

Summary of Benefits and Coverage and the Uniform Glossary and Templates, Instructions and Related Materials

Summaries of Proposed Rule and Solicitation of Comments

August 29, 2011

On August 22, 2011, the Departments of Treasury (Internal Revenue Service), Labor (Employee Benefits Security Administration) and Health and Human Services (Centers for Medicare & Medicaid Services) published in the *Federal Register* a notice of proposed rulemaking implementing the Affordable Care Act's¹ provisions related to the **Summary of Benefits and Coverage (SBC) and Uniform Glossary**. These disclosure provisions were intended to help individuals better understand their health coverage options so that they may make informed coverage choices. The disclosure requirements apply to insured and self-insured group health plans (e.g., employer and union-sponsored plans) and to health insurance issuers of group and individual coverage.

Also on August 22, 2011, the Departments published in the *Federal Register* a solicitation of comments for **Templates, Instructions and Related Materials under the Public Health Service Act**. The templates and instructions are intended to be used in making the disclosures required by the proposed rule.

Comments on both the proposed rule and the solicitation of comments are due on or before October 21, 2011.

A detailed summary of the proposed rule follows. Included as an attachment is a summary of the solicitation of comments on the Templates, instructions and related materials. **Bold font** indicates where the Departments have explicitly asked for public comment (although all aspects of the proposed rule, templates, instructions and related materials are open for comment).

¹ The Affordable Care Act refers to the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

OVERVIEW OF THE PROPOSED REGULATIONS

The proposed regulations would be codified as follows:

- 26 CFR Part 54 (Treasury)
- 29 CFR Part 2590 (Labor)
- 45 CFR Part 147 (Health and Human Services)

A. Summary of Benefits and Coverage (SBC)

1. In General

Under section 2715 of the Public Health Service (PHS) Act, added by the Affordable Care Act (ACA), the Departments are required to develop standards for use by a group health plan and a health insurance issuer in compiling and providing a Summary of Benefits and Coverage (SBC) that “accurately describes the benefits and coverage under the applicable plan or coverage.” To do this, the Departments are directed to consult with: the National Association of Insurance Commissioners (NAIC); a working group composed of representatives of specified stakeholders; and other qualified individuals.

The consultative process in developing these proposed regulations is described in this section of the preamble. The NAIC convened a working group comprised of a “diverse group of stakeholders,” which met frequently over the course of a year, seeking input from other interested parties. The working group’s draft documents were posted on the NAIC’s Web site for public review. The entire NAIC voted on and approved the working group’s recommended template for the SBC with instructions and samples to be used in completing the template as well as a recommended uniform glossary of insurance terms. These were then transmitted to the implementing Departments for their consideration. The Departments have proposed regulations that largely adopt the NAIC’s recommendations.

The regulations propose standards for group health plans (and their administrators) and health insurance issuers offering group or individual health insurance coverage that will govern who provides an SBC, who receives it, when it will be provided and how it will be provided. The accompanying template for the SBC and proposed uniform glossary are identical to those recommended by the NAIC (with the exception of one sample coverage example). The Departments say that changes to the SBC template “may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals or to improve the efficacy of the disclosures recommended by the NAIC.” Changes may also be needed because the NAIC’s documents were drafted primarily for use by health insurance issuers, whereas the requirements will apply to both issuers and group plan sponsors. *(Note that commenters may want to address concerns or questions in response to both this proposed regulation and the accompanying solicitation of comments on the templates, instructions and related materials.)*

The Departments note stakeholder concerns about potential redundancies and additional costs for those group plans and issuers that already provide a Summary Plan Description (SPD) (required

under ERISA regulations) when they must also provide a SBC. **Comments are invited on whether the SBC should be allowed to be provided within an SPD if the SBC is intact and prominently displayed at the beginning of the SPD and if the timing requirements for providing the SBC in the proposed regulations (described below) are satisfied. Comments also are invited on ways the SBC might be coordinated with other group health plan disclosure materials (e.g., application and open season materials) to communicate effectively with participants and beneficiaries to make it easy for them to compare coverage options while avoiding adding undue costs and burden on plans and issuers.** The Departments note that the proposed rules and accompanying solicitation for comment are guided by the overriding goals of balancing effective communication and ease of comparison for individuals with minimization of cost and duplication.

Effective Dates. PHS Act section 2715 directs group health plans and health insurance issuers to comply with the SBC requirements beginning on or after March 23, 2012. **Comments are requested regarding the factors that may affect the feasibility of implementation within this timeframe.** After the public comment period, the Departments will finalize the SBC template and instructions. Also, the Departments will periodically review and update the documents as appropriate, taking into account public comment.

2. Providing the SBC

Following the statute, the proposed rule would require that an SBC be provided by both group health plans and health insurance issuers offering group or individual health insurance coverage. A plan administrator of a group plan would be responsible for providing an SBC. The SBC has to be provided to the individual in writing free of charge.

Generally, the SBC has to be provided when a plan or individual is comparing health coverage options (when the coverage is offered and when a policy is issued). If the information in the SBC changes between the time of the person or plan's application and when a policy is issued (often the case only for individual market coverage), an updated SBC has to be provided. If the information remains unchanged, the SBC does not need to be provided again, except upon request.

a. Provision of the SBC Automatically by an Issuer to a Plan

It is proposed that an issuer offering group coverage provide the SBC to a group health plan (including its sponsor) upon an application or request for information by the plan about the coverage. The SBC must be provided as soon as practicable following the request, but in no event later than seven days following the request. If an SBC was provided upon request and the plan subsequently applies for health coverage, a second SBC must be provided automatically only if the information in the SBC has changed. If there is a change to the information in the SBC before the coverage is offered, or before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the date of the offer (or no later than the first day of coverage, as applicable). The Departments note that often, the only change to the SBC is a final premium quote (usually in the individual market or the small group market). **The Departments request comments on whether, in such circumstances, premium information**

can be provided in another way that is easily understandable and useful to plan sponsors and individuals, other than by sending a new, full SBC.

An issuer is required to provide a new SBC if and when the policy, certificate, or contract (referred to collectively hereafter as a “policy”) is renewed or reissued. If the issuer requires written application materials for renewal (in either paper or electronic form), it has to provide the SBC no later than the date the materials are distributed. If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year.

b. Provision of the SBC Automatically by a Plan or Issuer to Participants and Beneficiaries

A group health plan (including the plan administrator), and an issuer offering group coverage, is required to provide an SBC to a participant or beneficiary² with respect to each benefit package offered for which the participant or beneficiary is eligible. (In the case of an insured group health plan, if either the issuer or the plan provides the SBC, both have satisfied their obligations. Plans and issuers are expected to make contractual arrangements for sending SBCs.) The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan does not distribute such materials, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries. If there is any change to the information required to be in the SBC before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

The plan or issuer must provide the SBC to special enrollees within seven days of a request for enrollment pursuant to a special enrollment period. Additionally, the plan or issuer must provide a new SBC if and when the coverage is renewed. Specifically, if written application materials are required for renewal (in either paper or electronic form), the SBC must be provided no later than the date the materials are distributed. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of coverage in the new plan year.

c. Provision of the SBC Upon Request

It is proposed that an issuer offering group coverage be required to provide the SBC to a group health plan (and a plan or issuer must provide the SBC to a participant or beneficiary) upon request, as soon as practicable, but no later than seven days following the request. This is not statutory but the Departments believe that they have the authority under section PHS Act 2715(a) to provide for this requirement. The information in the SBC may be needed by plans and individuals at times other than those set forth in the statute to ensure continuous access to coverage and cost information that will enable them to make informed coverage choices. More administrative work for plans and issuers resulting from this requirement should be reduced by

² Under ERISA, a participant is defined as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.” A beneficiary is defined as “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.”

the special rules for avoiding duplication that are described next. In addition, such burden may be reduced by use of electronic transmittal of the SBC, where appropriate.

d. Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage

Three rules are proposed to streamline the provision of the SBC and prevent unnecessary duplication with respect to group health plan coverage:

1. The requirement to provide an SBC is satisfied for all entities if the SBC is provided by any entity, so long as all timing and content requirements are also satisfied. Thus, for example, if an issuer offering group coverage provides a complete, timely SBC to the plan's participants and beneficiaries, the plan's requirement to provide the SBC will be satisfied.
2. If a participant and any beneficiaries are known to reside at the same address, providing a single SBC to that address will satisfy the obligation to provide the SBC for all individuals residing at that address. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC must be provided to the beneficiary at the beneficiary's last known address.
3. With respect to a group plan that offers multiple benefit packages, in connection with renewal, the plan and issuer only need to automatically provide a new SBC with respect to the benefit package in which a participant or beneficiary is enrolled. SBCs are not required to be provided automatically with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package for which the participant or beneficiary is eligible, the SBC must be provided as soon as practicable, but in no event later than seven days following the request.

e. Provision of the SBC by an Issuer Offering Individual Market Coverage

The regulations for individual coverage are similar to those for group coverage with certain changes necessary to reflect the differences between the two markets (e.g., individual policyholders and dependents in the individual market are comparable to group health plan participants and beneficiaries). Accordingly:

1. An issuer offering individual coverage must provide an SBC as soon as practicable after receiving a request for application or a request for information, but in no event later than seven days after receipt of the request.
2. If an individual later applies for the same policy, a second SBC is required to be provided only if the information in the SBC has changed.
3. An issuer that makes an offer of coverage must provide an updated SBC only if it has modified the terms of coverage for the individual (including as a result of medical underwriting) that are required to be reflected in the SBC.
4. When an individual accepts the offer of coverage, if any terms are modified before the first day of coverage, an updated SBC must again be provided no later than the first day of coverage.
5. An issuer will provide an SBC annually at renewal, no later than 30 days before the start of the new policy year, reflecting any changes effective for the new policy year.

6. For coverage that covers more than one individual (or an application for coverage that is being made for more than one individual), if all those individuals are known to reside at the same address, a single SBC may be provided to that address. If an individual's last known address is different than the last known address of the individual requesting coverage, the policyholder, or a dependent of either, a separate SBC must be provided to that individual at the individual's last known address.

3. Content of the SBC

PHS Act section 2715(b)(3) requires that the SBC include the following content:

1. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
2. A description of the coverage, including cost sharing, for each category of benefits identified by the Departments;
3. The exceptions, reductions, and limitations on coverage;
4. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
5. The renewability and continuation of coverage provisions;
6. A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines;
7. A statement about whether the plan provides *minimum essential coverage* as defined under section 5000A(f) of the Code (added by the ACA), and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;
8. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage; and
9. A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

The Departments observe that the regulations that they have proposed generally parallel the content elements in the statute and reference the separate *Federal Register* solicitation of comments on the SBC template and instructions to satisfy the SBC content and appearance requirements of the statute. The templates and instructions are those recommended by the NAIC. However, the NAIC template includes four elements that are not specified in the statute:

1. For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of the network providers;
2. For plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage;
3. An Internet address where an individual may review and obtain the uniform glossary; and

4. Premiums (or cost of coverage for self-insured group health plans).

The Departments believe that inclusion of these NAIC-specified elements in the regulation is warranted to accurately describe the content of coverage. **Comment is invited on the Departments' approach (adoption in full of the NAIC's recommended template and instructions) and the four additional SBC content elements. Should, for example, there be a requirement that the SBC also disclose the option to receive a paper copy of the uniform glossary upon request?**

The NAIC instructions provide that the premium generally is the premium as charged by the issuer (which may be evidenced in a rate table attached to the SBC), or the cost of coverage in the case of self-insured plans. The template further instructs that in the case of a group health plan, a participant or beneficiary should consult the employer for information regarding the actual cost of coverage net of any employer subsidy. This complicates comparisons of premium or cost information between coverage options. **Comment is requested on whether the SBC should include premium or cost information and, if so, how best to display premiums or the cost of coverage in the case of self-insured plans to accomplish comparability.**

Glossary of definitions. The NAIC working group adopted a two-part approach to the definitions. First, it drafted a consumer-friendly uniform glossary, which includes definitions of health coverage terminology, to be provided in connection with the SBC. As discussed below, the Uniform Glossary is adopted in these proposed regulations. The NAIC working group and the Departments believe, however, that these generic glossary definitions, alone, are insufficient to help consumers understand what terms mean under a given plan or policy or to support meaningful comparison of coverage options. This is because the terms are not plan- or policy-specific and would not enable consumers to understand what the terms actually mean in the context of a specific contract. Therefore, in addition to the uniform glossary, the NAIC working group developed and the Departments have adopted a “*Why this Matters*” column for the draft SBC template (with instructions for plans and issuers to use in completing the SBC template). The instructions specify how plans and issuers must describe each coverage component in the SBC.

Minimum essential coverage. Because this content is not relevant until other elements of the ACA are implemented (beginning in 2014), these proposed regulations provide that the minimum essential coverage statement is not required to be in the SBC until the plan or coverage is required to provide an SBC with respect to coverage beginning on or after January 1, 2014.

Starting in 2014, certain individuals who purchase health insurance coverage through the new Affordable Insurance Exchanges may be eligible for a premium tax credit to help pay for the cost of that coverage. In general, individuals offered affordable minimum essential coverage under an employer-sponsored plan will not be eligible to receive a premium tax credit. The Departments advise that they are exploring several reporting options under the ACA and other applicable statutory authorities to determine how information about employer-provided coverage can be provided and verified in a manner that limits the burden on individuals, employers, and Exchanges. **Because the statutory SBC elements include the information in the minimum essential coverage statement, the Departments invite comments on how employers might**

provide this information to employees and the Exchanges in a manner that minimizes duplication and burden.³

Coverage Facts (Coverage Examples) Label. Under the proposed regulations, the coverage examples illustrate benefits provided under the plan or coverage for common benefits scenarios, including pregnancy and serious or chronic medical conditions. An example would estimate what proportion of expenses under an illustrative benefits scenario might be covered by a given plan or policy. Consumers then could use this information to compare their share of the costs of care under different plan or coverage options to make an informed purchasing decision.

Consistent with the NAIC's recommendations, the proposed regulation states that a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines available through the National Guideline Clearinghouse. The scenario would include the information needed to simulate how claims would be processed under the scenario to generate an estimate of cost sharing a consumer could expect to pay under the benefit package. The document published contemporaneously with these proposed regulations includes specific instructions necessary to simulate benefits covered under the plan or policy for specified benefits scenarios. An Excel spreadsheet is also provided for issuers' calculations.⁴ **The Departments note that the coding and reimbursement rate assumptions were developed by HHS and are open for public comment.**

The Departments propose to identify up to six coverage examples that may be required in an SBC but are starting with three coverage examples recommended by NAIC for inclusion: having a baby (normal delivery), treating breast cancer, and managing diabetes. (Six is considered the most that consumers may easily read, understand, and compare how benefits are provided for different common medical conditions, and the most that can fit within the prescribed page limitations for the SBC.) The template published contemporaneously with these proposed regulations adopts a phase-in approach to the coverage examples.

The Departments invite comments on:

- The proposed coverage examples;
- Whether additional benefits scenarios would be helpful and, if so, what those examples should be;
- The benefits and costs associated with developing multiple coverage examples; and
- How multiple coverage examples might promote or hinder the ability to understand and compare terms of coverage.

³“The Departments note that some of the plan level information required for the SBC is also required to be provided under section 6056 of the IRC (requiring employers to report to the IRS specific information related to employer-sponsored health coverage provided to employees). They are coordinating their efforts to determine how and whether the same data can be used for multiple purposes. The Treasury Department and the IRS intend to request comments on employer information reporting required under section 6056 of the IRC.

⁴ www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_template_blank.xls

The Departments anticipate that any additional coverage examples would only be required to be provided prospectively, and that plans and issuers would be provided with adequate time for compliance.

Comments are invited on whether and how to phase in the implementation of the requirement to provide coverage examples. For instance, one option would be to provide that in 2012, coverage examples would only need to be provided for the SBCs with respect to a subset of all benefits packages offered by group health plans or health insurance issuers, with coverage examples required to be provided for all benefits packages in later years.

Comments are also requested on whether it would be feasible or desirable to permit plans and issuers to input plan- or policy-specific information into a central Internet portal, such as the Federal health care reform website (www.healthcare.gov) that would use the information to generate the coverage examples for each plan or policy. The examples would then be available on the Internet portal for access by individuals. Alternatively, plans and issuers might provide individuals, in a convenient format in the SBC, the several items of plan- or policy-specific information necessary to generate the coverage examples and a reference to the Internet portal, so that individuals can input the information into the Internet portal to generate the coverage examples for the plan or policy. **The Departments solicit comments on the cost and benefits of these alternatives, including whether such approaches would provide an efficient and effective method for individuals, plans, and issuers to generate or access the coverage examples and how any such approaches could adequately serve individuals who do not have regular access to the Internet** (for example, by disclosing in the SBC the option to obtain paper copies of coverage examples generated by the plan or issuer).

4. Appearance of the SBC

Section 2715 of the PHS Act provides that the SBC be presented in a uniform format, utilizing terminology understandable by the average plan enrollee, not exceed four pages in length, and not include print smaller than 12-point font. The proposed regulations, consistent with the NAIC recommendation, interpret the four-page limitation as four double-sided pages, considered the appropriate length and format to enable group plans, participants and beneficiaries, and individuals in the individual insurance market to receive enough information to shop for, compare, and make informed decisions regarding various coverage options that may be available to them. **The Departments seek comments on these policies.**

The SBC must be provided as a stand-alone document in the form authorized by the Departments and completed in accordance with the instructions and guidance for completing the SBC that are authorized by the Departments. **Comments are invited on whether and how the SBC might best be coordinated with the SPD and other group health plan disclosure materials** (see also the discussion in A.1 above)

5. Form and Manner

a. Group Health Plan Coverage

Rules are proposed to facilitate electronic transmittal of the SBC, where appropriate. An SBC provided by a plan or issuer to a participant or beneficiary may be provided in paper form. For plans and issuers subject to ERISA or the Internal Revenue Code (IRC), it may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor are met.⁵

For non-Federal governmental plans, the SBC may be provided electronically if either the substance of the provisions of the Department of Labor's electronic disclosure rule are met or if the provisions governing electronic disclosure in the individual insurance market (described below) are met.

With respect to an SBC provided by an issuer to a plan, the SBC may be provided in paper form or electronically (such as e-mail transmittal or an Internet posting on the issuer's website or on www.healthcare.gov). For electronic forms, the format must be readily accessible by the plan; the SBC must be provided in paper form free of charge upon request; and for Internet postings, the plan must be notified by paper or e-mail that the documents are available on the Internet, and given the web address.

The Departments invite comments on whether any clarifications are needed with respect to the “readily accessible” standard (e.g., whether the requirements for passwords or special software create a sufficient burden that the documents are not “readily accessible”). **The Departments also invite comment on whether modifications or adaptations of the SBC are needed to facilitate or improve electronic disclosure.**

b. Individual health insurance coverage

Unless specified otherwise by an individual, an issuer would be required to provide an SBC (and any subsequent SBC) in paper form if, upon the individual's request for information or request for an application, the individual makes the request in person, by phone or by fax, or by U.S. mail or courier service; or if, when submitting an application, the individual completes the application for coverage by hand, by phone or by fax, or by U.S. mail or courier service. **As an alternative, the Departments seek comments on whether it might be appropriate to allow issuers to fulfill an individual's request in electronic form, unless the individual requests a paper form.** An issuer may provide an SBC (and any subsequent SBC) in electronic form (such as through an Internet posting or via electronic mail) if an individual requests information or requests an application for coverage electronically; or, if an individual submits an application for coverage electronically.

To ensure actual receipt of an SBC provided in electronic form, certain safeguards are proposed for electronic disclosure in the individual market. An issuer that provides the SBC electronically must:

- Request that an individual acknowledge receipt of the SBC;
- Make the SBC available in an electronic format that is readily usable by the general public;

⁵ See 29 CFR 2520.104b-1(c).

- If the SBC is posted on the Internet, display the SBC in a location that is prominent and readily accessible to the individual and provide timely notice, in electronic or non-electronic form, to each individual who requests information about, or an application for, coverage, that apprises the individual the SBC is available on the Internet and includes the applicable Internet address;
- Promptly provide a paper copy of the SBC upon request without charge, penalty, or the imposition of any other condition or consequence, and provide the individual with the ability to request a paper copy of the SBC both by using the issuer's Web site (such as by clicking on a clearly identified box to make the request) and by calling a readily available telephone line, the number for which is prominently displayed on the issuer's Web site, policy documents, and other marketing materials related to the policy and clearly identified as to purpose; and
- Ensure an SBC provided in electronic form is provided in accordance with the appearance, content, and language requirements of this section.

The Departments welcome comments as to whether these or other safeguards are appropriate.

To reduce the burden of providing an SBC to individuals who are shopping for coverage, the Departments propose that an issuer that complies with the requirements set forth in the interim final rule implementing the Health Care Reform Insurance Web Portal⁶ for reporting to the Portal would be deemed to comply with the requirement to provide the SBC to an individual requesting information about coverage prior to submitting an application. Any SBC furnished at the time of application or subsequently, however, would be required to be provided in a form and manner consistent with the rules described above.

6. Language

Consistent with the ACA requirement under PHS Act section 2715 (b)(2) that federal standards ensure that the SBC “is presented in a culturally and linguistically appropriate manner,” the plan or issuer would be required to follow the rules for providing appeals notices in a culturally and linguistically appropriate manner.⁷ These rules state that in specified counties of the U.S., plans and issuers must provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages. In addition, in such counties, English versions of the SBC must disclose the availability of language services in the relevant language. The counties in which this must be done are those in which at least ten percent of the population residing in the county is literate only in the same non-English language, as determined in guidance. **The Departments welcome comments on whether and how to provide written translations of the SBC in these non-English languages.**

⁶ See 45 CFR 159.120 (75 FR 24470).

⁷ See 75 FR 43330 (July 23, 2010) and as amended by 76 FR 37298 (June 24, 2011).

To ensure non-discrimination on the basis of national origin, recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons.⁸

B. Notice of Modifications

Under the statute, a group health plan or issuer offering group or individual health insurance coverage must provide notice of a material modification if it makes a material modification (as defined under ERISA) in any of the terms of the plan or coverage involved that is not reflected in the most recently provided SBC. The proposed regulations interpret the statutory reference to the SBC to mean that only a material modification affecting the content of the SBC would require plans and issuers to provide this notice. In these circumstances, the notice must be provided to enrollees/ policyholders no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided and occurs other than in connection with a renewal or reissuance of coverage.⁹

The statute and these proposed regulations establish the timeframes for when a notice of material modification must be provided in situations other than upon renewal at the end of a plan or policy year when a new SBC is provided under the rules described above. If a plan or policy implements a midyear change that is a material modification that affects the content of the SBC, and that occurs other than in connection with a renewal or reissuance of coverage, a notice of the modification would have to be provided 60 days in advance of the effective date of the change. This notice could be satisfied either by a separate notice describing the material modification or by providing an updated SBC reflecting the modification. **The Departments invite comments on this expedited notice requirement, including whether there are any circumstances where 60-day advance notice might be difficult. The Departments also solicit comments on the format of the notice of modification, particularly for plans and issuers not subject to ERISA.**

C. Uniform Glossary

The ACA directs the Departments to develop standards for definitions for certain insurance-related terms (e.g., co-insurance, copayment, deductible, excluded services, grievance and appeals, etc.). Standards for definitions are also required for certain medical terms (e.g., durable medical equipment, emergency medical transportation, emergency room care, physician services, etc.), and for such other terms that will help consumers understand and compare the terms of coverage and the extent of medical benefits (including any exceptions and limitations).

⁸ More information is at: Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” available at www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

⁹ A material modification, within the meaning of section 102 of ERISA, includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other terms of coverage under the plan or policy. A material modification may be an enhancement or a reduction in covered services or benefits or more stringent requirements for receipt of benefits.

The NAIC working group recommended and the Departments are proposing to adopt for this purpose, inclusion of additional terms in the uniform glossary (e.g., allowed amount, balance billing, complications of pregnancy, emergency medical condition, etc.) The uniform glossary proposed by the Departments is included in the solicitation of comments of the Template and additional materials published concurrently with this proposed regulation.

Comments are invited on the uniform glossary, including the content of the definitions and whether additional terms should be included in the uniform glossary so that individuals and employers may understand and compare the terms of coverage and the extent of medical benefits (or exceptions to those benefits). It is anticipated that any additional terms would be included in the uniform glossary prospectively, and that plans and issuers would be provided adequate time for compliance.

The proposed regulations direct a plan or issuer to make the uniform glossary available upon request within seven days. A plan or issuer may satisfy this requirement by providing an Internet address where an individual may review and obtain the uniform glossary. This Internet address may be a place the document can be found on the plan's or issuer's website. It may also be a place the document can be found on the website of either the Department of Labor or HHS. However, a plan or issuer must make a paper copy of the glossary available upon request. Group health plans and health insurance issuers will have to provide the uniform glossary in the appearance authorized by the Departments, so that the glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee or individual covered under an individual policy.

D. Preemption

The Departments are proposing to implement the applicable preemption provisions of the ACA to provide that State laws that impose on issuers requirements that are stricter than those imposed by the ACA are not superseded by the Act. States may therefore impose separate, additional disclosure requirements on health insurance issuers. (State laws that provide less information than that required under the applicable provisions of the ACA are preempted.) The Departments note the need to balance States' interest in information disclosure regarding insurance coverage with the primary objective of PHS Act section 2715 (as stated in the section title) of providing for the development and use of a short, uniform explanation of coverage document so that consumers may make apples-to-apples comparisons of plan and coverage options.

E. Failure to Provide

Under the statute (2715(f) of the PHS Act as added by the ACA), a group health plan (including its administrator), and an issuer offering group or individual health insurance coverage, that "willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure." In addition, a separate fine may be imposed for each individual or entity for whom there is a failure to provide an SBC. Due to the different enforcement jurisdictions of the Departments, as well as their different underlying enforcement structures, the mechanisms for imposing the new penalty "vary slightly."

1. Department of HHS

Application of the relevant enforcement provisions of the ACA results in providing a State with the discretion to enforce its provisions against health insurance issuers in the first instance, and the Secretary of HHS only enforces a provision after she determines that a State has failed to substantially enforce the provision. If a State enforces a provision such as PHS Act section 2715, it uses its own enforcement mechanisms. If the Secretary enforces, the statute provides for penalties of up to \$100 per day for each affected individual.

Under the statute, an entity that willfully fails to provide the required information is subject to a fine of not more than \$1,000 for each such failure. A failure with respect to each enrollee constitutes a separate offense. This penalty can only be imposed by the Secretary. States have primary enforcement authority over issuers for any violations, whether willful or not, using their own remedies. However, the proposed rules clarify that the Secretary has authority to impose penalties for willful violations regardless of State enforcement. The Department notes that the Secretary intends to use enforcement discretion if the Secretary determines that the State is adequately addressing willful violations.

The Secretary of HHS has direct enforcement authority for violations by non-Federal governmental plans. The preamble states that she will use the appropriate penalty for violations of section 2715, depending on whether the violation is willful.

2. Departments of Labor and the Treasury

The Department of Labor enforces the requirements of part 7 of ERISA and Treasury enforces the requirements of chapter 100 of the IRC with respect to group health plans maintained by an entity that is not a governmental entity.¹⁰ A prior memorandum of understanding between the Departments of Labor and Treasury designed to coordinate enforcement and avoid duplication of effort for shared jurisdiction will apply in implementing section 2715.

a. Department of Labor

The Department of Labor will issue separate regulations in the future describing the procedures for assessment of the civil fine provided under PHS Act section 2715(f) as incorporated by section 715 of ERISA. This fine cannot be assessed against a health insurance issuer.

b. Department of the Treasury

If a group health plan (other than a plan maintained by a governmental entity) fails to comply with the applicable requirements (chapter 100 of the IRC), an excise tax is imposed, generally \$100 per day per individual for each day that the plan fails to comply with chapter 100 with respect to that individual. Rules under section 4980D of the IRC reduce the amount of the excise tax for failures due to reasonable cause and not to willful neglect. Special rules apply for church plans. Section 2715(f) of the PHS Act subjects a plan sponsor or designated administrator to a

¹⁰ The one exception is that the Department of Labor does not enforce the ERISA requirements with respect to church plans.

fine of not more than \$1,000 for each failure to provide an SBC. Specific proposed rules for reporting such fines are established.

F. Applicability

The statute provides that the SBC requirement applies not later than 24 months after the date of enactment (*i.e.*, beginning on or after March 23, 2012). The SBC requirement is applicable to both grandfathered and non-grandfathered health plans. The NAIC transmitted its final materials to the Departments on July 29, 2011. In recognition of existing disclosure requirements under ERISA regulations for those group health plans that already provide SPDs to participants and concerns raised about providing SBCs by the statutory deadline, **comments are solicited on whether and, if so, how practical considerations might affect the timing of implementation.** In coordination with the request for comment elsewhere in the preamble on a potential phase-in of the implementation of the requirement to provide coverage examples, **comments are invited also on how any such phase-in could or should be coordinated with the timing of the effectiveness of the general SBC standards. The Departments also request comments on whether any special rules are necessary to accommodate expatriate plans.**¹¹

III. ECONOMIC IMPACT AND PAPERWORK BURDEN

A. Executive Orders 12866 and 13563 – Departments of Labor and HHS

These Executive Orders direct federal agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. This rule has been designated a “significant regulatory action” and has been reviewed by the Office of Management and Budget.

A regulatory impact analysis of these proposed regulations has found that they would not have economic impacts of \$100 million or more in any one year or otherwise meet the definition of an “economically significant rule” under Executive Order 12866. Nonetheless, consistent with Executive Orders 12866 and 13563, the Departments have provided an assessment of the potential benefits and the costs associated with this proposed regulation. **The Departments invite comment on this assessment.**

1. Current Regulatory Framework

Health plan sponsors and issuers do not currently uniformly disclose information to consumers about benefits and coverage in a simple and consistent way. The SPDs required under ERISA for private sector group health plans have increased in size and complexity and are not standardized. Also, ERISA’s requirements do not extend to all group health plans. For example, governmental

¹¹ The Departments note that, in the context of group health plan coverage, section 4(b)(4) of ERISA provides that a plan maintained outside the U.S. primarily for the benefit of persons substantially all of whom are nonresident aliens is exempt from ERISA title I, including ERISA section 715. At the same time, in the Department of HHS’s interim final regulations relating to medical loss ratio (MLR) provisions published at 75 FR 74864, a special rule was included for expatriate insurance policies. The Departments invite comments on whether any adjustments are needed under PHS Act section 2715 for expatriate plans and, if so, for what types of coverage.

plans, including those offered by federal, state and local governmental employers are not subject to ERISA. In the individual market, issuers are subject to various and diverse laws and few states have established minimum standards for disclosure of insurance information. In some states with minimum disclosure laws, the laws apply only with respect to current enrollees so that individuals shopping for coverage do not receive information about insurance options.

2. Need for Regulatory Action

Congress added new PHS Act section 2715 through the ACA to ensure that plans and issuers provide benefits and coverage information in a more uniform format that helps consumers to better understand their coverage and better compare coverage options. These proposed regulations are necessary to provide standards for a summary of benefits and coverage and a uniform glossary of terms used in health coverage. This approach is consistent with Executive Order 13563, which directs agencies to “identify and consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public. These approaches include [...] disclosure requirements as well as provision of information to the public in a form that is clear and intelligible.”

The Departments note that the ways in which the current “patchwork” of consumer disclosure requirements “makes the process of shopping for coverage an inefficient, difficult, and time-consuming task,” and illustrates the problems that consumers encounter, both because of lack of comparable information and the lack of understanding of how insurance works. As a result, consumers and employers may not always make informed purchasing decisions that best meet their health and financial needs or those of their employees. In addition, insurers and employers “may face less pressure to compete on price, benefit and quality, leading to inefficiency in the health insurance and labor markets.”

3. Summary of Impacts

This section provides an accounting statement summarizing the Departments’ assessment of potential benefits, costs, and transfers associated with this regulatory action for the period 2011–2013. Estimates are not provided for subsequent years. The Departments explain that this is because significant changes will occur “in the marketplace in 2014 related to the offering of new individual and small group plans through the Affordable Insurance Exchanges, and the wide-ranging scope of these changes makes it difficult to project results for 2014 and beyond.” The Departments conclude that the benefits, in terms of improving the ability of consumers to make better coverage decisions, justify the expected costs, estimated to be about \$50 million each year. (This estimate is uncertain due to data limitations and uncertain economies of scale that exist for disclosing this information.)

4. Benefits

The Departments assess the potential effects of the proposed regulations, including costs, benefits, and transfers. Data limitations preclude the quantification of expected benefits. Nonetheless, the Departments identify several benefits:

- Consumers will make better coverage decisions, which more closely match their preferences with respect to benefit design, level of financial protection, and cost. The Departments believe that such improvements will result in a more efficient, competitive market.
- By ensuring consumers have access to readily available, concise, and understandable information about their coverage options, these proposed regulations could reduce consumers' cost of obtaining information and may increase health insurance purchase rates.
- Greater transparency in pricing and benefits information will allow consumers to make more informed purchasing decisions, resulting in cost-savings for some value-conscious consumers who today pay higher premiums because of imperfect information about benefits. Consumers will thus be able to derive higher value from their coverage.
- It will be easier for consumers to understand their coverage and they will therefore be better able to use the coverage they have. Additionally, the uniform format will make it easier for consumers who change jobs or insurance coverage to see how their new plan or coverage benefits are similar to and different from their previous coverage.

5. Costs

The Departments provide their estimates of the costs to plans and issuers associated with these regulations to implement the SBC requirements (that include coverage examples (CEs)) and a uniform glossary of health coverage and medical terms). The Departments have attempted to quantify onetime start-up costs as well as maintenance costs and estimate that issuers and third party administrators will incur approximately \$25 million in costs in 2011, \$73 million in costs in 2012, and \$58 million in costs in 2013. Assumptions about the number of affected entities, staffing and labor costs are identified. Also factored into the estimates are assumptions about changes needed in information technology systems and workflow processes. Finally, the Departments factor in assumptions regarding the distribution of the SBC disclosures to individuals. Tables are provided on pages 52457 and 52458 of the August 22nd *Federal Register* displaying the hour burden, equivalent cost and cost burden estimates as well as the estimates related to staffing the processes needed to comply with the regulations.

6. Regulatory Alternatives

The Departments note the different policy choices considered in developing the rules to implement the SBC and related requirements. The first policy choice involved determining how to minimize the burden of providing the SBC to individuals and employers shopping for health insurance coverage. Since issuers may find it difficult to provide accurate information about the terms of coverage prior to underwriting, the Departments have proposed that if issuers make information for their standard policies available on the Secretary of HHS's Web portal (HealthCare.gov), the issuers will have satisfied the requirement to provide an SBC to individuals who request information about coverage. The Departments believe this approach promotes regulatory efficiency, minimizing the administrative burden on health insurance issuers without lessening the protections under PHS Act section 2715.

A second policy choice relates to whether, in the case of covered individuals residing at the same address, one SBC would satisfy the disclosure requirement with respect to all such individuals, or whether multiple SBCs would be required to be provided. In these proposed regulations, the Departments have chosen to allow a plan or issuer to provide a single SBC in circumstances in which a participant and any beneficiaries (or, in the individual market, the primary subscriber and any covered dependents) are known to reside at the same address. In the group market, the proposed regulations would further limit burden by requiring a plan or issuer to provide, at renewal, a new SBC for only the benefit package in which a participant or beneficiary is enrolled. Participants and beneficiaries would be able to receive upon request an SBC for any benefits package for which they are eligible.

A third policy choice relates to the interpretation of the ACA's provision that requires notice of any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC (PHS Act section 2715(d)(4)). To minimize burden, the proposed regulations would interpret this provision as requiring notice only for a material modification that (1) affects the information in the SBC; and (2) occurs other than in connection with renewal or reissuance of coverage (that is, a mid-plan or –policy year change).

B. Regulatory Flexibility Act—Departments of Labor and Health and Human Services

Under the Regulatory Flexibility Act (RFA), agencies that issue a regulation are required to analyze options for regulatory relief of small businesses if a proposed rule has a significant impact on a substantial number of small entities.¹² The Departments describe in detail their analysis of potential impact on small issuers and third party administrators and conclude that the proposed rules will not have a significant economic impact on a substantial number of small entities and that a regulatory flexibility analysis is not required.

C. Special Analyses-Department of the Treasury

For purposes of the Department of the Treasury, it has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866 and that a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these proposed regulations. The conclusion is that the collections of information contained in this notice of proposed rulemaking will not have a significant impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

D. Unfunded Mandates Reform Act—Departments of Labor and Health and Human Services

The Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any proposed rule that includes a Federal mandate that could

¹² The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of “small entity.”)

result in expenditure in any one year by State, local or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars updated annually for inflation (\$136 million in 2011). The Departments have tentatively determined that these proposed regulations do not impose an unfunded mandate on State, local or Tribal governments or the private sector. They conclude that, “Regardless, consistent with policy embodied in UMRA, this notice of proposed rulemaking has been designed to be the least burdensome alternative for State, local and Tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.”

E. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

To implement the relevant SBC and related provisions of the ACA, certain information collection requirements will result:

- Summary of benefits and coverage.
- Coverage examples (as components of each SBC).
- A uniform glossary of health coverage and medical terms (uniform glossary).
- Notice of modifications.

The Departments are soliciting public comments for 60 days concerning these disclosures and have also submitted these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. **The Departments and OMB are particularly interested in comments that:**

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency’s estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Information on submission of comments is provided on p. 52460 of the August 22nd *Federal Register*.

The Departments’ analysis of paperwork burden on respondents (private sector issuers, third party administrators, non-Federal governmental plans), categorized in terms of size of entity, is described. Burden estimates are presented for 2011, 2012 and 2013 in terms of the tasks that each entity has to perform in each year (e.g., SBC, Coverage Examples, Notices of Modifications, etc.).

F. Federalism Statement – Departments of Labor and Health and Human Services

Under Executive Order 13132, federal agencies are required to adhere to specific criteria in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. The Executive Order also requires the federal agencies to consult with state and local officials and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble of the regulation.

In the Departments’ view, these proposed rules have federalism implications. Background on the interaction between section 514 of ERISA and the applicable provisions of the ACA is provided. The major conclusion of this analysis is that “states may continue to apply state law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law. However, under these proposed rules, a State would not be allowed to impose a requirement that modifies the summary of benefits and coverage required to be provided under PHS Act section 2715(a), because it would prevent the application of this proposed rule’s uniform disclosure requirement.”

The Departments report that they have engaged in efforts to consult with and work cooperatively with the states (and the NAIC) and that they expect to act in a similar fashion in enforcing the ACA, including the provisions of section 2715 of the PHS Act. They have, throughout the process, attempted to balance the states’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every state. By doing so, it is the Departments’ view that they have complied with the requirements of Executive Order 13132.

Summary of Benefits and Coverage and Uniform Glossary— Templates, Instructions, and Related Materials under the Public Health Service Act

Summary
August 29, 2011

I. INTRODUCTION

On August 22, 2011, the Departments of Health and Human Services, Labor and Treasury published in the *Federal Register* a **solicitation of comments** on a proposed template for a Summary of Benefits and Coverage (SBC); instructions, sample language, and a uniform glossary that would satisfy the disclosure requirements under section 2715 of the PHS Act as added by the Affordable Care Act (ACA). As noted above, the solicitation was published concurrently with a proposed rule to implement the related requirements on health insurance issuers and group health plans to provide a Summary of Benefits and Coverage and a Uniform Glossary. **Comments are due on the Templates, Instructions and Related Materials on or before October 21, 2011.**

Much of the introductory parts of the preamble for the solicitation of comments repeat material presented in the proposed rule. The process of consultation with the National Association of Insurance Commissioners (NAIC) is described and it is noted that the NAIC working group recommended use of a uniform SBC template, as well as a uniform glossary, for the individual and group insurance markets. The Departments relate that in developing these recommendations, the NAIC's draft SBC template, including the coverage examples, and the draft uniform glossary underwent consumer testing, sponsored by both consumer and insurance industry groups to ensure that that the final products would be consumer friendly.

The Departments have received transmittals from the NAIC that include a recommended template for the SBC with instructions, samples, and a guide for coverage examples calculations to be used in completing the SBC template. The NAIC transmittals also included a recommended uniform glossary of coverage and medical terms (referred to in this document as the "uniform glossary").

Like the proposed regulations for the SBC and Uniform Glossary, the draft template, instructions and other materials presented are almost identical to the documents developed by the NAIC, including the SBC template (with instructions, sample language, and a guide for coverage examples calculations to be used in completing the SBC template) and the uniform glossary. **Comment is invited on these materials.** The Appendices (which are the actual templates and instructions) do not include, however, a sample coverage example calculation for breast cancer in the individual market that was transmitted by the NAIC. This is because the Departments found that some of the data in the example might be subject to copyright protection; also, the sample coverage example calculation was limited to breast cancer in the individual market and did not address the other two coverage examples – maternity coverage and diabetes. Another concern was that the data included in the sample would become outdated relatively quickly because particular coding information and pricing information included in the sample would

change annually. For these reasons, and as discussed below, HHS is publishing on its website the coding and pricing information necessary to perform coverage example calculations for all three coverage examples. HHS will update this information annually.

The Departments note that “changes to the SBC template may be appropriate to accommodate various types of plan and coverage designs, to provide additional information to individuals, or to improve the efficacy of the disclosures recommended by the NAIC. In addition, the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers. The NAIC states in its transmittal letter that additional modifications may be needed for some group health plans.” **Comments are, therefore, requested on these issues specifically and on the SBC template, sample completed SBC, instructions for both group health plan coverage and individual health insurance coverage, sample language for the “Why this Matters” section of the SBC, guide for coverage examples calculations, and on the uniform glossary generally.**

After the public comment period, the Departments will finalize these documents. Consistent with PHS Act section 2715(c), the Departments will periodically review and update these documents as appropriate, taking into account public comments.

II. PROPOSAL

The SBC template, sample completed SBC, instructions for both group health plan coverage and individual health insurance coverage, sample language for the “Why This Matters” section of the SBC, guide for coverage examples calculations, and uniform glossary are identical to the documents transmitted by the NAIC. These items are contained as Appendices to the Solicitation for Comments. As noted above, the specific information needed to simulate benefits covered under the plan or policy for the coverage examples portion of the SBC (including specific medical items and services, dates of service, billing codes, and allowed charges for each claim in the three specified benefits scenarios) is being made available on the Web.¹³ HHS will update this information annually on its website.

The Departments propose that plans and issuers not be required to update their coverage examples for SBCs provided before the date that is 90 days after the date that HHS provides this updated information. If HHS releases updated information on September 15 of a year, for example, SBCs required to be provided on or after December 14 of that year would need to include coverage examples calculated using the new information. However, these updates alone will not be considered a material modification. **Comments are invited on this information as well, including the annual update provision.**

Comments also are requested on the following:

- Those who address the requirement to provide updated coverage examples are encouraged to consider how updates would be made and what additional instructions

¹³ <http://cciio.cms.gov>; see also www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_template_blank.xls

should be added to address updates and a possible phased-in approach to implementation discussed in the preamble to the 2011 proposed regulations.

- How might employers provide the information included in the minimum essential coverage statement and other plan-level reporting in a manner that minimizes duplication and burden?
- The SBC template recommended by the NAIC and located in Appendix A-1 includes websites for individuals to access the uniform glossary, for information about prescription drug coverage, and for information about the plan or coverage provider network. These are not working websites, however. Plans and issuers will need to modify this aspect of the SBC template to include relevant, working web addresses (for the uniform glossary, this may be the web address of either the Department of Labor or HHS website, or on the plan's or issuer's own website). **Comment is invited on whether this statement in the SBC template regarding the electronically available uniform glossary should be modified to include a statement that the uniform glossary is available in paper form upon request.**

III. SOLICITATION OF COMMENTS

The Departments solicit comments generally on the SBC template and related documents and the uniform glossary (see Appendices), as well as on specific issues set forth below (including on what modifications, if any, are needed for group health plans to use the SBC template). Comments are solicited, for example, on whether color printing of the SBC should be required or should a plan or issuer be considered compliant if it uses either the color version (available on the websites of the Departments of Labor and HHS), as recommended by the NAIC, or the grayscale version (included in the Appendices). What is the reaction to the proposed four, double-sided, page limit, which the Departments say will permit a plan or issuer with different benefit designs (such as multiple, tiered provider networks) to provide all the necessary information, and that additional coverage examples could be added in the future, within four double-sided pages?

To make it as easy as possible for individuals to understand the terms of their own coverage and compare coverage and benefits efficiently and accurately, the statute provides for, and the NAIC recognized the importance of, presenting the SBC in a uniform format. **Comments are invited on how this statutory requirement should be applied, including the nature and extent of the uniformity that should be required in the specific language of the SBC and the manner and sequence in which the information in the SBC is presented. Comments proposing that flexibility be permitted in aspects of the presentation of the SBC should explicitly address the potential positive or negative effects on individuals' ability to effectively compare benefits and coverage among and across individual policies and group health plans.**

The Departments also invite comments on the following specific issues:

1. Is the SBC template appropriate for different types of plan or coverage designs (e.g, designs using tiered provider networks or group health plans that may use multiple issuers or service providers to provide or administer different categories of benefits within a benefit package)?
2. Are modifications needed for use by group health plans (e.g., with respect to disclosure regarding cost of coverage and changes in terminology required for self-insured plans, such as use of the term “plan year” instead of “policy period”)?
3. Should the SBC require inclusion of additional information, such as information regarding any preexisting condition exclusion under the plan or policy, status as a grandfathered health plan, or other information that might be important for individuals to know about their coverage and how the SBC template could be modified to ensure effective disclosure of these additional elements, while respecting the statutory formatting requirements? For example, comments are requested on whether a simplified reporting method, such as a checkbox, could be used to disclose preexisting condition exclusions and grandfather status.
4. The fourth page of the SBC template includes a list of services that plans and issuers must indicate as either excluded or covered in the “Excluded Services & Other Covered Services” chart. Should services be added or removed from this list? Is the disclosure (stating that the list is not complete) adequate?
5. The SBC template includes a disclosure on the first page indicating to consumers that the SBC is not the actual policy and does not include all of the coverage details found in the actual policy. Is this disclosure adequate?

For the uniform glossary (see Appendix E), the Departments propose that plans and issuers cannot make any modifications to this glossary. They note that the NAIC consumer testing found that certain terms relating to cost-sharing provisions were particularly difficult for consumers to understand. As a result, the NAIC developed diagrams to accompany the textual definitions of these terms. **The Departments solicit comments on the uniform glossary, including its terms and definitions, and whether other terms should be added to the glossary, as well as whether any of the terms would be considered inaccurate or misleading based on a particular plan or coverage design.**

IV. OVERVIEW OF APPENDICES

Five appendices are presented. **The Departments invite comments on all of the documents in the Appendices their use in relation to the requirements of the 2011 proposed regulations and the Solicitation of Comment for the Templates and related materials:**

Appendix A-1: SBC template.

Appendix A-2: Sample completed SBC, using information for a sample individual health insurance policy. The Departments note that while the sample completed SBC may not align perfectly with the instructions in every way, the document is useful in providing a general illustration of a completed SBC for a sample insurance policy.

Appendix B-1: Instructions for group health coverage to use in completing the SBC template

Appendix B-2: Instructions for individual health insurance coverage to use in completing the SBC template.

Appendices C-1 and C-2: The SBC instructions include language that must be used when completing the "Why This Matters" column on the first page of the SBC template. Depending on the design of the policy or plan, two language options are provided in Appendices C-1 (for when the answer in the applicable row is "yes") and C-2 (for when the answer in the applicable row is "no"). Appendices C-1 and C-2 provide an example of how this column will look when populated with the required language, as applicable depending upon the terms of the plan or coverage.

Appendix D: Contains a guide for use by a plan or issuer in compiling information related to the coverage examples. This document, together with information provided in Microsoft Excel format by HHS at <http://cciio.cms.gov>, comprises the information necessary to perform coverage example calculations for all three coverage examples. With respect to the annual updates, the Departments propose that 90 days after HHS updates the information, SBCs that are otherwise required to be provided under paragraph (a) of the 2011 proposed rules would take into account the new information when providing coverage examples.

Appendix E: Uniform Glossary of Health Insurance and Medical Terms. (Definitions for terms such as allowed amount, balance billing, medically necessary, physician services and provider may be of particular interest.) The Uniform Glossary can be found at: *Federal Register*, August 22, 2011, pp. 52528-52530.