February 3, 2015

Jennifer Cook
Life and Health Counsel
National Association of Insurance Commissioners
700 Hall of the States
444 North Capitol Street, N.W.
Washington, D.C. 20001-1509

Dear Ms. Cook:

Thank you for the opportunity to provide comments to the National Association of Insurance Commissioners (NAIC) Consumer Information (B) Subgroup on the Summary of Benefits and Coverage and Uniform Glossary Proposed Rule issued by the U.S. Department of Health and Human Services, Department of Labor and Department of Treasury (the Agencies). The National Women’s Law Center (the Center) is a non-profit organization dedicated to expanding possibilities for women and girls. Since its founding in 1972, the Center has worked to improve women’s health and to eliminate the discrimination and barriers women experience in the health care system.

The Summary of Benefits and Coverage (SBC) is an important health insurance information tool for women. Estimates from the Department of Labor indicate that women make approximately 80% of health care decisions for their family.¹ A clear, understandable, and accurate SBC will be used by millions of women as they make decisions about health insurance and health care for themselves and their families. We have been concerned about aspects of the SBC that could mislead or confuse women and result in health care decisions based on misinformation and misunderstanding. The NAIC can play an important role in providing comments to the Agencies that will help improve the SBC so that all health care consumers, including women, can rely on SBC documents in making health care decisions.

We are providing recommendations to the Consumer Information (B) Subgroup to include in the NAIC comments on the proposed rule to the Agencies. These comments are based on our expertise in women’s health, review of SBCs completed by Qualified Health Plans and other health plans, and discussions with enrollment assisters.

1. **The SBC Should Provide Clearer Information on Deductibles**

The SBC does not provide strong enough requirements for issuers to explain how deductibles apply in each health plan. Without stronger requirements, women and other health care consumers may make decisions based on a misunderstanding of the deductible. For example, misunderstandings could result in thousands of dollars of unexpected costs if a woman enrolls in

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a plan with an aggregate deductible but expected her plan to start paying for her covered services once she met the individual deductible. Another misunderstanding could result in a woman enrolling her family in a plan because it has a low deductible but not understanding that an alternative plan applies the deductible to fewer services. The following recommended changes to the SBC would provide clear information of how the deductible applies in family coverage and consistency for when the deductible applies to services.

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

  **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.

  **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.

- Require plans to include “after deductible” or “deductible does not apply” in each row under the cost columns for both in-network and out-of-network providers.

- The coverage examples should include both the individual deductible and family deductible. The coverage examples currently assume the individual deductible applies and that there are no other medical expenses covered under the plan. Therefore, the entire individual deductible is applied in determining the patient costs in the coverage example. However, this total cost is misleading if a family must meet the family deductible before the plan pays for covered services. The coverage examples should include both the total amount the patient pays if enrolled in individual coverage and the total amount the patient pays if enrolled in family coverage.

**2. Preventive Services Should Be Its Own “Common Medical Event”**

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

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2 The CDC defines professional breastfeeding support as occurring in many settings: “Professional support can be given in many different ways and settings—in person, online, over the telephone, in a group, or individually. Some women receive individual in-home visits from health care professionals, while others visit breastfeeding clinics at...
commonly used contraceptive, birth control pills, through pharmacies, not a provider’s office. In both examples, the woman may not understand from the SBC that she can access her preventive service without cost-sharing despite receiving the service outside of a provider’s office. In addition, many preventive services fit into other common medical events on the SBC, which furthers the confusion that may occur by the category. Women may expect cost sharing for services such as preventive blood tests and mammograms to be addressed as “Diagnostic test” and “Imaging” services under “If you have a test” and cost sharing for contraceptives to be detailed under “If you need drugs.”

We recommend that the Agencies create a new category under “Common Medical Event” to specify the coverage of preventive services, including a notation that the services may fit into other medical events listed on the document. Below is our suggested language for an additional row:

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost if You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need preventive care</td>
<td>Listed preventive screenings, check-ups, patient counseling, and services</td>
<td>No cost for listed services; deductible does not apply</td>
<td>Plan should list any applicable cost sharing</td>
<td>See full list of preventive services covered without cost-sharing at [website].</td>
</tr>
</tbody>
</table>

We further recommend that the SBC link to a comprehensive list with all the preventive services. This list should be updated to include new recommendations. A comprehensive list allows consumers to know what is covered as preventive services.

The final rules should include additional directions for grandfathered plans to ensure consumers can clearly understand their plan’s coverage of preventive services. Grandfathered plans that provide some, but not all, preventive services without cost sharing should provide a direct link to a description of the preventive services covered without cost-sharing. The final rules should also include language for grandfathered plans to include under “Limitations & Exceptions” that clearly explain that the plan does not cover all the preventive services without cost-sharing that new plans must cover.

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3 In 2011-2013, oral contraception was the most commonly used form of contraception. (Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief No. 173, “Current Contraceptive Status Among Women Aged 15-44: United States 2011-2013,” Dec. 2013.)
3. Abortion Services

The proposed rule requires QHP issuers to disclose whether abortion services are covered or excluded and whether coverage is limited to excepted abortion services. The draft instructions require coverage of abortion services to be listed in the “Services Your Plan Does Not Cover” or “Other Covered Services” section. In order to ensure that all consumers have accurate, easy-to-understand information about plans’ coverage of abortion, we recommend instead:

- Information about coverage of abortion services in the SBC should be required of all plans and not just QHPs. If only QHPs include information about abortion coverage, consumers comparing QHPs to non-QHPs could be misled.

- Information about abortion coverage should be listed under the Common Medical Events section of the SBC, instead of being included in the “Excluded Services & Other Covered Services.”4 Enrollees are unlikely to look at that section for abortion coverage since all other options for pregnancy are explicitly listed in the Common Medical Events section. Abortion could be included in the “If you are pregnant” row or it could be listed on a separate row, immediately below “If you are pregnant.”

- Plans should disclose cost-sharing amounts and important limitations and exceptions on abortion coverage. Additionally, all plans should include a link to their plan documents where consumers can find more information about the coverage details. Listing abortion under Common Medical Events will enable plans to disclose this information, which will help a woman make an informed choice about her health plan. Plans that do not cover abortion at all should indicate the exclusion of coverage both in the “Limitations and Exceptions” column as well as in the “Services Your Plan Does Not Cover” section of the SBC.

4 Abortion is a common medical procedure, one that more than one million U.S. women obtain every year. Three in 10 women will have an abortion before the age of 45. Guttmacher Institute, Induced Abortion in the United States (July 2014), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

4. Network and Formulary Links Should Connect to Plan Specific Information

The SBC fails to provide adequate information if URL links provided to do not go directly to plan specific information. Links to plan networks and formularies often take consumers to an insurance company’s home page or a landing page for all the issuer’s networks or formularies. Consumers often must click through multiple pages to get to the network or formulary information and, during that process, may have to choose from a list of various networks or formularies. As a result, some consumers may not find the network or formulary information and other consumers may inadvertently choose a network or formulary for the wrong plan. We therefore recommend that plans be required to:

- Provide a network link that is a direct URL to a provider directory specific to the plan.

- Provide a formulary link that is a direct URL to a formulary specific to the plan.
5. **Cost Sharing Information Should Be Provided for All Network Tiers**

The SBC does not provide consistent and clear information on cost sharing for plans that have multiple in-network tiers. Plans are increasingly using tiered network designs. The percentage of employers offering health benefits that included a plan with a tiered network design increased from 15% in 2007 to 19% in 2014. However, plans are not required to list the cost sharing for each network tier, making it difficult for consumers to understand how cost sharing will be applied.

- We recommend the instructions require plans that have multiple in-network tiers to provide cost-sharing information for each network tier under the “Your Cost If You Use An In-network Provider” column next to each service.

6. **We Support Allowing Plans with a Global Maternity CPT Code to Accurately Reflect Cost Sharing**

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

Thank you for this opportunity to submit recommendations on strengthening the SBC. We look forward to continuing to work with the NAIC to ensure consumers have accurate and complete information about their health coverage.

Sincerely,

[Signature]

Gretchen Borchelt
Acting Vice President, Health and Reproductive Rights
National Women’s Law Center

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