coverage dimension, but the the “Answer” box blank. Employers, brokers, navigators and others could help the consumer fill in the amount, once known. Alternatively, the NAIC should consider having plans list the premium amount based on 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 cost. To avoid confusion, this row should 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. Contact {xxx} to learn your 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

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¹ [http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_soc_populated.pdf](http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_soc_populated.pdf)

Instructions described how to populate the premium field.


Finally, we urge the NAIC to recommend the Departments consumer-test the options to ensure they are understandable and actionable for consumers.

- Provide information needed 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 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.

To accomplish this, for group plans the NAIC should 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 can get premium assistance.”

Moreover, for group plans, we recommend the NAIC urge the Departments to require a checkbox in the same general area that requires an employer to indicate whether the plan is the “lowest cost plan” among plans that meet the minimum value requirement. The box will only require a small amount of space, but will make it easy for consumers to quickly learn if a plan that meets the minimum value is the lowest cost plan offered. NAIC should urge the Departments to include this information in the SBC as this is the only place where consumers will be able to find this information. Consumers are currently unprotected, as they do not have a form where employers are required to report this information.

- Clarify needed information about deductibles. A health plan’s annual deductible is one of the most important cost-sharing features facing enrollees, yet the SBC does not currently present all of the information people might need to understand how deductibles work. Moreover, the variations in types of deductibles appear to be increasing, as insurers try out new and different benefit designs. We urge the NAIC to recommend that the SBC be updated to:
  
  a. Require plans to show in a consistent manner when the deductible does not apply to a particular item or services. For example, many plans cover prescription drugs or outpatient physician services without requiring an enrollee to first pay the annual deductible amount (an “exception” to the deductible). Sometimes, a limited number of prescribed drugs or physician visits are exempted from the deductible each year. Insurers have at times attempted to communicate this information in the SBCs, but not in a standardized way. Sometimes this information is not stated on the SBC at all. On page 1, we recommend adding a new second row with the "Important Question" listed as "Is there anything to which the deductible doesn’t apply?" and an explanation in the "Why This Matters" column that says, "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." We note that for all plans, ACA-required
preventive services would be exempt from the deductible. This is discussed further below.

b. **Require plans to clarify how any deductible that is separate from the overall medical deductible (i.e., a prescription drug deductible) interacts with the overall medical 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. 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.

- **Clarify how deductibles and out-of-pocket maximums apply in family plans.** Annual cost-sharing charges in plans covering more than one individual can be either "embedded" or "aggregate."
  
  *We urge the NAIC to recommend the SBC template be updated so that plans are required to note whether out-of-pocket costs are “embedded” or “aggregate” and why it matters.*
  
  Specifically,

  a. On page 1, explain if the overall deductible is embedded or aggregate under “Why this matters” for the “What is the overall deductible?” row.

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

    ii. If aggregate: “If you are enrolled in family coverage, once the family has met the family deductible ($ZZZZ), the plan pays claims for covered services. The individual deductible does not apply in family coverage.”

  b. Explain if the out-of-pocket maximum is embedded or aggregate under “Why this matters” column for the “Is there an out-of-pocket limit on my expenses?” row.

    i. If embedded: “If you are enrolled in single/individual coverage, once you meet the individual out-of-pocket maximum ($YYYY), the plan will pay 100% of the cost of covered services. If you are enrolled in family coverage, once an individual family member has met the individual out-of-pocket maximum ($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 ($WWWWW), the plan will pay 100% of the cost of covered services for all members of the family.”
ii. If aggregate: “If you are enrolled in family coverage, once the family meets the family out of pocket maximum ($WWWW), the plan will pay 100% of the costs of covered services. The individual out of pocket maximum does not apply in family coverage.”

- **Clearer Treatment of Exclusions.** The NPRM proposed to eliminate two rows from page one of the document – annual limits and services the plan doesn’t cover. **We urge the NAIC to recommend replacing these two rows with a single row on page 1 that signals to the consumer there are limits to coverage.** This might be entitled “Does this coverage have limits?” and the “Why this matters” might 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 could include alternate standard phrases for when scripts are limited and for other types of limitations. In testing, consumers appreciated the reminder about exclusions.3 Further, this sort of information provided up front helps the consumer navigate the interior pages of the SBC.

- **Add Coverage Examples.** During consumer testing, Coverage Examples were found by two studies to be one of the most helpful aspects of the SBC.4 They provide a bottom line cost to consumers 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. They are the only tool that allows consumers to rank order their choices based on an overall measure of cost-sharing.5

The NPRM adds an additional coverage example and updates the costs underlying the all coverage examples to be a more accurate reflection of prices negotiated in the Marketplace. **We applaud both these enhancements and urge the NAIC to recommend the SBC include more examples, including an expensive, catastrophic event example (for example, cancer treatment).** 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.

- **End the Use of the Coverage Examples Calculator.** **We strongly urge the NAIC to recommend the Departments prohibit insurers from continuing to use the temporary calculator.** The issues associated with this calculator are well-documented and have not been resolved. The temporary calculator allows plans to take shortcuts by using simplified assumptions. We are concerned the temporary calculator is less accurate, can mask cost-sharing differences between plans, and make the coverage examples less useful. For example, a particular concern with the

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5 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.
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 1/3 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 (DME) 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 extended any further.

- **Signal which services are include/excluded from the category rehabilitation services.** *We urge the NAIC to recommend the SBC specifically list the core types of covered therapies.* Core types of therapies under the categories of rehabilitation and habilitation (physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, cardiac and pulmonary rehabilitation) should always be listed in the SBC if they are in fact covered, so that it is clear to consumers when any of those therapies are not covered. In addition, if there are any limitations on coverage of those services (such as quantity limits), the SBC should continue to clearly specify that limit in the “Limitations & Exceptions” column for each type of service.

- **Improve Consumers’ Ability To Determine Drug Cost-Sharing.** For people who take multiple prescription drugs, being able to compare plans based on their expected out-of-pocket cost for these drugs is very important. The current and proposed SBC needs several changes for people to more effectively compare their prescription drug costs under various plan scenarios.
  
  a. **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 4.” But in the SBC the drug is captioned Generic, Preferred Brand, Non-Preferred Brand and Specialty. Given the likelihood that most on-line formularies will use the least amount of characters (e.g. 1, 2, 3, and 4), our suggestion is that the SBC put the phrase “usually tier 1” behind “generic,” and “usually tier 2” behind “preferred brands” etc. on page 2 of the SBC.

  b. **Sometimes health plans split category like “generic” or “specialty” into more than one tier,** so the NAIC should consider urging the Departments to require “If one of these categories of drug is divided into more than one tier, this should be clearly indicated on the SBC.”

  c. **One of the most significant barriers to applicants being able to calculate their projected drug costs is that many preferred brands and specialty drugs are subject to coinsurance rather than a specific copayment.** This could be addressed by a link on the SBC to the formulary,

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with the formulary containing 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.

- **Revise SBC language access requirements to comply with existing DOL regulations and DOJ/HHS guidance.** We believe the standards for translating the SBC should align with existing HHS and DOL guidance and include both a numeric and percentage thresholds. **We urge the NAIC to recommend requiring 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.** 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 (LEP), particularly in certain industries or if a plan markets to them, than county data demonstrates.

**In addition, we urge the NAIC to recommend the SBC include “taglines” in other languages.** At a minimum, we recommend including in-language taglines in at least 15 languages on all SBCs indicating the availability of translated SBCs and oral language services. 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 information is available in their languages.

We thank you for consideration of our comments. Many of the health-related Consumer Representatives compiled the recommendations for revising the SBC for the Subgroup’s consideration. If you have any questions, please do not hesitate to contact Lynn Quincy (lquincy@consumer.org) who coordinated these comments.