American Hospital Association

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March 2, 2015

Daniel Maguire
Office Director
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W., Room N-5653
Washington, DC 20210

RE: Proposed Rule: RIN 1210-AB69 Summary of Benefits and Coverage and Uniform Glossary, (Vol. 79, No. 249, December 30, 2014)

Dear Mr. Maguire:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on proposed revisions of the summary of benefits and coverage (SBC) published jointly by the departments of Labor, Health and Human Services, and Treasury. Particularly important are the proposed changes to:

1. The required templates for formatting the SBC;
2. The uniform glossary of terms used in the SBC; and
3. The instructions for completing the SBC templates.

Taken together, the SBC rules and these companion documents describe the information that must be given to every enrollee or prospective enrollee in health plans, whether employer group health plans (both fully insured and self-insured) or health insurance coverage offered in the group and individual markets under the provisions of the Affordable Care Act (ACA).

The AHA appreciates the joint effort of the departments to make continued improvements to the SBC rules and guidance documents. These requirements help ensure that consumers understand and compare health plan options based on premium, benefits covered, cost sharing, exclusions and provider networks. As such, it is critically important that the requirements be clear and consistently enforced. At the same time, we are concerned that the proposed changes do not resolve some key sources of confusion among consumers and are being rushed into implementation.

KEY SOURCES OF CONSUMER CONFUSION

The AHA urges the departments to rapidly address several sources of potential consumer confusion not addressed by the proposal. These include greater clarification around tiered provider networks, better links to the provider network used for specific plan offerings, and the exclusion of cost-sharing for out-of-network provider services from counting toward out-of-pocket limits.

Tiered Networks. When the initial SBC was developed, tiering was used predominantly for pharmaceutical coverage and the SBC sought to provide clarity around which drugs were included in which tier. While the issue of tiered provider networks was raised at that time, the practice was limited in its use. Since that time, tiered provider networks have become more prevalent. However, the SBC format and the glossary are not helpful in explaining the concept to consumers, many of whom are still struggling with the basic concept of provider networks. The terms in the glossary do not clearly describe the status of different providers within a network, and the SBC does not require clear descriptions of different levels of coverage or cost sharing tied to a provider's status.

The AHA recommends that the SBC glossary be revised to adopt standardized terms that better match provider classifications and that are more familiar to consumers. We also recommend that the SBC format and instructions require plans to list coverage and cost sharing for each tier or type of provider. The format could follow the same approach already used for tiered drug benefits. For example:

- Consumers recognize the terms "participating provider" or "in-network provider" as meaning providers that have contracted with a health plan to be in its network. Neither the current, nor the proposed glossary, define the term "participating provider." The fact that a provider contracts with a plan to participate in its network is important because it carries a variety of consumer protections with it, including prohibitions on balance billing and hold harmless/continuation of coverage provisions, in addition to agreed-upon discount rates.

- The term "preferred provider" is defined, but it includes multiple variations on how plans use the term. The glossary should be changed to describe only a preferred tier of providers within a network, just as it is used in describing the difference between preferred and non-preferred brand name covered drugs. Plans should be using the same terms in a standard way. Variations in terminology do not support consumer understanding or comparison shopping.

- The term "non-preferred provider" is used to describe out-of-network or non-participating providers, but also includes a confusing discussion about checking to see if enrollees can use any participating provider in a plan's network or whether the plan uses

a tiered provider network. This term should be limited to describe participating providers who are not preferred in a tiered network.

- The terms "out-of-network" or "non-participating provider" also are more commonly understood by consumers, but neither term is defined in the glossary, even though there are a host of other terms defined that refer to "out-of-network" copayments and coinsurance. These terms should be defined and included, focusing on the fact that their status does not carry the same consumer protections and may result in greater out-of-pocket expenses.

The potential differences in the cost and coverage of benefits related to a provider's network status are significant and require simplification. Consumers would benefit greatly from a simple approach that distinguishes in-network (or participating) providers, preferred or non-preferred providers who are subsets of providers in a tiered network, and out-of-network (or non-participating) providers.

Links to Provider Network Directories. **We recommend that the instructions require that hyperlinks to provider networks in the SBCs direct the viewer to the specific network used by that plan, or include instructions on which provider directory on an issuer's website is used for that particular plan.** All too often, the hyperlinks included in SBCs go just to the issuer's website, which often includes multiple directories used for different plans.

Out-of-Pocket Limits. Under current rules, health plans are free to decide whether cost sharing (but not balance billing) for services delivered by out-of-network providers will be counted toward the out-of-pocket limits required by the ACA. There is a box on the front page of the SBC template that identifies what is not included in the out-of-pocket limits, but the examples of how a plan would apply cost-sharing and out-of-pocket limits could easily lead some consumers to think that, once they spend the out-of-pocket limit amount, the plan will cover everything. **The AHA recommends that all of the required documents be scrubbed to ensure that exclusions to out-of-pocket limits are much clearer and the examples help put consumers on notice to look for exclusions.** Most consumers think of out-of-pocket limits in a very straightforward and absolute way. They should not be surprised to find out about exclusions only after making significant out-of-pocket expenditures.

IMPLEMENTATION TIMETABLE

We have been participating in calls held by the National Association of Insurance Commissioners (NAIC) Consumer Information Subgroup that developed the original SBC format and glossary of terms for use by the departments. A host of issues have been raised, including whether the timing of the proposal and its likely finalization will allow for successful implementation by Sept. 1 of this year – in general, for 2016 plans. **The AHA supports expeditious changes to fix identified problems, but recommends that changes for 2016 plans be limited to those that can be implemented by revising the glossary or instructions for completing the template, then proceeding with other changes the next year or so to the templates and, consequently, the information systems that produce the SBCs.** The extra time

could be well utilized by asking the NAIC subgroup to engage all stakeholders in a full review with recommendations on how to further reduce consumer confusion.
Thank you for your consideration of our comments. If you have any questions, please contact, Jeff Goldman, vice president for coverage policy, at (202) 626-4639 or jgoldman@aha.org or Ellen Pryga, director of policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development