March 28, 2016

Submitted via *OIRA_submission@omb.eop.gov*

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

RE: Summary of Benefits and Coverage and Uniform Glossary (CMS-10407)

Dear Sir or Madam:

UnitedHealthcare appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments in response to the Information Collection Request related to the Summary of Benefits and Coverage (SBC) and Uniform Glossary.

UnitedHealthcare, a division of UnitedHealth Group, is dedicated to helping people live healthier lives. As a recognized leader in the health and well-being industry, we strive to improve the quality and effectiveness of health care for all Americans, enhance access to health benefits, create products and services that make health care more affordable, and use technology to make the health care system easier to navigate. UnitedHealthcare serves many of the country's most respected employers, and we are also the nation's largest Medicare health plan - serving nearly one in five seniors nationwide - and one of the largest Medicaid health plans, supporting underserved communities in 24 states and the District of Columbia.

UnitedHealthcare asks that CMS consider the following recommendations for clarifications regarding the SBC Templates, Instruction Guides, and Uniform Glossary. Given the changes that are required to incorporate the revised SBC into business operations we ask that CMS promptly review any potential revisions to the template and instructions and release the final versions as expeditiously as possible.

I. SBC TEMPLATE / SBC SAMPLE

Disclaimer

The Instruction Guide for the SBC indicates that the disclaimer at the top of page 1 should be replicated exactly, without changes to the font size, graphic, or formatting. Plans and issuers must insert contact information into the fourth sentence of the disclaimer. We recommend that issuers be permitted flexibility regarding the exact wording to fit any unique needs of the specific health plan when inserting the fourth sentence. For example, issuers should be permitted to modify the language so that it reads harmoniously: "For more information about your coverage, or to get a copy of the complete terms of coverage, please visit [insert website] or call [insert phone number]." Permitting flexibility for this sentence will ensure consumers are provided appropriate information to contact the issuer regarding the health plan.

Are there services covered before you meet your deductible?
The "Why This Matters" text does not accurately reflect all plan designs. Some plan designs, including an HSA Plan, apply all member costs (except for those preventive services required by the Affordable Care Act (ACA)) towards the deductible and after the deductible is met, copays and / or coinsurance will apply.

In order to lessen consumer confusion and ensure consumers are provided with actionable language in the SBC, we recommend issuers be permitted flexibility to use optional text: "You must meet the deductible for all services, unless stated as "No charge", and then any applicable [copayment or] coinsurance will apply." We recommend the bracket around "copayment" because there are some plans that apply a flat dollar copay after the deductible and other plans that apply straight coinsurance. We believe this flexibility will allow issuers to appropriately describe the benefits as consumers review the various SBCs.

Additionally, the Instruction Guide provides that if there are services covered before the deductible is met, plans and issuers must answer "Yes" and list major categories of covered services that are NOT subject to the deductible, for example, preventive care. We seek clarification as to what is considered a "major" benefit category as listing out too many categories could result in exceeding the page 1 limits. Alternatively, issuers should be permitted flexibility in determining major categories of covered services as they design plans and options to meet the specific needs of the consumers. Additionally, issuers should be provided a good safe harbor from any enforcement in their determination of what constitutes a major category of service.

Do you need a referral to see a specialist?
As issuers encourage the use of non-paper communications and interactions with consumers and providers, the use of electronic referrals assists consumers in quicker referrals while enhancing communications between providers, specialists and the issuer. Additionally, issuers are moving to plans with only electronic referral in order to receive additional benefits.

Therefore, we recommend that issuers be permitted to, as needed, include appropriate language clarifying that electronic referral information should be noted in the "Why This Matters" column.

Deductible/OOP maximum
Currently, there is no wording that addresses if there are separate network and non-network deductibles and/or separate network and non-network out-of-pocket maximums and the amounts cross apply (e.g., in-network amounts for the deductible and out-of-pocket maximum count toward out-of-network amounts and vice versa.)

We recommend the following wording be used, as appropriate, in the "Why This Matters" column to ensure consumers are provided meaningful information regarding the differences between network and non-network costs:

- Network and Non-Network deductibles cross apply.
- Designated Network and Network deductibles cross apply.
- Network and Non-Network out-of-pocket maximums cross apply.
- Designated Network and Network out-of-pocket maximums cross apply.

Disclaimer
The disclaimer on page 2 reads, "All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a deductible applies." We are concerned that consumers may miss this disclaimer or not understand when a deductible applies to a particular service. In addition to this disclaimer, we recommend that if the plan has a deductible, the term "after deductible" should be shown in each cell, as applicable. If the plan has a deductible and the deductible does not apply to a particular benefit, the term "deductible does not apply" should be used for that particular benefit (in-network or out-of-network cell, depending on plan design). We believe this will help consumers better understand their benefit plan and possible out-of-pocket costs they may incur.

What You Will Pay
Depending upon the type of coverage and the number of preferred provider networks, plans and issuers may vary the number of columns within the header "What You Will Pay". Page 10 of the Instruction Guide provides:

- Plans and issuers should insert the terminology used in the policy or plan document to title the columns. For example, the columns may be called "Network Provider" and "Out-of-Network Provider", or "Preferred Provider" and "Non-Preferred Provider" based on the terms used in the policy. The sub-headings should be deleted for non-networked plans with only one column.
- The columns should appear from left to right, from most generous cost sharing to least generous cost sharing. For example, if a 3-column format is used, the columns might be labeled (from left to right) "Network Preferred Provider," "Network Provider," and then "Out-of-Network Provider."

While this description is helpful in determining the column headers, we seek clarification as to what to show in the parentheticals if we have a 3-tier plan. We recommend issuers be permitted to use the following language and request validation that this is an acceptable designation as we believe this language will more clearly communicate to the consumers the terms of their benefit design:

Designated Network	Network	Non-Network
(You will pay the least)	(You will pay more)	(You will pay the most)

Additionally, we believe this recommendation is consistent with the "Why This Matters" responses on page 1 for "Will you pay less if you use a network provider?"

Limitations and Exceptions
In the "Limitations and Exceptions" column, plans and issuers must list the significant limitations, exceptions, and other important information for each service listed under the Common Medical Events. The Instruction Guide further provides in part, that, "... if there are no items that meet the significance threshold described above, then the plan or issuer should show "----------None----------" for each Common Medical Event in the chart...". We understand

and agree that the reason for including this text is to ensure that consumers understand when there are no limitations or exceptions. However, for technical reasons, we request that plans and issuers are given flexibility to remove the dashes around the word "None" since the dashes do not provide any substantive information or value to members, but can be very difficult and costly to program. Removing the dashes would also provide additional space on the document.

If you are pregnant

Within the "Common Medical Events" column on page 3 of the SBC, there is a row for "If you are pregnant". The row is divided further into three rows: Office Visits / Childbirth/delivery professional services / Childbirth/delivery facility services. This layout is a change from the last SBC Template, which contained two rows. While we appreciate the modification, we recommend an additional change to further clarify the services provided and to help avoid consumer confusion:

> "Office visits" should be titled "Prenatal Office visits", which would allow continued use of the term "No charge" in the "Network Provider" column as plans do not have a separate charge for prenatal office visits.

If you need help recovering or have other special health needs

"Habilitation services" is listed as one of the services a consumer may need under this Common Medical Event and is defined in the Uniform Glossary. Under the ACA, there are 10 broad categories that encompass Essential Health Benefits, including "habilitative" services and devices. Since the Essential Health Benefits rules use the term "habilitative" we recommend replacing "habilitation" with "habilitative" to be consistent with the terms used on other documents.

II. SBC INSTRUCTION GUIDE (GROUP)

Defined Terms

The Instruction Guide states that: "Terms that are defined in the Uniform Glossary should be underlined in the SBC. Plans and issuers providing an electronic SBC ***may*** hyperlink defined terms directly to the Uniform Glossary, ideally directly to the definition in the Uniform Glossary for that term. Plans and issuers ***may*** also choose to utilize hover text applications in the electronic SBC that allow for a text bubble to appear with the definition when a reader places their cursor over the term."

We appreciate and support the flexibility provided here with the use of the word "may" as it is critical to allow plans and issuers to have these options.

Coverage Period - Effective Date

The Instruction Guide provides that: If a plan has a plan year that differs from the benefit year; for example the plan year begins Oct. 1, but the benefits (e.g. deductibles and out-of-pocket limits) reset on Jan. 1; the plan or issuer may choose, based on a determination of what is most relevant to the consumer, to reflect the coverage period as either the plan year or the benefit year. We recommend a set rule on this to prevent possible consumer confusion if issuers and plan sponsors implement this requirement differently. Our recommendation is that the coverage period should reflect plan year because that is when a member is covered.

Barcodes/Control Numbers
The Instruction Guide permits plans and issuers to add barcodes, control numbers, or other similar language to the SBC for quality control purposes. The SBC Template places the page number on the bottom right corner of the page. Since the SBC rules require that plans and issuers follow the SBC Template exactly, CMS and states review the SBCs that have been submitted for approval very carefully.

To ensure that plans and issuers can comply with these requirements while balancing the needs of printing vendors, we recommend revising the Instruction Guide to provide issuers and plans with flexibility regarding the location of the page number and the bar code.

Special Rule for 3.a. core limitations, exceptions, and other important information
Plans and issuers must accurately describe as many core limitations and exceptions specified in 3.a. as reasonably possible, in a manner that is consistent with the instructions and template format. The Instruction Guide provides an exception process in the event inclusion of all such limitations and exceptions would make compliance with the four double-sided page limit not reasonably possible. Part of this exception process involves including a footnote cross referencing the pages or the sections where the limitations and exceptions are described in the summary plan description or policy document.

We recommend that the cross reference requirement be removed. The limitations and exceptions column is intended to capture significant limitations and exceptions for benefits and services that have high utilization and significant financial impact to the consumer. Plans and issuers often have numerous benefit designs and it is not feasible to include the page number and/or section of the plan document on the SBC for each benefit design. Additionally, many issuers produce SBCs via systems that do not have the capability to cross reference from the plan documents. Consumers are already provided with contact information and links to sample documents in the event they would like to explore a particular benefit or service further.

Other significant limitations, exceptions, and other important information
The Instruction Guide provides: "If there are no items that meet the significance threshold described above, then the plan or issuer should show "----------None----------" for each Common Medical Event in the chart, the plan or issuer should merge the boxes in the Limitations, Exceptions, and Other Important Information column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space."

To ensure correct interpretation and make the section easier to understand for consumers, we recommend that this description should be revised into two separate sentences by replacing the comma with a period after the word "chart" as follows:

If there are no items that meet the significance threshold described above, then the plan or issuer should show "None" for each Common Medical Event in the chart. The plan or issuer should merge the boxes in the Limitations, Exceptions, and Other Important Information column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

Also, as discussed above, we believe the use of dashes before and after "None" should be eliminated.

Specific Additional Instructions for Some of the Common Medical Events: If you visit a health care provider's office or clinic
The Instruction Guide indicates that if space allows (i.e., the four double sided page limit would not be exceeded), plans and issuers may include information on additional types of practitioners, such as nurse practitioners or physician assistants. To ensure consistency within the SBC templates in various states and for ease of administration, we recommend modifying the Instructions Guide to clarify that plans and issuers have sole discretion for determining whether to include information on additional types of practitioners. This will allow plans and issuers to avoid unnecessary state variation and the potential for rejected filings.

What You Will Pay
The Instruction Guide provides that: "Plans and issuers should denote in these columns exceptions, such as when a specific service is subject to a separate deductible or is covered at no cost."

With respect to showing a separate deductible, since page 1 of the SBC already contains the question "Are there other deductibles for specific services?" we believe this requirement is duplicative and may even cause confusion. We recommend use of a simpler statement, such as "$35 copay after deductible" (not "$35 copay after prescription drug deductible").

Limitations, Exceptions, & Other Important Information
Plans and issuers must indicate in this column when cost sharing for covered in-network services does not count toward the out-of-pocket limit. Since this information is already stated on page 1, we recommend that plans and issuers not be required to restate it in each specific benefit category.

III. SBC INSTRUCTION GUIDE (INDIVIDUAL)

Your Rights to Continue Coverage
We seek clarification on certain aspects of the language that is to be provided under this section on the SBC. The Instruction Guide states the following:

> "This section must appear as shown on the template. Insert contact information for the issuer in the second sentence. In the second sentence:
>
> State insurance department contact information [Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html].
>
> State consumer assistance program, if other than state insurance department [provide state-specific contact information available from http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.]
>
> Office of Personnel Management Multi State Plan Program: https://www.opm.gov/healthcare-insurance/multi-state-plan-program/externalreview/.

Healthcare.gov www.HealthCare.gov or call 1-800-318-2596 OR state health insurance marketplace or SHOP."

We believe issuers would benefit from examples of how this should be worded. Such examples will ensure issuers are provided sufficient direction to provide consumers with the needed information regarding their rights.

Finally, on the last bullet, we request confirmation that issuers should include this bullet only in the Individual Exchange SBCs (not off-Exchange), particularly since there is a reference to the "SHOP", which is the small employer group exchange.

IV. COVERAGE EXAMPLES

In order to ensure consumers are provided more meaningful information, we recommend the following modifications to the Coverage Example, "Peg is Having a Baby":

- We recommend just stating "Pre-Natal Care" as in some cases, OB/GYN's are not treated as a specialist (e.g. State Mandate in Florida). Also, on some gated products, the PCP and OB/GYN copays are always the same due to the fact that referrals are prohibited.

- For the Specialist Visit (anesthesia), the anesthesiologist is actually paid under the Hospital Benefit (deductible/coinsurance level) and not at a Specialist visit level. Since Facility Services are already mentioned, it is recommended the last section be removed in totality.

This EXAMPLE event includes services like:	This EXAMPLE event includes services like:
Specialist office visits (prenatal care)	~~Specialist office visits~~ Pre-Natal Care
Childbirth/Delivery Professional Services	Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services	Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)	Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)	~~Specialist visit (anesthesia)~~

Additionally, we believe CMS should clarify the following features for all coverage examples:

- Specialist copay: How do we reflect plan design if there is no specialist copay? For example, a plan may require that coinsurance applies to specialist visit.
- Hospital coinsurance: How do we reflect plan design if the hospital benefit is a copay and not coinsurance?
- Other coinsurance: What benefit category drives this coinsurance amount?
- We noticed the plan summary is repeated for each coverage example. We recommend adding one "Plan Summary" above the Blue Headers that states:

  Plan Deductible $X,XXX
  Other Deductible (if applicable) $X,XXX
  Office Visit (PCP) $[XXX] [/] [XX%]
  Office Visit (Specialist) $[XXX] [/] [XX%]
  Inpatient Hospital: $[XXX] [/] [XX%]
  Tier 1 Pharmacy Copay: $[XXX] [/] [XX%]

We offer the following clarifying recommendations for the following features for all coverage examples:

- Deductibles: As mentioned above, we recommend adding a separate line under "Deductibles" for "Other Deductibles" (e.g., RX deductible) so the consumer understands why the total deductible owed may be MORE than the plan's overall deductible.
- The new SBC Template contains a new row for "Cost Sharing" in each example, however, we recommend removing it as it is not necessary and takes up space.

Finally, the last line of the coverage examples page is cut-off in the SBC Sample. According to the SBC Template it should read, "The plan would be responsible for the other costs of these EXAMPLES covered services."

V. SBC/UNIFORM GLOSSARY/INSTRUCTION GUIDE CONSISTENCY

We believe the use and highlighting of terminology should be consistent across the SBC, Instruction Guide, and Uniform Glossary. For example, all terms that are defined in the Uniform Glossary should be underlined in the SBC.

We note the following examples of inconsistencies in the use of underlining of defined terms:

- In the disclaimer on page 1 on both the SBC Template and the SBC Sample:
  - "Plan" is a defined term, but it is not underlined.
  - "Premium" is a defined term, but is not underlined.
  - "Underlined" is not a defined term, but it is underlined.
- The word "specialist" is not underlined the second time it appears on page 1 of the SBC Sample (Example), in the "Why This Matters" section of this Important Question "Do you need a referral to see a specialist?"
  - This plan will pay some or all of the costs to see a specialist have a referral before you see the specialist.
- The Minimum Essential Coverage (MEC) and Minimum Value Standards (MV) statements contain terms that are defined in the Uniform Glossary, but the MEC and MV statements that appear in the SBC Template and both Instruction Guides contain terms that are not underlined.

Important Questions: What is the out-of-pocket limit for this plan?

- The "No" answer for "Why this Matters" is not listed in either Instruction Guide. For consistency with the rest of the instructions, the "No" answer should be included in both Instruction Guides.

In the Common Medical Events table, we note the following inconsistencies:

- If you visit a health care provider's office or clinic:
  - Preventive care/screening/immunization: the Instruction Guides say use "No charge" but the SBC Sample says "No charge for covered services". We recommend that SBC Sample be updated to remove "for covered services" to be consistent with how "No charge" is represented throughout the SBC.
- If you need immediate attention:

    - Urgent care shows "$30 copay". However, it should say "$30 copay/visit" to be consistent with how copays are represented throughout the SBC.
- If you are pregnant:
    - The wording in both Instruction Guides is not consistent with the SBC Sample. The SBC Sample includes the words "to certain" in the following sentence in the limitations and exceptions column, "Cost sharing does not apply to certain preventive services." The Instruction Guides state the same sentence as follows, "Cost sharing does not apply for preventive services."
- If you need help recovering or have other special health needs (visit limit description):
    - Instruction Guides are not consistent with how visits are shown in the SBC Sample. We recommend using "XX visits/year" to show frequency and also address that some plans accumulate limits on a calendar year basis versus a policy year basis. The Instruction Guides should be updated with these instructions: "Information provided should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows: "XX visit limit", "No coverage for XXX", "$XX/visit limit", and/or "$XX annual max"."

Finally, the Instruction Guide indicates that if the plan has a wellness program that varies the deductibles, 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 the wellness program. Further, the Wellness Program Disclaimer on the last page of the SBC states in pertinent part, that, "These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs." It appears however, that the Coverage Examples Calculator (assumptions) has not been updated to reflect this. The assumptions still reflect that the plan must complete the calculations for that treatment scenario assuming that the patient is participating in the wellness program.

Thank you for taking time to review our comments. We appreciate your consideration and welcome the opportunity to discuss further.

Sincerely,

Chris Byrnes

Chris Byrnes
Sr. Vice President, E&I Exchange Operations