**America's Health Insurance Plans**

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

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OMB, Office of Information and Regulatory Affairs
Attention: CMS Desk Officer; Desk Officer for DOL-EBSA; Desk Officer for Treasury
Submitted via e-mail: OIRA_submission@omb.eop.gov
Re: Agency Information Collection Activities: Submission for OMB Review; Comment Request (CMS–10407)

**RE: AHIP's Comments on Summary of Benefits and Coverage and Uniform Glossary Revisions**

To the Tri-Agency Officers,

We are writing on behalf of America's Health Insurance Plans (AHIP) and appreciate the opportunity to offer comments in response to the revised Summary of Benefits and Coverage ("SBC") and Uniform Glossary ("Revisions"), as issued by the Departments of Treasury, Labor, and Health and Human Services (the "Departments") on February 26, 2016 (81 Fed. Reg. 9860, 9887, 9945).

AHIP acknowledges changes the Departments have made to the proposed SBC revisions and remains concerned that many of the Revision's substantive changes are being imposed in an attempt to enable completed SBCs comply with the imposition of a new "hard" 4-page or 8-side length limit. As the Departments are aware, current SBC rules permit health plans and issuers to extend the length of completed SBCs in instances when, notwithstanding good faith efforts to comply with the 4-page or 8-side length limit, health plans and issuers are unable to provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage as required under the law. These substantive changes would permit, and in a number of instances may require, health plans and issuers to utilize production techniques that will, as outlined in the NAIC consumer testing report, reduce consumers ability to obtain , understand and compare SBC related information. We refer to the various approaches offered, such as narrow fonts, wide margins, reduced white space, and references to other more complex documents such as ERISA plan SPDs.

We continue to find these changes create an unworkable approach that will result in otherwise avoidable additional expenses for employers, insurance companies and consumers.

We recognize the Departments accepted some recommendations proposed by the NAIC's Consumer Information Subgroup. However numerous other recommendations developed by the Subgroup though nearly a year long collaborative process involving state regulators, consumer

and industry representatives and based upon learnings from consumer testing have not been incorporated into the revised standards.

Thus we remain concerned that a number of revised SBC requirements undermine the key policy goals underpinning the production and usefulness of SBCs. The applicability date for open enrollments for group business on or after 4/1/2017, the imposition of a "hard" 4-page or 8-side length limit, the creation of separate SBC versions for groups and for individual (non-group) users during 2017, and for separate SBC versions for use for Marketplace qualified health plans (QHPs) and plans outside of the marketplaces complicate the process inordinately. As we have previously noted, health plans and issuers will face considerable costs in implementing new SBCs and it is critical that the changes benefit the consumer and do not make complicated insurance information more difficult to understand.

Our comments and recommendations have been formed through extensive consultations with health plan policy experts and operational leaders who have had extensive experience with implementing the SBC. Our goal is to promote SBC utilization by individual consumers and employer groups by the production of the useful and actionable information as outlined within section 2715 of the Public Health Service Act.

- **Applicability Dates: We recommend that the Departments should establish a common applicability date for all SBCs of 1/1/2018.** A common applicability date will eliminate consumer confusion related to differing SBC forms for individual and group, while providing regulators and issuers with adequate time to ensure a compliant roll out of the revised template and related documents. A mid-year effective date for the new SBC template will cause significant implementation timing, cost and staffing issues. This is due primarily to two concerns: first, a mid-year date does not align with health insurers current processes for making system updates; second, the mid-year date will likely require a number of issuers to file 2017 SBCs with the states twice (the older template as part of product filings and the new template as part of the implementation transition), which increases costs and reduces time available for implementation. In addition, there are no clear instructions on how insurers are to file revised SBCs with the FFE and how insurers are to coordinate those filings with any SBC form filings required by state regulators.

  State filing deadlines for 2017 plans are fast approaching. The 2017 SBCs will be submitted to the states using the 2016 template. States, however, are already indicating that they will require the SBCs to be resubmitted on the new template once it is finalized. This will require plans to spend several months to implement the new requirements and

complete the IT development, testing and deployment of the new template. Implementing the new template for 4/1/17 will be a burdensome undertaking, as the Departments have substantially changed the textual composition of the SBC to include a number of "if/then" changes, which means the new template will require a significant amount of re-coding of current SBC production programs, which requires a substantial amount of time to accomplish.

- **Instructions for SBC Production: We recommend that the Departments grant issuers additional guidance to meet with the 4-page, 8-side length requirement, to include greater flexibility to make alterations to the format and content of the SBC template to allow the accurate portrayal of coverage terms.** Under the current SBC rules, issuers have considerable flexibility to exceed the 4-page, 8-side length limit when necessary to accurately portray information required under the law. The revised instructions indicate that SBCs issued after the new applicability dates will have to comply with the 4-page, 8-side length limit. Currently many SBCs cannot comply with a 4-page, 8-side length limit. While the revised instructions will allow more SBCs to comply, the revised instructions recognize that not all SBCs will comply without removing PHSA required information and replacing it with references to group Summary Plan Description ("SPD") documents. Our members assure us that the SBC template changes made by the revised instructions, including the ability to reference SPD documents, will not of themselves allow all SBCs that currently exceed 4 pages and 8 sides in length to meet that length requirement. If issuers are not permitted to exceed this length limit though the General Instructions' Special Rule, we recommend that the Departments revise the individual and group instructions to remove newly required specific deductible information for inclusion within the "Your Cost If You Use a Participating Provider' and the "Your Cost If You Use a Non-Participating Provider" columns, and that the Departments also permit issuers to delete information required under the PHSA when replacing it with citations to other coverage documents in those instances where issuers cannot otherwise in good faith comply with the length limit.

- **Coverage Examples: We recommend that the Departments clarify carrier instructions as they apply to the existing Coverage Examples, and that they delete the newly added example, titled *Mia's Simple Fracture*.** Our members remain concerned that consumers can be misled by the current and proposed service portrayals provided by the Coverage Examples. The services outlined by the existing examples, such as birthing classes, anesthesia for the maternity claim either do not show up or are

now zeroed out. It is possible the anesthesia is bundled into the inpatient hospital claim; the inpatient claims for mother and newborn are not separately identifiable as they would be billed. A new footnote is to be included that states: "The **plan** would be responsible for other costs of these EXAMPLES. While this statement is no doubt correct in that the plan would pay for other costs not identified within the examples, consumers might also believe that if other costs were incurred they would be payable regardless of policy language. We note that this language was not subjected to NAIC consumer testing. We therefore strongly recommend that line be removed.

The inclusion of a new Coverage Example for Mia's broken foot continues these concerns. Our review of this example with member plans indicates this example is inconsistent with the general way in which these services are typically billed. For example, the instructions indicate that the follow up visit is at the hospital outpatient facility rather than at a physician's office. Such differences will impact how these services would be mapped to a plan's or insurer's benefit structure for the purposes of completing the example. Until these issues are addressed we would recommend this third example be deleted.

- **Good Faith Compliance Safe Harbor: We recommend that the Departments once again issue a first year good faith safe harbor for issuers who conduct their SBC implementation activities in good faith to fully comply with the revised template and related documents.** We recognize the efforts that the Departments have taken to reduce the length of the SBC template. An unintended consequence of this effort has been an increase in the complexity of the implementation effort issuers will have to undertake to comply with the revised template and related documents. In addition to the new "if / then" statements contained within the instructions which require new, more complex computer programming logic along with additional computer programming to access data for completion of SBCs, issuers will have to determine what information can and should be stricken from SBCs to be replaced by citations to other coverage documents. These activities may be made more complex by the fact many such documents may not as yet be in existence when SBCs are produced. Until issuers have worked through these issues, our members anticipate there will be a heightened probability for process and human errors despite the best efforts to comply with the law in implementing the revised SBC template and related documents. The Departments recognized the complexity especially facing the employer and issuer communities during the initial implementation of the SBCs. We thus recommend that the Departments again recognize the considerable

operational challenges that will be faced by employers, state and federal regulators, and issuers, and renew the first year compliance safe harbor for good faith implementation efforts.

Finally, we are concerned that the Departments' new SBC template and instructions are often so specific as to that they will create inaccurate or misleading when applied to specific coverage plans or insurance policies. This is an alarming result, as the purpose of the SBC is to help consumers to better understand their coverage. This risks defeating the purpose of the SBC by misleading or confusing consumers.

Again, AHIP appreciates the opportunity to offer these comments on the revised SBC template and related documents. We strongly urge consideration of the specific detailed recommendations included in our attached comments, which are intended to help avoid the perverse outcomes or the unintended consequences the proposed rules would cause if implemented as proposed.

AHIP and our member plans remain committed to working with all stakeholders to promote the goals for the SBC for consumer product education and for the provision of actionable consumer product information.

Sincerely,

Matthew Eyles

Matthew Eyles
Executive Vice President
Policy and Regulatory Affairs

**AHIP's Detailed Comments on the Revised SBC Template and Related Documents**

We have organized our detailed comments and recommendations into the following sections:

**I. Proposed Changes to SBC Template**

**II. Proposed SBC Instructions**

**III. Coverage Examples**

**IV. Other Requirements**

## I. Proposed Changes to SBC Template

**A. <u>Disclaimer at the top of page 1 of the template regarding how to obtain a copy of the actual individual policy or group certificate</u>** - The Revised SBC instructions do not include a reiteration of the requirements found within the final 2017 QHP issuer letter, page 84.

Excerpt from page 84 of 2017 QHP Issuer Letter:

> Lastly, we remind issuers that all URL links included on the SBC must be readily obtainable (that is, without requiring logging on to a website, entering a policy number, clicking through several web pages, or creating user accounts, memberships, or registrations) to consumers, including shoppers, and link directly to the information referenced on the SBC. For example, in accordance with 45 CFR 147.200(a)(2)(i)(L), the link for obtaining information on prescription drug coverage in the SBC must directly link to the formulary for the benefit package reflected on the SBC, as noted previously. Similarly, pursuant to 45 CFR 147.200(a)(2)(i)(J), the web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained must also link directly from the appropriate space on the SBC and be readily obtainable to shoppers.

The Revised instructions simply state:

> **Disclaimer (page 1):** The disclaimer at the top of page 1 should be replicated exactly, without changes to the font size, graphic, or formatting. The issuer should insert contact information (such as telephone number and/or website) for obtaining more detail or a copy of the complete terms of coverage. Issuers must also include a website where consumers can review and obtain copies of the individual insurance policy. Finally, the

issuer must include a website and telephone number for accessing or requesting copies of the Uniform Glossary. (One or both of the following Internet addresses may be used as a website designated for obtaining the Uniform Glossary: www.dol.gov/ebsa/healthreform or www.cciio.cms.gov.)

**Recommendation:** That the Revised instructions clearly reflect current requirements, and that the instruction be revised to read as follows:

**Disclaimer (page 1):** The disclaimer at the top of page 1 should be replicated exactly, without changes to the font size, graphic, or formatting. The issuer should insert contact information (such as telephone number and/or website) for obtaining more detail. Issuers must also include a web address where a copy of the actual individual coverage policy or group certificate can be reviewed and obtained by shoppers. Finally, the issuer must include a website and telephone number for accessing or requesting copies of the Uniform Glossary. (One or both of the following Internet addresses may be used as a website designated for obtaining the Uniform Glossary: www.dol.gov/ebsa/healthreform or www.cciio.cms.gov.)

**B. Formatting of Excluded Services & Other Covered Services.** Within the *Excluded Services & Other Covered Services* boxes, the column aligned alphabetizing of services has been replaced with row aligned alphabetizing of services. NAIC consumer testing and its deliberations, and our members have identified no issues of consumer comprehension arising out of the current format for this information. The current format should be retained, which will have the additional benefit of not incurring unnecessary re-programming costs.

**Recommendation:** That the current formatting of services by alphabetizing services in columns within the *Excluded Services & Other Covered Services* boxes be maintained.

## II. Proposed SBC Instructions

**A. Instructions, General Rule.** The General Instructions state that form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. While the instructions permit minor adjustments to row or column size in order to accommodate the plan's information, as long as information is understandable, the instructions do not generally permit the optional combining of cells in the *What You Will Pay* column or in the *Limitations, Exceptions, and Other Important Information* column, or the use of separate cells for these columns were appropriate to portray information in a meaningful manner. In light of changes permitted to facilitate compliance with the 4-page / 8-side length limit, we would recommend that plans and issuers be permitted to combine or

separate cells in these columns when undertaken in a good faith effort to portray information in a meaningful manner.

**Recommendation:** That the General Instructions provision for individual or non-group SBCs be amended to permit health plans and issuers greater flexibility to regarding the formatting of cells within the *What You Will Pay* column and in the *Limitations, Exceptions, and Other Important Information* column for the purpose of enhancing clarity and readability.

**B. Naming convention for prescription drugs.** The individual (non-group) and group instructions at page 12, item 2, second bullet, line 7, directs health plans and issuers to identify "corresponding terms" in place of "generic, preferred, non-preferred, or specialty". Some drug plans do not use the "generic, preferred, non-preferred, or specialty" drug identifiers or other equivalent grouping for drugs. In their place, these drug plans use drug tier names. These instructions should make it clear that in instances where drug plans do not use the "generic, preferred, non-preferred, or specialty" drug identifiers, health plans and issuers may amend the *If you need drugs to treat your illness or condition* row of SBCs to portray the drug categories used by the plan or policy.

**Recommendation:** That the individual (non-group) and group instructions be amended to allow SBCs to portray drug information according to the drug groupings utilized by their plans and policies and that they not be limited to four groupings based upon the four "generic, preferred, non-preferred, or specialty" drug identifiers or other equivalent grouping for drugs.

**C. Listing of state and federal agencies.** Within the individual (non-group) and group instructions pertaining to *Disclosures, B.Your Rights to Continue Coverage*, the instructions set forth the manner in which SBCs are to portray state and federal agencies contact information. These instructions will increase the likelihood that SBCs will have to list these agencies several times, which will exasperate the 4 page / 8 side length limit compliance issue. This issue and its ramifications for SBC and consumer comprehension were investigated at length by the National Association of Insurance Commissioners' (NAIC) work group. We believe the NAIC approach contained within its recommendations to the Secretary of Health and Human Services more appropriately addresses both concerns and reduces the possibility of requiring SBC contain redundant information on the same page.

**Recommendations:** That the individual (non-group) and group instructions be amended to adopt the NAIC proposal addressing the portrayal of state and federal contact information

relating to *Your Rights to Continue Coverage*, and to *Your Grievance and Appeals Rights* which would require SBCs to portray the state and federal agency contact information one time while denoting in a separate cell on the right edge of the page, when the agency addresses complaints, grievances and appeals, and or continuation of coverage issues.

**D. Individual instructions requiring minimum value status.** The instructions for individual or non-group policies require those SBCs to address minimum value (MV) status. Individual policies demonstrate value standards though the metal level value standards. Minimum Value is a group concept, designed to value employer and group insurance products, and its use should be stricken from individual or non-group SBCs.

**Recommendations:** That the individual (non-group) instructions delete its requirement to address MV. If the Departments intend to maintain the inclusion of a MV statement and related instructions for individual (non-group) SBCs, we would recommend that the Departments make clear the intended purpose for including this employer / group valuation of coverage so that consumers are not confused by its inclusion.

**E**. **Portrayal of separate deductibles within the *What You Will Pay* column.** The individual (non-group) and group instructions at *III. COMMON MEDICAL EVENT, SERVICES, WHAT YOU WILL PAY, LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION, 2. What You Will Pay columns* will require the portrayal of separate deductibles which can apply to a Common Medical Event. Depending on the benefit structure, this new provision may require the use of significant *What You Will Pay* real estate threatening the 4-page / 8-side limit, thus requiring SBCs to refer consumers to other coverage documents for exceptions, limitations and other important information. This may occur due to the fact that the current and the revised templates utilize narrow columns for this information. The Department's sample template portrays a simple two tier provider networked product. Point of Service products require an additional column to portray their three levels of provider network. If such a product employs a so-called medical home, a fourth column might be required. The requirement that these columns include descriptive language describing the application of specific service level deductibles could significantly increase the length of these SBCs beyond the 4-page / 8-side limit. Today, to the extent that such specific deductibles are meaningful to the portrayal of SBC information, such information is found within the *Limitations and Exceptions column.* This new requirement should be deleted.

**Recommendation:** That the new requirement that *What You Will Pay* columns include specific deductible information be stricken.

**F. Individual instructions permitting reference to SPDs.** The instructions for individual or non-group policies permit carriers facing the possibility of producing SBCs longer than 4-pages / 8-sides to remove certain information within the *Limitations and Exceptions and Other Important Information* column to be replaced by citations to an SPD. Such a reference appears to be a clerical error and we would recommend that the term SPD be stricken and replaced by a reference to "coverage documents" in the individual market SBC and instructions should be replaced with "coverage document(s)".

**G. "Major categories" for services available before meeting deductibles.** The individual (non-group) and group instructions establish a new SBC requirement 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. Neither instruction provides any guidance as to the nature of "major categories of covered services". In efforts to promote uniformity, we recommend the instructions in relation to the question "Are there services covered before you meet your deductible" align with the 10 categories of essential health benefits. A "yes" answer should be listed for any of the 10 categories of essential health benefits.

**Recommendation:** That the Departments clarify the "major categories of covered services" to mean the 10 categories of essential health benefits.

**H. Deductible disclaimer:** The individual (non-group) instructions indicate that the deductible disclaimer must be included if a deductible applies, and imply that the disclaimer may be removed if there is no deductible on the plan. While we understand CMS' objective to alert the consumer of their deductible, this approach assumes that plans have a deductible that applies across the board, or do not have a deductible at all. Frequently, however, plans with a deductible include specific services or have various tiers that do not apply the deductible. For instance, many plans apply a deductible only on the out-of-network services. These instructions also indicate that the columns are intended to reflect the consumer costs after the deductible has been satisfied. For many health plans and insurers this will require changes to all the logic on how these SBCs portray cost share in the columns. At present, if a service takes the deductible, the SBC will state "Deductible" or "x% coinsurance after deductible". That way, the consumer is clear on what they are paying. With the new rule, it is unclear how the consumer is supposed to know what services take the deductible and which do not. This uncertainty begs the question whether plans need to add the phrase "deductible does not apply" after every cost share that does not take a deductible. Adding this phrase after every

cost share that does not take a deductible will increase the overall length of the SBC and add unnecessary text that may be distracting to the consumer.

**Recommendation:** That the individual (non-group) and group instructions be amended to allow for an additional disclaimer option for plans with only an out of network deductible, such as the following: "All out-of-network copayment and coinsurance costs shown in the chart are after your deductible is met."

**I. Special Rule exception for cross referencing to other plan documents.** The individual and group instructions expressly state that an SBC may not "substitute a cross-reference to the SPD or other documents for any content element of the SBC, except as permitted in the *Limitations, Exceptions, and Other Important Information* column." Our members remain very concerned that SBCs produced for a number of their products may exceed 4-page / 8-side limit without the removal of information they believe is required by law or by rule notwithstanding efforts by the Departments to shorten the SBC template. The Departments have implicitly recognized this possibility by permitting SBCs to reference other documents in the *Limitations, Exceptions, and Other Important Information* column. By extending this permission to the remaining parts of SBCs in situations where SBCs would otherwise exceed the 4-pages / 8-sides length limit, may provide a means to produce compliant SBCs with regard to the length limitations.

**Recommendation:** That the individual and group instructions be amended to permit the substitution of a cross-reference to other coverage documents by page number or by section header for any content element of the SBC when such substitution is made in good faith to comply with the SBC's 4-pages / 8-sides length limit.

**J. Preventative care services hyperlink to Healthcare.gov.** In certain situations where SBCs describe the availability of certain preventive services without cost sharing and before deductibles are met, the individual (non-group) and group instructions require non-grandfathered plans and coverage to insert the following information in the *Why It Matters* column: "For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/." Plans are not required to immediately provide preventive services as they are adopted and posted to this website. Consumers should be referred to their plan or to their insurer for the current listing of covered preventive services.

**Recommendation:** That the individual (non-group) and group instructions for the preventive services hyperlink be amended to state: "For a list of preventive services contact: [plan or insurance company contact information]."

K. **Plans with $0 deductible.** The individual (non-group) and group instructions do not include an appropriate *Why this Matters* language for the *Are there services covered before you meet your deductible* row for plans with $0 deductibles as the only choices of language pertain to when no services are covered before the deductible, or when "some" services are covered before the deductible.

**Recommendation:** That the individual (non-group) and group instructions be amended to include appropriate *Why this Matters* language for the *Are there services covered before you meet your deductible* row to permit health plans and issuers denote that there are no deductibles for these plans as a third option.

**III. Coverage Examples**

**A. Coverage Example page overflow.** The new third coverage example along with new required language, including foot notes for related HSAs and wellness program disclosures that are not shown on the Department's sample completed SBC from, may overflow the examples to an additional page. Guidance is requested for health plans and issuers on how to carry information onto an additional page.

**Recommendation:** That the Departments issue instructions to health plans and issuers addressing how SBCs should portray information in the event that Coverage Example information has to flow onto the next page of a completed form.

B. **Other costs footnote.** The Revisions include the following new Coverage Example page footnote: "The **plan** would be responsible for the other costs of these EXAMPLE covered services." This footnote appears confusing as it categorically states the plan will pay for the other costs without providing consumers with any information concerning those costs, and whether any other costs actually exist. These examples are merely an educational tool to assist consumers in understanding how the coverage portrayed on the SBC could apply in these fictitious scenarios. There is no educational benefit for consumers arising out of this footnote that hints there may be more benefits payable in these scenarios. In point of fact

consumers may be misled to believe that there are undisclosed financial benefits to the policy which may inappropriately influence any choice decisioning undertaken in reliance on the SBC information. We would recommend that this footnote be stricken as not supplying actionable information for consumers while utilizing scarce real estate of the template.

**Recommendation:** That the footnote at the bottom of the Coverage Example page be deleted.

**C. Mia's Simple Fracture:** Out members have identified concerns with the fractured foot coverage example based on a review of how services have historically been billed. The two items classified 'Other Facility Service' and 'DME' would typically be billed as part of the ER Facility claim, but there is not a claim for ER Facility services. In addition, the charges/allowances for the cast and crutches were both very small, whereas you would expect the cost for the ER Facility claim to be much higher. Two line items for professional services (follow up to ER) are listed as being performed at an outpatient hospital setting instead of an office setting. Typically a member would follow up at an Orthopedist office, not an outpatient hospital setting.

**Recommendation:** That the new third coverage example be removed at this time from the Revised SBC template.

**D. Inclusion of separate deductibles for specific services within the Coverage Examples.** The individual (non-group) and group instructions set forth directions that "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." It appears form the Department's sample completed Coverage Examples that specific services were subject to separate deductibles for drugs and occupational therapy. However the sample completed Coverage Examples do not portray this information within the respective benefits on the chart. The inclusion of specific deductibles should affect only a minority of Coverage Examples, and since the Coverage Examples are not intended nor designed to serve as a cost calculator, the inclusion of these adjustments serve little or no educational value, rather they may serve to confuse consumers with a level of unnecessary detail that will diminish the learning value of the Coverage Examples.

**Recommendation:** That the instruction "“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[.]” be stricken from the individual (non-group) and group instructions.

**E. Footnote related to Wellness Programs.** The individual (non-group) and group instructions require that if the SBC portrays a benefit structure that 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. Additionally, if applicable, the plan or issuer must include a box below the coverage examples with the following language (and appropriate contact information): “Note: 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. For more information about the wellness program, please contact: [insert].”

While we recognize participation in wellness programs may reduce consumer costs, this footnote does not reference program requirements and participation responsibilities, while the coverage example expressly notes it does not portray any such savings. Such information goes beyond the intent and scope of the SBC as an informational tool and not as a cost calculator, and does so while requiring the footnote for all SBCs related to plans and policies with wellness program features, which will exacerbate formatting and printing challenges to maintain the coverage examples on one page.
**Recommendation:** That the individual and group instructions be amended to require that the Coverage Examples be completed without reference to wellness program provisions, and that current footnote be deleted from those instructions.

## IV. Other Requirements

**A. Foreign translations.** While the Departments have released four SBCs in foreign languages as required under the provisions of the PHSA, some carriers are presently encountering issues in complying with the 4-side / 8-page length requirement due to complications with translating variable language that they must provide on an SBC. These carriers remain concerned that the Revised SBC template, although shortened, will also present this type of challenge when implemented. We would recommend that for the first year of implementing foreign language translations of the SBC that the Departments establish a non-enforcement safe harbor for those carriers attempting in good faith to comply with the individual and

group instructions regarding length of SBCs that are translated in languages other than English.

**Recommendation:** That the Departments establish a non-enforcement safe harbor for carriers attempting in good faith to comply in the first year with Revised instructions regarding length of foreign language translations of SBCs.

**B. Additional SBC translation requirements.** The Department of Health and Human Services has indicated that the new requirements included in the 2016 Payment notice for language access requirements (45 CFR 155.205(c)) that apply to QHPs apply to SBCs. These new requirements establish additional specified language access standards related to critical access documents including SBCs for which CMS has indicated that QHPs may provide notice for such access through cover letters to the SBCs, an alternative that is inconsistent with the SBC rule. We recommend that the Departments should work to harmonize the various language access standards, while recognizing that the ACA provides specific language access requirements for SBCs. This additional requirement may confuse consumers in situations where one family member may have access to a QHP based additional foreign language translation for one SBC only to have another family member, perhaps a spouse, not able to obtain the same language translation for a non-QHP product. Such a situation could easily and perhaps unnecessarily complicate these consumers ability to utilize SBCs. We believe that the language access provisions expressly found within the ACA's statutory SBC language should control.

**Recommendation:** That the Departments harmonize the language access requirements applicable to, as well as related to, the production of SBCs.

**C. Coverage for abortion services.** The individual (non-group) and group instructions set forth directions for QHPS that must provide information on an SBC relating to abortion coverage, and for those non-QHP health plans and carriers that wish to voluntarily provide information on an SBC relating to abortion coverage. The instructions indicate by double quotation marks language for use on the form. By special exception this section permits SBCs to reference other plan or policy documents for additional information. Recognizing the need for specificity surrounding the portrayal of these services recognized by the Departments in the special instructions for this sections of the SBC, we would recommend that health plans and be permitted flexibility in portraying this coverage within a completed

SBC so that it accurately portrays benefits. In addition, the federal Office of Personnel Management requires the use of the phrase "termination of pregnancy". Flexibility under the Departments' instructions would allow for consistency of language for those carriers doing multi-state business.

**Recommendation:** That the individual (non-group) and group instructions be revised to permit health plans and carriers greater flexibility in portraying abortion coverage by not requiring the use of the language within the instructions abortion related language portrayed in double quotation marks. In addition, we recommend that the term "termination of pregnancy" be permitted to be used in place of the word "abortion" within the SBC.

**D. Calculator formats.** Unlike the current Coverage Example calculator, the revised calculator format does not line up with the calculator. We do not understand the need or benefit from altering the calculator format.
**Recommendation: That the Departments maintain the current calculator format.**

**V.** Other Issues and Questions

**A.** Page 5B of the Instructions provides two URLs that may be used as a website for obtaining the Uniform Glossary: www.cciio.cms.gov and www.dol.gov/ebsa/healthreform. However, neither of these URLs link directly to the Uniform Glossary, and the website www.cciio.cms.gov cannot be linked to a pdf (SBCs are provided online as a pdfs). Will this be fixed or will another web address be provided?