March 28, 2016

The Honorable Sylvia Matthews Burwell
Secretary, Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Jacob J. Lew
Secretary, Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Thomas E. Perez
Secretary, Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Comments regarding the information collection request (ICR) revision titled, "Summary of Benefits and Coverage and Uniform Glossary Required Under the Affordable Care Act"

Dear Secretaries Burwell, Lew and Perez:

Partners for Better Care ("Partners") appreciates the opportunity to comment on proposed revisions to the Summary of Benefits and Coverage (SBC) and Uniform Glossary (81 Fed. Reg. 38, 9860 (Feb. 26, 2016)). As a partnership of patient and disease advocacy groups and industry leaders representing over 55 million people living with chronic conditions and disabilities nationwide – including AIDS United, American Liver Foundation, Amputee Coalition, Christopher & Dana Reeve Foundation, Hemophilia Federation of America, The MAGIC Foundation, National MS Society, National Patient Advocate Foundation, Parkinson's Action Network and United Cerebral Palsy – we believe that Americans should have access to the tools necessary to make the best and most informed decisions for their health and the health of their families.

Although more Americans than ever before now have health care coverage, out-of-pocket costs, including deductibles and cost-sharing for medical services, are escalating at substantially disproportionate rates compared to the wages of the average American. Additionally, complicated benefit designs such as prescription tiering and narrow physician networks are making it increasingly difficult to access quality care, and increasingly essential for patients to understand how to purchase coverage.

Partners believes that all consumers should have easily understood and accessible up-to-date information about covered services, providers, formularies and out-of-pocket costs in all insurance plans during enrollment periods and throughout the year. The SBC document is an important tool that facilitates consumer understanding of a plan's benefits and associated cost sharing to inform appropriate plan selection. As such, Partners provides the following comments regarding revisions to the SBC and accompanying documents.

Delayed Implementation

Partners is disappointed with plans to delay implementation of the revised SBC template for most carriers until 2018. We strongly encourage agencies to honor the initial January 1, 2017 implementation date.

Deductible Language Within the SBC

Given most exchange plans have high deductibles, understanding exactly when the deductible applies has significant implications for consumer cost sharing. For this reason, Partners supports the inclusion of the question "Are there services covered before you meet your deductible?" in the important questions and answers section of the revised SBC to help consumers better understand when medicines and other services are exempt from the deductible.

While pre-deductible services are also identified in the Common Medical Events section of the revised SBC template, we believe there are improvements that could be made to help consumers recall how a deductible will apply without having to flip or scroll through multiple pages of the SBC. For example, an additional column could be added to the Common Medical Events section of the proposed template where a checkmark could accompany each service indicating if it is subject to a deductible.

Finally, there are certain plans that apply a deductible to all services (other than preventive). We recommend including additional language in the individual and group instructions for the "Why This Matters" column of the question "Are there services covered before you meet your deductible?" to address these types of plans. We support the following language proposed by the National Association of Insurance Commissioners (NAIC):

> *"You must meet the deductible for all services, unless stated as "no charge" and then any applicable copayment or coinsurance may apply."*

Embedded Deductibles and Out-of-Pocket Limits

Partners supports proposed revisions to the instructions that accompany the revised SBC template that require family coverage plans to disclose whether the health plan has either "embedded deductibles" or out-of-pocket limits. However, we believe that revisions to the embedded deductible language in the "Why This Matters" column of the "What is the

Overall Deductible" section should be considered. The current language reads: "If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible has been met."

Again, we support the following language proposed by the NAIC:

> *"Generally, the plan will only begin to pay its share of the cost of covered services that an individual family member receives once that family member's individual deductible has been met. Other family members must pay the full cost of covered services until they meet their own individual deductible or until the total amount of deductible expenses paid by family members meets the overall family deductible."*

Coverage Examples

Partners believes the format used for the three coverage examples included in the revised SBC is an improvement on the version included in the Notice of Proposed Rulemaking (NPRM) and that the focus on cost-sharing is beneficial for consumers.

Tiered Networks

Partners supports proposed changes to the revised instructions that require the disclosure of tiered networks in response to the question, *"Will you pay less if you use a network provider?"* Specifically, we support proposed language that would be required:

- when there is a simple in-network/out-of-network coverage arrangement and for plans using a tiered network, including language that informs consumers that they might receive a bill from a provider for the difference between the provider's charge and what is paid by the plan (balance bill), when using an out-of-network provider; and
- when a provider uses any form of provider network, including language that informs consumers that a network provider might use an out-of-network provider for some services, and encourages consumers to check with their provider before they receive services.

Plan Designs Including Classes of Drugs in More than One Tier

Partners would like to highlight an issue identified by the NAIC in its October 2015 comments regarding the lack of clear guidance in the "Specific Additional Instructions for Some of the Common Medical Events" for the "Services You May Need" column under "If you need drugs to treat your illness or condition" in situations where plan designs include classes of drugs that appear in more than one tier. We agree with the NAIC that the current instructions are problematic for plans that have tier designs that do not correlate with the categories listed in the instructions, and support the association's proposed recommendation to address this issue.

Specifically, under the “Services You May Need” column, the plan or issuer should list the categories of prescription drug coverage using the same terminology used in the formulary, in the policy or plan document and on the website. After describing the category, the plan or issuer should include a parenthetical describing the category of drugs in terms of its cost to the consumer using language similar to the following, as appropriate: “(You will pay less of the cost)”/ “(You will pay more of the cost)” / “(You will pay even more of the cost)” / “(Additional higher cost options)”.

Limitations, Exceptions and Other Important Information

Partners believes consumers should have easily understood and accessible up-to-date information about covered services, providers, formularies and out-of-pocket costs. This includes information regarding prior authorization requirements that could restrict access to care and therapies – including prescriptions and devices. Therefore, Partners supports changes proposed in the revised instructions that require disclosure of certain “core” limitations, exceptions, and important information. Specifically:

- when a service category or substantial portion of a service category is excluded from coverage;
- when cost sharing for covered in-network services does not count toward the out-of-pocket limit;
- when there are limits placed on the number of visits or on specific dollar amounts payable under the health benefit plan; and
- when prior authorization is required for services.

Habilitative and Rehabilitative Services and Devices

Partners supports the robust coverage of the habilitative and rehabilitative services and devices required by the Affordable Care Act (ACA). We believe that consumers will have best access to this Essential Health Benefits (EHB) category when they understand their coverage. To support full access, we recommend the following revisions to the revised SBC template:

- Under the “Services You May Need” column, “Habilitation services” and “Rehabilitation services” should be relabeled “Habilitation services and devices” and “Rehabilitation services and devices” to make it clear to consumers that they should have coverage for devices, consistent with the final Notice of Benefit and Payment Parameters for 2016, and ACA §1302.
- Page 3 currently lists a joint visit limit for habilitation and rehabilitation under “Limits, Exceptions, & Other Important Information.” Under the final Notice of Benefit and Payment Parameters for 2016, every state’s EHB plan must not impose combined limits on habilitative and rehabilitative services and devices for 2017 plan years. We believe

the template should be modified to include separate limitations for rehabilitation and habilitation services.

Partners appreciates this opportunity to offer our input on revisions to the Summary of Benefits and Coverage (SBC) documents and requirements. If you have any questions or need any further information relating to our comments, please do not hesitate to contact me at mrichards@partnersforbettercare.org.

Sincerely,

Mary Richards
Executive Director
Partners for Better Care