

March 2, 2015

Phyllis C. Borzi, Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Summary of Benefits and Coverage and Uniform Glossary

Dear Ms. Borzi:

As organizations that share a strong commitment to the health of our nation's children, we appreciate the opportunity to comment on the proposed changes to the Summary of Benefits and Coverage (SBC) and Uniform Glossary for group health plans and health insurance coverage in the individual and group markets. We commend the Departments of Labor, Treasury, and Health and Human Services (the agencies) for your ongoing efforts to provide consumers with timely, accurate, and comprehensive information about their health plans. However, we are concerned that the SBC and Uniform Glossary lack key information as well as the clarity that is necessary for families to make effective and informed decisions about their children's health care.

It is critical that parents and guardians providing coverage for children understand the full range, and limitations, of the pediatric primary and specialty services covered by their health plan. Children are continuously growing and developing and their families must be assured that their coverage provides the full range of benefits and providers necessary to meet their unique health needs. Though we believe that the SBC and Uniform Glossary have great potential as a consumer information tool for families, we are concerned that the exclusion of certain information and the lack of clarity around other types of information compromise that potential.

Therefore, we respectfully submit the following suggestions that we believe will strengthen the quality and clarity of information in the SBC and Uniform Glossary for children and their families:

- **Specific information on pediatric benefits and services should be included as a “Common Medical Event” in the SBC.** As currently structured, the SBC does not make any reference to pediatric coverage with the exception of pediatric vision and dental coverage. It is critically important that families have key information, through the SBC, about all pediatric services covered and not covered by their health plan.
- **Additional information should be provided about the types of services covered by the habilitative services benefit as well as limits on that coverage.** Furthermore, habilitative devices are a key component of habilitation and should be referenced in the SBC and Glossary of Health Coverage and Medical Terms (“Glossary”). Families need to understand the scope of their health plan's coverage of habilitative services and devices to ensure that children can fully benefit from these critically important interventions in order to reach and maintain their full potential.
- **The SBC must include clear information about the type of provider network utilized by the health plan along with information about the process to access specialty care and out of network care if needed.** It is critically important that plan enrollees, particularly families of children with serious, chronic or complex conditions, have clear information in the SBC regarding their provider networks, including the impact of a tiered network and changing networks on their access

to care. A comprehensive and stable provider network are particularly important to families of children with a serious, complex or chronic condition who need timely access to an appropriate pediatric specialist or subspecialist.

- **The SBC must include clear information regarding deductibles.** Families with seriously or chronically ill children often face large out-of-pocket expenses. They will need concise and accurate information regarding their potential expenses that may result from various types of deductible requirements and calculations.

Our more detailed comments and recommendations are provided below.

BENEFITS

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

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

- **Recommendation: The definition of habilitative services in the Glossary should be revised to include specific examples of habilitative services AND devices.** We urge the agencies to add references in the Glossary and the SBC to habilitative “devices,” as well as “services.” This change would align with the Final HHS Notice of Benefit and Payment Parameters for 2016 and more appropriately represent the full meaning and scope of habilitation. Habilitative devices – such as durable medical equipment (e.g., wheelchairs), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech, and other assistive technologies and supplies – are a critical component of the habilitative benefit, enabling children to function at the highest level possible.

Furthermore, we believe that a certain minimum core set of basic habilitative services and devices should be identified in the Glossary for illustrative purposes to ensure that consumers understand the scope of this benefit. A core list of covered services should also be included as a link from the reference to habilitative services in the SBC. An example of a minimal core list of services and devices would be: “Habilitative services include, but are not be limited to, physical and occupational

therapy, speech-language pathology, behavioral health services, audiology, rehabilitation medicine, and developmental pediatrics. Habilitative devices include, but are not be limited to, durable medical equipment (e.g., wheelchairs and related accessories), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech, and other assistive technologies and supplies.”

- **Recommendation: The SBC must include clear information regarding visit limitations for habilitative services and devices.**

It is critically important that the SBC clearly specify quantitative limits for any covered habilitative service or device (e.g. number of days, hours, frequency of device replacement, etc.). Coverage of habilitative services and devices is especially important for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury that prevents normal skills development and functioning. Receiving sufficient habilitative services that helps the child *acquire*, improve, or retain a skill or level of functioning that they did not previously possess can mean the difference between talking and not talking, walking and not walking. Though we continue to seek comprehensive coverage of habilitation without arbitrary limits on number of visits or types of services, we know that private plans do, in fact, place limits on this important benefit. Therefore, families with children who need habilitative services and devices must understand the limitations of this benefit in order to plan for the most appropriate care and equipment for their child.

- **Recommendation: The final rule should require plans to provide specific information in the SBC about consumers’ rights to continue coverage during an ongoing course of treatment.**

We recommend that plans be required – at a minimum – to clarify that individuals in active treatment may continue coverage, as required by state or federal law. Plans should be required to provide this more specific language about families’ rights for transitional coverage under the “Your Rights to Continue Coverage” section of the SBC. Information about continuity of coverage and benefits is particularly important for families with children who suffer from serious, chronic or complex health condition. Significant disruptions of care and provider relationships resulting from an unexpected plan change (such as a change in the provider network) or plan termination could be catastrophic to the development and health of these children. Therefore, it is critically important that families with children undergoing active care understand their rights to a care transition plan and coverage continuity.

PROVIDER NETWORKS

- **Recommendation: The final rule should require issuers to provide consumers with specific information regarding cost-sharing responsibilities associated with tiered networks, as well as prior approval, appeals or other processes to access care in those networks.**

We respectfully recommend the addition of language in the final regulation to require the inclusion of clear information about the cost-sharing implications of tiered networks in the SBC. Tiered provider networks may be designed such that not all covered services are provided in every tier, resulting in a potentially discriminatory benefit design for children with serious, chronic or complex health conditions. We have previously urged regulators to establish standards for these types of network designs to ensure that there are a full range of providers for all covered services in the lowest cost-sharing tier and that those providers may be accessed without additional administrative delays. However, many tiered network designs continue to place certain specialty providers into higher cost-sharing tiers. This tiering of specialty providers, as well as the outright exclusion of specialty providers from a network, is problematic because it may result in unanticipated costs for patients enrolled in the plan and deter patients with serious medical needs from timely care.

We also recommend several specific changes to the SBC and the Glossary, to ensure that families, particularly those with a seriously or chronically ill child, have accurate information about their plan's provider network:

- A question about tiered provider networks should be added to the "Important Questions" portion of the SBC. The question could be phrased, "If this plan uses a network of providers, are there different cost-sharing and/or prior authorization requirements for some in-network providers?" The answer to this question should clearly explain the cost-sharing requirements, as well as the approval processes needed to access providers in higher tiers.
- Specific cost-sharing requirements should be provided for each network tier under the "Your Cost If You Use an In-network Provider" column adjacent to each medical service.
- A definition of "tiered network" should be added to the Glossary. The National Association of Insurance Commissioners (NAIC) is considering the inclusion of such a definition in its revised network adequacy standards. We encourage the agencies to align the Glossary definition with that of the NAIC. Our recommended definition is: "A 'tiered network' means a carrier's network that identifies and groups participating providers into specific groups to which different provider reimbursement, enrollee cost-sharing, provider access requirements, or any combination thereof, apply as a means to control cost, utilization, quality or to otherwise incentivize enrollee or provider behavior."

- **Recommendation: The SBC should include information on prior authorization requirements and appeals processes to see a specialist or access necessary out-of-network care.**

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

Therefore, we suggest the following specific changes to the proposed SBC and Glossary:

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

- **Recommendation: The SBC should include language to remind families that their provider network may change during the plan year.**

We urge the agencies to require plans to include a link to their provider directory in the SBC to ensure that families have current information regarding their plan's network. We also recommend that the following language be added to page 3 of the SBC under "Your Rights to Coverage:"

- "A given provider network may change during a coverage period"

- “Enrollees should regularly refer to the provider directory for a current list of participating providers.”

Per our comments above, it is critical that children, particularly those with serious, complex or chronic health conditions, have access to uninterrupted, medically necessary services and to a comprehensive and stable provider network, to the extent possible. Our recommendations can help ensure that families can work to identify a new provider or make other arrangements so their child can experience a seamless transition of care when a provider network is modified.

DEDUCTIBLES

- **Recommendation: The SBC must specify the types of services to which deductibles apply and how the plan’s deductible is calculated for family coverage.**

The SBC must include clear information regarding the application of deductibles to specific types and numbers of covered services and describe any differences between family and individual deductibles. In the absence of clear information, families who use the information provided by the proposed SBC may find themselves subject to unanticipated out-of-pocket costs because they are not fully aware of the services to which the deductible applies. For instance, families may be unaware that their plan includes an “aggregate” deductible, under which all family members must meet the total family deductible before the plan pays for covered services for any family member. A plan with an aggregate deductible presents a financial challenge to a family with a child with special health care needs who frequently utilizes health care services because the total higher family deductible would need to be met prior to the plan covering the cost of care.

Given the complexity and confusion around different types of deductibles, we urge the agencies to make the following changes to the SBC:

- On page 3 of the SBC, add simple language to indicate whether the deductible applies to each Common Medical Event listed. For example, phrases such as “after deductible” or “deductible does not apply” can be inserted under the “Cost” columns.
- In the “Important Questions” portion of the SBC, add clarifying language to specify whether each individual in the family must meet the deductible before the plan covers the costs of care or if there is a family (“aggregate”) deductible that must be met before family members receive plan benefits. This language should be added under the “Why This Matters” column related to the question, “What is the overall deductible?”

In conclusion, we urge the agencies to conduct consumer testing of the revised SBC and Glossary to ensure that these important documents are adequately serving their intended purpose. In particular, we recommend that feedback be gathered from families of children with serious, chronic and complex health conditions who will have a unique and critically important perspective on this valuable consumer education resource.

The undersigned organizations look forward to working with you to refine the SBC and Glossary to ensure that they meet the health care needs of children and their families. If we may provide further information or otherwise be of assistance, please contact [Jan Kaplan](#) (202-753-5384) at the Children’s Hospital Association.

American Academy of Family Physicians
American Academy of Pediatrics
Children’s Hospital Association

Family Voices
First Focus
March of Dimes
National Alliance to Advance Adolescent Health
National Association of Pediatric Nurse Practitioners