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October 21, 2011

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9982-P
PO Box 8016
Baltimore, MD 21244-1850

RE: File Code CMS-9982-P (Summary of Benefits and Coverage and the Uniform Glossary)

Dear Sir or Madam:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate the opportunity to offer our comments on key issues related to implementation of Section 2715 of the Patient Protection and Affordable Care Act (ACA), which is intended to help consumers, including patients, better understand their insurance coverage, as well as other coverage options that may be available to them.

Section 2715 requires creation and use of a standard form for describing health insurance coverage, called the Summary of Benefits and Coverage (SBC), that is understandable to the average consumer. The SBC will be perhaps the most important document consumers will obtain to allow them to make “apples to apples” comparisons of health plans, select the plan that best meets their needs, and better understand their health insurance coverage. Section 2715 also calls for a consumer-friendly Uniform Glossary of Medical and Insurance terms (Glossary) to be developed and made available to further help consumers understand their health plans and provide greater consistency in usage of terms across plans.

The benefits of a standard disclosure form and glossary are great. Consumer confusion regarding health plan terms—particularly cost-sharing terms—is well documented. If consumers can't understand the coverage offered by a plan, they can't make an informed selection. When consumers do not understand their choices, they often make a decision based on premium alone and find themselves in plans that don't have the coverage they need.

The proposed rule makes great strides in providing an understandable health insurance disclosure to consumers. Our comments below are intended to ensure that the SBC is useful to as many consumers as possible and that consumers' ability to use the form is monitored and improved over time.

Coverage examples

The ACA requires that the SBC contain a “coverage facts label,” referred to in the proposed rule as “coverage examples,” that would illustrate how a plan’s coverage would apply to claims scenarios for common conditions to assist patients in selecting the plan that best addresses their health care needs. The statute requires that the examples illustrate common benefits scenarios, including specifically “pregnancy and serious or chronic medical conditions” for which recognized clinical practice guidelines are available.

The rule proposes that HHS may identify a maximum of six coverage examples that may be required to be covered in an SBC. HHS is further proposing a phased-in approach to including coverage examples in the SBC and proposes starting with the three coverage examples modeled by the NAIC— having a baby, treating breast cancer, and managing diabetes. The Departments of Health and Human Services, Labor, and Treasury (the Departments) invite comments on whether additional benefits scenarios would be helpful and, if so, what those examples should be.

We recognize the competing interests that the Departments are trying to balance by limiting the coverage examples that health plans would have to provide to six. On one hand, providing too many examples in the SBC could make it too long and overwhelming for consumers and patients to read. On the other hand, however, these examples were viewed as extremely helpful and informative by consumers in the limited, independent consumer testing that was conducted by Consumers Union and the insurance industry, and participating consumers expressed a desire for more examples. Providing only three examples may limit their relevance to a relatively small subset of the population and lessen their utility as a valuable consumer tool. We therefore strongly recommend that six coverage examples be required to be included in the SBC beginning immediately in 2012.

When selecting the treatment scenarios to include, the Departments should choose examples that are relevant to as wide and diverse a population as possible. Specifically, we urge the Departments to take into account the following factors:

- Prevalence of conditions in the population overall.
- Prevalence of conditions in key subpopulations. There should be coverage examples that are relevant to both men and women of all ages of diverse backgrounds.
- Scenarios that illustrate differences in how health insurance coverage varies for different types of care. Typically health plans apply different coverage rules, limits, and cost sharing for certain types of benefits – hospitalization, outpatient prescription drugs, rehabilitative services, etc. Selection of coverage illustrations should show consumers how these coverage differences work under each plan.

A number of cardiovascular conditions meet the statutory criteria for “serious or chronic medical conditions,” and meet the factors recommended above and would be very appropriate for selection as coverage examples. For example, all of the following conditions have evidence-based clinical practice guidelines available through the National Guideline Clearinghouse and affect a substantial number of Americans, including both men and women of varying ages, races, and ethnicities. We strongly recommend that you consider including the following conditions as coverage examples:

- **Myocardial infarction (heart attack):** A heart attack is a serious, potentially life-threatening condition that generally requires immediate emergency care and hospitalization, as well as follow-up care and cardiac rehabilitation to prevent additional attacks and prevent additional adverse consequences. Approximately 935,000 individuals experience a new or recurrent

heart attack each year in the United States, and a total of about 7.9 million American adults have experienced a heart attack at some point in their lives. According to 2008 prevalence data, about 60 percent of individuals who have had a heart attack are male and 40 percent are female.

- Ischemic stroke: Stroke is a leading cause of death and serious long-term disability and generally requires immediate emergency care, hospitalization, rehabilitation, and follow-up care to maximize recovery and prevent additional strokes. Each year, about 795,000 people experience a new or recurrent stroke, and 87 percent of these strokes are of the ischemic type (caused by a blockage in an artery in the brain). Overall, an estimated 7 million adults in the United States have had a stroke; 60 percent of them are female and 40 percent are male.
- Hypertension (high blood pressure): High blood pressure is a serious chronic condition that can lead to heart attack, stroke, kidney failure and other consequences, particularly if not adequately treated and controlled. One in 3 U.S. adults – an estimated 76.4 million people -- has high blood pressure. Overall, about 52 percent of those adults with high blood pressure are female and 48 percent are male. According to 2005-2008 data, 71 percent of those with hypertension were under current treatment for the condition.

The proposed rule also requests comment on whether plans and issuers should only be required to provide consumers raw information about coverage features that consumers would then use to generate their own coverage illustrations. We would strongly oppose such a change. Consumers already face tremendous barriers to understanding their health insurance coverage today. Consumer testing underscores that the public has difficulty understanding the meaning of basic coverage features, such as deductibles, co-pays, and coinsurance. It would hardly be reasonable to expect consumers to know how to successfully estimate out-of-pocket costs that could result from such features. Asking consumers to take on the burden of generating their own coverage illustrations would be unfair and would ensure that few if any consumers would ever be able to obtain this information.

We do, however, favor a requirement that plans and issuers should display SBCs, including coverage examples that they have generated, on www.healthcare.gov so that the public can readily find this information. Further, we favor a requirement that the federal government should establish support resources and technical assistance to plans and issuers as they begin to generate SBCs. We would note in particular that technical support provided by HHS has been highly effective and made possible the reporting and display of extensive information about all individual and small group market health insurance plans in a short period of time. We trust that HHS and the Department of Labor will continue to provide this level of technical assistance to health insurance issuers and health plan sponsors so that they can comply with Section 2715 disclosure requirements in a timely and efficient manner.

RECOMMENDATIONS: Require inclusion of six medical scenarios in the SBC beginning immediately in 2012. The six examples should be chosen for their relevancy to as wide and diverse a population as possible. We specifically recommend the inclusion of scenarios related to cardiovascular disease and stroke. The Departments should closely monitor consumer satisfaction with the coverage examples feature of the SBC, and if warranted, consider requiring insurers to generate additional coverage examples that would be made available on www.healthcare.gov for enrollees or prospective enrollees seeking an example for additional conditions. However, plans and issuers, not consumers, must be responsible for generating coverage illustrations.

Availability of SBC to all private health plan enrollees

The ACA requires that *all* private health plans provide the SBC and glossary to enrollees and those shopping for coverage—group and non-group, grandfathered and non-grandfathered, inside or outside the exchange. When consumers use the same form across these settings, as the ACA requires, it allows them to “learn” the form. Investing the time in understanding how to use the form pays off because they can apply their knowledge regardless of the source of private health insurance.

Provision of the uniform SBC to enrollees in employer-sponsored group health plans is particularly important. The vast majority of privately insured people – 150 million non-elderly Americans in 2011 – are covered by employer-sponsored group health plans. If the SBC is not provided to people in such plans, the protections Congress intended under Section 2715 would be denied to most privately insured Americans.

Information disclosure for consumers in Employee Retirement and Income Security Act (ERISA) group health plans today is inadequate. For decades, ERISA has required private sector group health plan sponsors to disclose in a summary plan description (SPD) information to enrollees about covered benefits and enrollee rights and responsibilities. However, over the years the SPD has developed into a bulky, complex document that few consumers can understand. Other summary information provided by employers (for example, at open season) is inconsistent. A body of research documents that consumers do not understand how their health insurance works or what it covers. As a result, too often consumers may learn too late – when they get sick and make claims – what their health plan does and doesn’t cover. In addition, the new coverage examples that will be made available through the SBC are not routinely provided today under SPDs. Working Americans and their families enrolled in ERISA health plans should not be deprived of this information.

Requiring the SBC for all private health plans is also important because current ERISA health plan information disclosure requirements do not apply to tens of millions of public employees who are covered under state, county, and municipal governmental health plans. As written, the proposed rule implementing Section 2715 would close that gap. We urge that FEHBP plans also provide this information for federal employees, retirees, and their dependents.

RECOMMENDATION: Adhere to the requirement in the ACA and require all private health insurance plans and issuers to use the same form.

Effective date for compliance with SBC requirements

The proposed rule seeks public comment on the feasibility of timely implementation of Section 2715 requirements. We strongly urge prompt publication of a final rule with the requirements of this section taking effect no later than two years after the date of enactment of the Affordable Care Act, as the statute requires. We note that the National Association of Insurance Commissioners (NAIC) working group required by Congress to assist in the development of the SBC invested hundreds of hours of study and deliberation involving a broad range of subject matter experts to arrive at its recommendations for the SBC, including coverage examples. Drafts of the SBC and coverage examples were tested with plans and consumers to validate both costs and benefits of this new information resource. The Administration, in turn, took another four to five months to consider the NAIC’s March 2011 recommendations before publishing its proposed rule this summer. In light of the thorough work undertaken by so many to design the SBC, we urge timely implementation.

Timely implementation will help consumers better understand their coverage and health insurance options and reduce the costs and frustrations of trying to decipher the confusing coverage documents people must rely on today. One industry survey found most people would rather go to the gym or work on their income taxes rather than try to read their health insurance policy!¹ Going forward, we further urge the Administration to engage in ongoing efforts to monitor the costs and benefits of the SBC as it is implemented, including by conducting additional consumer testing, and to make future refinements and improvements based on such monitoring. Even with additional consumer testing, consumers' ability to use the SBC will not be fully revealed until the form is in widespread circulation. The Departments should anticipate that additional issues will be identified and establish a process for periodic review and improvement of the form.

RECOMMENDATIONS: Implement the SBC on time, no later than March 23, 2012, as the ACA requires. Establish a process for annual review and improvement of the form, allowing input from consumer, provider and insurer stakeholders. Conduct periodic consumer testing, including non-English speaking and hard-to-reach populations, to monitor consumers' ability to use the form.

Providing the SBC to consumers

We strongly support the requirements outlined in the proposed regulation that the SBC must be provided free of charge "with respect to each benefit package offered by the plan or issuer for which the participant is eligible" when an employer or individual is comparing health coverage options. The proposed rule recognizes that there are different scenarios for when an SBC should be made available to a consumer. We agree that the SBC should be provided when the issuer renews or reissues the policy, any time an applicant or group plan requests it, whenever application materials are distributed by the plan or issuer for enrollment, and whenever there is a change in plan information or benefits. We believe that the SBC will provide significant benefit to consumers in these instances. We recommend that insurers additionally be required to provide the SBC along with marketing materials that may be provided to prospective plan applicants. Applicants do not always review all of the materials they are provided and in these cases it is important that the first documents a prospective applicant reviews describe the terms and benefits of the plan accurately.

The proposed regulation specifies that the SBC must be provided as part of any written enrollment application materials distributed by the plan or issuer, or if a plan or issuer does not distribute written materials, the SBC must be provided no later than the first date a participant is eligible to enroll in coverage. We urge the Departments to require the SBC to be made available at least seven days prior to when a participant is eligible to enroll. This is consistent with the timeframe included in the rule for special enrollment. Sufficient lead time is important. Consumers choosing health coverage need adequate time to review materials and fully understand their options in order to make an informed decision.

We concur with the rule's proposal to make the SBC available – either in the case of special enrollment or when an SBC is requested at a time other than enrollment periods - within seven days and believe this gives consumers sufficient time to review the information. We also want to ensure that the requirement that issuers provide the SBC upon request at any time permits consumers to request an additional copy of the SBC for their plan if they misplace, damage or lose the document. We understand the concern some insurers have about the potential administrative burdens if a significant number of consumers make requests for SBCs outside of the enrollment period. While

¹ ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008, available at http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712.

we do not believe most consumers will want or need an SBC at other times we suggest that the Departments monitor the number of requests during the first year to determine whether changes in the policy are warranted.

RECOMMENDATIONS: As called for in the proposed rule, require the SBC to be made available at least seven days prior to when a participant is eligible to enroll. Insurers should provide the SBC along with marketing materials for a plan that may be provided to prospective applicants. If any information included in the SBC changes insurers should be required to issue an amended SBC within the timeframes specified in the regulation. The requirement that issuers provide the SBC upon request should permit consumers to request an additional copy of the SBC for their plan if they misplace, damage or lose the document.

Sample Completed SBC

We are concerned that “bariatric surgery” and “weight loss programs” are included on page 4 of the sample completed SBC as “excluded services.” Although we understand that this is just a sample form and is not intended to cause health plans to alter the services they cover in a way that would negatively impact consumers, we worry that the sample form may send the wrong message to health plans that are considering whether to cover these services. As you know, obesity is a significant public health problem and a major risk factor for cardiovascular disease, cancer, diabetes, and early death. It also leads to increased health care costs. Fortunately, obesity is a modifiable risk factor, and federal policies should support coverage for evidence-based services that promote sustained weight loss.

RECOMMENDATIONS: If the sample completed SBC is to be made available as part of the final rule to implement Section 2715, we request that bariatric surgery and weight loss programs be removed from the list of excluded services. Further, the proposed instruction guides for individual and group health plan coverage should be amended to be consistent with this recommendation.

Additions and Changes to the Glossary of Health Insurance and Medical Terms

Consumer testing² of the Glossary by Consumers Union found that a number of the definitions contained in the Glossary were unclear, often because the definitions used additional terminology that they did not understand. For example, the definition of “coinsurance” relied on “allowed amount” that, in turn, referenced “balanced billing,” all terms the respondents did not understand. While some changes were made to the Glossary since that research was conducted (including addition of the above-referenced terms), the Glossary has not been retested to ensure that consumers understand the added definitions.

In addition, several consumer testing studies³ have demonstrated that key terms are missing from the Glossary. We recommend that a number of additional, consumer-tested definitions of the following key terms be added to the Glossary: Add consumer tested definitions for “network,” “preferred,” or “participating providers” (and explain that they are similar in terms of their import for consumers), and the following terms:

² *Early Consumer Testing of New Health Insurance Disclosure Forms*, People Talk Research and Consumers Union, December 2010, http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU_Consumer_Testing_Report_Dec_2010.pdf

³ See, for example, *Early Consumer Testing of Actuarial Value Concepts*, Kleimann Group and Consumers Union, September 2011, http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/prescriptionforchange.org_testing_actuarial_value_concepts.pdf

- HMO/Health Maintenance Organization
- Point of Service HMO
- PPO/Preferred Provider Organization
- EPO/Exclusive Provider Organization
- Actuarial Value (or corresponding term used on materials)
- Out-of-network provider
- Catastrophic plan
- Cost sharing
- Prescriptions—generic, non-preferred brand, preferred brand
- Prescriptions – retail vs. mail-order
- medical underwriting
- prescription drug “tiers”
- specialty drugs
- formulary

RECOMMENDATIONS: Conduct additional consumer testing of the Glossary (including the new recommended additions above), modifying definitions until they are understandable to the average enrollee, to ensure that this document meets the goals of Section 2715.

Thank you again for the opportunity to share our comments on these issues related to the availability of a uniform summary of benefits and coverage to all privately insured individuals. If you have any questions, please feel free to contact Stephanie Mohl, Government Relations Manager, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

A handwritten signature in blue ink, appearing to read 'G. Tomaselli', with a long horizontal flourish extending to the right.

Gordon F. Tomaselli, MD, FAHA
President