March 28, 2016

Office of Information and Regulatory Affairs
Attn: OMB Desk Officer for DOL-EBSA
Office of Management and Budget
Room 10235
725 17th Street, N.W.,
Washington, DC 20503

On behalf of the nearly 30 million Americans with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) appreciates the opportunity to submit to the Office of Management and Budget comments on the Information Collection Request revision titled, "Summary of Benefits and Coverage and Uniform Glossary Required Under the Affordable Care Act" [OMB Control Number 1210-0147] published in the Federal Register on February 26, 2016.

Access to adequate, affordable coverage is critically important for people with, and at risk for, diabetes. When people are not able to afford the tools and care necessary to manage their diabetes, they scale back or forego the care they need, which often leads to disabling and costly complications and suffering that could have been prevented.

The Affordable Care Act (ACA) made important improvements in access to health coverage for individuals with preexisting conditions, including diabetes. The Summary of Benefits and Coverage (SBC) and the Uniform Glossary are important educational and transparency provisions included in the ACA. If people with diabetes do not understand their insurance choices, they could find themselves in a plan that does not provide adequate and/or affordable coverage. For example, the SBC could help a person with diabetes considering a plan with a very high deductible understand that he/she is likely to pay a large amount of money out of pocket – due to the need to manage diabetes – before coverage starts. We offer the following comments and recommendations related to the revised SBC template and instructions to enhance the quality, utility and clarity of the information on the SBC and with the goal of ensuring this important consumer tool maximizes its potential to help individuals understand their coverage options.

<u>Management of Type 2 Diabetes Coverage Example</u>
We are pleased the coverage example for managing type 2 diabetes remains part of the SBC. It is a relevant example for millions of Americans due to the extraordinary and growing burden of diabetes in the United States. Although it is not intended as a tool to estimate an individual's actual costs under the plan, the coverage examples are intended to be used by consumers when shopping for coverage to compare the portion of costs sample patients would pay across various plans. Therefore, it is important plans estimate the patient's out of pocket costs in a consistent way so apples to apples comparisons can truly be made.

In our comments on the *Notice of Proposed Rulemaking: Summary of Benefits and Coverage and Uniform Glossary* in March 2015, we recommended a statin drug be added to the diabetes treatment scenario. **We are very pleased a statin drug was added to the diabetes treatment scenario.**

Revised Coverage Examples page on the proposed SBC
The Coverage Examples page on the proposed SBC template has been significantly changed compared to the template currently in use. At the top of the diabetes scenario, four lines have been added to show

the plan's overall deductible, specialist copayment, hospital (facility) coinsurance, and "other coinsurance." However, there aren't any instructions on how plans should populate these lines in the Instruction Guides. It appears these lines are intended to show actual cost sharing for particular services under the plan. **We recommend instructions be given to plans on how to populate this new section of the Coverage Examples page in order to ensure plans complete this section in a consistent way.**

While these added lines allow consumers to compare cost sharing for certain benefits and plan features, it is not clear what is meant by "other coinsurance" since plans may have different coinsurance for different benefits in the plan. This line is too general to provide meaningful information for consumers and could easily be confusing. **As such, we recommend "Other Coinsurance" be replaced with "Diabetes Education Copayment or Coinsurance" and plans should be instructed to display the cost sharing under the plan for Diabetes Self-Management Education (DSME).** The American Diabetes Association's *Standards of Medical Care in Diabetes -2016* recommends DSME for all patients with diabetes at diagnosis and as needed thereafter,[1] and the coverage example includes two DSME visits. Specifying cost sharing for DSME under the plan on the Coverage Examples page would allow consumers to easily see what plan enrollees would pay for this important benefit all people with diabetes need, which may not be readily apparent in plan documents.

The middle section of the diabetes coverage example begins "This EXAMPLE event includes services like:" and lists "Primary care physician office visits (including disease education)" on the first line. **Given the diabetes scenario includes both primary care office visits and specialist office visits (podiatry and ophthalmology), we recommend this line be changed to read "Primary care and specialist physician office visits." This conveys a broader view of the diabetes scenario. Because diabetes education might not occur during a primary care physician visit, and may be subject to different cost sharing, we recommend removing the "including disease education" in parentheses. Once making these changes, if there is an additional line available in this section, we recommend adding a separate line for "Blood glucose testing supplies" below the line "Durable Medical Equipment."**

Wellness Program Calculation and Related Disclaimer for the Coverage Examples

In previous comments, we recommended plans be required to calculate the diabetes coverage example assuming no participation in a wellness program (i.e., incentives are not earned). Thus, the higher cost sharing enrollees may be subject to would be reflected in the diabetes coverage example. We were concerned the out of pocket cost estimates assuming participation in the wellness program could provide individuals comparing plans who might have difficulty participating in or meeting any required outcomes with an artificially low impression of out-of-pocket costs under the plan. It also confounded the goal of being able to make "apples to apples" comparisons between plans. **Therefore, the Association is very pleased the proposed Instruction Guides for group and individual health insurance coverage now instruct plans as follows: "If the plan has a wellness program that varies the deductible, copayments, coinsurance, or coverage for any of the services listed in a treatment scenario, the plan or issuer must complete the calculations for that treatment scenario assuming that the patient is NOT participating in a wellness program." We strongly support this revision and recommend it remain in the final version of the Instruction Guides.**

In accordance with this change to the Instruction Guides, language in the disclaimer plans are instructed to use on the coverage examples page was changed. If applicable, the plan or issuer is instructed to include a box below the coverage examples with the following language and appropriate contact

[1] American Diabetes Association. Standards of Medical Care in Diabetes – 2016;39(Supplement 1)S1-S112.

information: "These numbers assume the patient does not participate in the wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs." **The Association supports the revised language plans are required to use. Taken together, we believe these changes result in a much more consumer-friendly way to account for wellness programs which vary cost sharing in the coverage examples. Consumers will see a coverage example reflecting the higher cost sharing an enrollee in the plan could be subject to and will be informed the plan has a wellness program under which participants might lower their costs.**

Technical change needed to Proposed Guide for Coverage Examples Calculations for consistency
While we are pleased with the changes discussed above, we noted the "Proposed Guide for Coverage Examples Calculations – Maternity Scenario, Diabetes Scenario, Foot Fracture" appears to not have been similarly updated regarding wellness programs. Under "Standard Assumptions," the instructions in this document still say the plan must complete the calculations for that treatment scenario assuming that the patient is participating in the wellness program. **In order to ensure consistency, we recommend the Proposed Guide for Coverage Example Calculations be revised to mirror the language in the proposed Instruction Guides for group and individual health insurance coverage with respect to wellness programs. Thus, the Proposed Guide for Coverage Example Calculations should be revised to say: "If the plan has a wellness program that varies the deductible, copayments, coinsurance, or coverage for any of the services listed in a treatment scenario, the plan or issuer must complete the calculations for that treatment scenario assuming that the patient is NOT participating in a wellness program."**

<u>Deductibles</u>
Deductibles are important cost-sharing features of a plan with big implications for individuals with chronic diseases who have care needs on a regular, ongoing basis. We are pleased the revised SBC requires some additional information about the deductible(s) under the plan, including the addition of a new "Important Question" on page 1 of the SBC which asks: "Are there services covered before you meet your deductible?" and an explanation in the "Why this Matters" column which says, "This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply." As a result, plans will now be required to show in a consistent manner when the deductible does not apply to particular items or services.

We continue to recommend that plans be required to clarify how any deductible that is separate from the overall medical deductible (e.g., a prescription drug deductible) interacts with the overall medical deductible. While the SBC template does specify the amount of separate deductibles and to what items or service 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.

<u>Premium Information</u>
We previously recommended the SBC include a blank row at the top of page 1 labeled "Premium" to remind consumers of this important cost-sharing feature. Consumers with the help of employers, brokers, navigators and others could fill in this information. While we are disappointed our recommendation was not taken, we appreciate the additional note at the top of page 1 stating: "Information about the cost of this plan (called a premium) will be provided separately." This at least serves to notify consumers the premium is separate from the out of pocket costs shown on the SBC, and we recommend this note remains in the final SBC.

<u>Overarching Comment</u>

As a final overarching comment, we recommend further consumer testing of the SBC by the Administration, including any changes made to the proposed template after the comment period ends. We note the final SBC template recommended to the Administration by the National Association of Insurance Commissioners in October 2015 was not consumer tested. Given the proposed SBC template has a number of differences from the current SBC, including the format of the coverage examples, we recommend further consumer testing be done.

Thank you for the opportunity to comment on the Information Collection Request revision titled, "Summary of Benefits and Coverage and Uniform Glossary Required Under the Affordable Care Act." Should you have any questions, please contact me at (703) 299-5528 or lmciver@diabetes.org.

Sincerely,

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American Diabetes Association