

## **Background**

The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) published a second notice of proposed rulemaking on December 30, 2014 to propose revisions to the regulation regarding the summary of benefits and coverage (SBC) for group health plans and health insurance coverage in the group and individual markets (2014 NPRM), as well as the templates, instructions, and related materials.<sup>1</sup> On March 30, 2015, the Departments released an FAQ, which stated that the Departments intend to finalize changes to the regulations in the near future but intend to utilize consumer testing and offer an opportunity for the public, including the National Association of Insurance Commissioners (NAIC), to provide further input before finalizing revisions to the SBC template and associated documents.<sup>2</sup> A final rule (2015 Final Rule), without final revisions to the SBC template and associated documents, was published on June 16, 2015.<sup>3</sup> On February 26, 2016, the Departments published a coordinated information collection request (2016 ICR) proposing a new SBC template and instructions, an updated uniform glossary, and other associated materials consistent with the requirements of the Paperwork Reduction Act.<sup>4</sup> The Departments addressed the implementation timeline for the revised SBC and its supporting documents with the release of FAQs About Affordable Care Act Implementation part 30, (published on March 11, 2016) which stated that the intention of the Departments was for health plans and issuers that maintain an annual open enrollment period to be required to use the new SBC template and supporting documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 with respect to coverage for plan years (or, in the individual market, policy years) beginning on or after that date. For plans and issuers that do not use an annual open enrollment period, the new SBC template and supporting documents would be required beginning on the first day of the first plan year (or, in the individual market, policy year) that begins on or after April 1, 2017. The Departments maintain and finalize this approach here.

Many comments received in response to the 2016 ICR mirrored the comments the Departments received in response to the 2014 NPRM. Below is the Departments' response to the comments received during the 2014 NPRM comment period and 2016 ICR comment period.

### **2014 NPRM**

PHS Act section 2715(b)(1) requires that the SBC be “presented in a uniform format that does not exceed 4 pages in length.” The NAIC commented that the Departments should interpret the statutory page limit as applicable to the blank SBC template only and not to the completed SBCs that have been filled out by plans and issuers. The Departments decline to adopt this

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<sup>1</sup> 79 FR 78577.

<sup>2</sup> See Frequently Asked Questions about Affordable Care Act Implementation Part XXIV (available at <http://www.dol.gov/ebsa/faqs/faq-aca24.html> and [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs24.html](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs24.html)).

<sup>3</sup> 80 FR 34292.

<sup>4</sup> 81 FR 9860, 9887, 9945.

interpretation. The Departments have determined that the statute does not permit completed SBCs to exceed four double-sided pages. However, the Departments have made several changes to address concerns related to the page limit. To the extent that certain limitations and exceptions are required to be identified in the Common Medical Events Chart, plans and issuers now have the flexibility to cross reference the applicable page or section of the plan or policy documents where a description can be found. Additionally, the requirement for plans and issuers to describe applicable limitations and exceptions for the services identified in the “Services Your Plan Does Not Cover” section has been removed. The caption for the section has been changed to “Services Your Plan Generally Does Not Cover” and directs the consumer to check the plan or policy document for more information. The final group and individual instruction guides now only require that limitations be described for services identified in the “Other Covered Services” section.

Under 45 CFR 155.205(c)(2)(iii), Qualified Health Plans (QHPs) offered through the individual or Small Business Health Options Programs (SHOP) Marketplace must include taglines regarding language access services in at least the top 15 languages spoken by individuals with limited English proficiency in the relevant State. The instruction guides and the 2017 Letter to Issuers provides that issuers preparing an SBC for a QHP may include these taglines in an addendum to the SBC. The addendum, which must only include language access services taglines, will not count toward the page limit requirement of PHS Act section 2715(b)(1) because it is authorized to be provided along with the SBC by separate legal authority.

The NAIC and other commenters recommended additional information be included in the Important Questions chart of the SBC regarding embedded and non-embedded deductibles, embedded and non-embedded out-of-pocket limits, and preventive services that must be provided without cost sharing under PHS Act section 2713. The Departments have made several changes to the Important Questions chart to include additional information. The instructions and answers that plans and issuers must use to complete the “Why This Matters” column have been modified to include further explanation of embedded and non-embedded deductibles as well as embedded and non-embedded out-of-pocket limits. A new important question has been added that asks “Are there services covered before you meet your deductible?” The answer for the corresponding “Why this Matters” box is an explanation that certain preventive services must be provided without any cost sharing and includes a URL address maintained by HHS that links to a list of covered preventive services that are generally required to be provided at no cost.

The Departments received several comments relating to the Common Medical Events (CME) chart. The NAIC working group and other stakeholders commented that the CME chart did not adequately make clear that the displayed cost-sharing amounts reflect the amount a participant or enrollee would be liable for after the deductible has been met (if a deductible applies). Accordingly, the chart is now preceded by a statement that explains this to the reader. The NAIC also recommended that changes be made to the section demonstrating prescription drug coverage so that plans and issuers could describe tiered coverage using terminology that is

consistent with their plan or policy documents. The instruction guides now provide that plans and issuers may include, in parenthesis in the “Services you may need” fields, the terms used to describe tiered prescription drug coverage in their prescription drug formularies. The NAIC and other commenters also suggested that the “Services you may need” field corresponding with “If you are pregnant” should be modified in order to more accurately reflect the way plans and issuers commonly distinguish maternity and obstetrical services for purposes of cost sharing. The Departments have adopted this recommendation and have incorporated the proposed modifications that were provided by the NAIC.

Previous instruction guides directed plans and issuers to complete the Coverage Examples section assuming participation in a wellness program. The NAIC recommended that plans and issuers instead be required to complete the coverage examples assuming no participation in a wellness program. The Departments have adopted this recommendation and the instruction guides provide that, if applicable, plans and issuers must include a text box with additional information on any available wellness program that may reduce the patient’s costs.

The NAIC and stakeholder comments offered suggestions regarding how the Coverage Examples could be improved to make their purpose clearer to consumers, many of which the Departments have adopted. Specifically, each coverage example has been changed to reflect the costs a hypothetical participant would be responsible for under the plan or policy. Costs for specific services have been removed so that only the total example cost and cost-sharing amounts are shown. The term “example” has also been added in several places. Commenters also recommended updates to the coverage examples cost sharing calculator. The Departments have made improvements to the calculator based on this feedback. The new calculator provides increased flexibility and additional options allowing plans and issuers to more accurately reflect the benefits under the plan or policy. In addition to these changes, the Departments are finalizing the template with the addition of the third coverage example, simple foot fracture.

Several commenters recommended requiring plans and issuers to provide a direct link to the provider directory and a direct link to the plan drug formulary in the SBC to make it easier for consumers to locate these lists. The Departments have adopted these recommendations. The NAIC and other commenters also suggested that plans and issuers insert hyperlinks into the SBC wherever terms are used that are defined in the Uniform Glossary to make it easier for consumers to locate the definition of these terms. The instruction guides now provide that plans and issuers may, but are not required to, include hyperlinks and hover-text functions in electronically distributed SBCs. HHS will maintain a micro-site for the Uniform Glossary on [HealthCare.gov](https://www.healthcare.gov/uniform-glossary/) allowing plans to electronically link defined terms in the SBC directly to the term’s definition on the webpage. This allows consumers one-click access to a term’s definition rather than having to navigate the full Uniform Glossary. While providing SBCs with embedded links is not a requirement, the Departments are providing a template with embedded hyperlinks and a list of terms with corresponding anchor links to encourage issuers to provide this feature. The NAIC and stakeholder commenters also had many suggestions regarding the definitions used in the

Uniform Glossary and requests to remove or add specific terms. The Departments appreciate these comments and have incorporated changes to the definitions to improve readability for consumers and have added new terms, including Maximum Out-of-Pocket Limit and Orthotics and Prosthetics.

Section 1303(b)(3)(A) of the Affordable Care Act requires QHP issuers that elect to cover abortion services for which public funding is prohibited (non-excepted abortion services) to provide a notice to enrollees of coverage of such services as part of the SBC provided at the time of enrollment. Commenters urged the Departments to expand this requirement to require all plans and issuers to include information related to coverage of abortion services. However, the Departments have determined that the statute clearly requires disclosure of abortion services coverage only in SBCs prepared for QHPs. Accordingly, the instruction guide provides that plans and issuers of non-QHP policies may, but are not required to, provide information regarding coverage of abortion services under the “Services Your Plan Generally Does NOT Cover” or “Other Covered Services” sections in the SBC.

## **2016 ICR**

Several commenters expressed questions and concerns regarding the Departments intended implementation timeline for the SBC template and supporting documents. The Departments addressed this issue with the release of FAQs About Affordable Care Act Implementation Part 30, (published on March 11, 2016), which stated that the intention of the Departments was that health plans and issuers that maintain an annual open enrollment period will be required to use the new SBC template and supporting documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 with respect to coverage for plan years (or, in the individual market, policy years) beginning on or after that date.<sup>5</sup> For plans and issuers that do not use an annual open enrollment period, the new SBC template and supporting documents will be required beginning on the first day of the first plan year (or, in the individual market, policy year) that begins on or after April 1, 2017.

The Departments received suggestions to improve information regarding deductibles. The proposed SBC Instruction guides would have required plans and issuers to include certain language explaining embedded deductibles in the “Why this Matters” column of the Important Questions chart when the SBC portrays family coverage with an overall deductible. The NAIC and other stakeholders commented that this description of embedded deductibles did not adequately clarify to consumers that each family member’s payment towards their own deductible contributes to meeting the family’s overall deductible. Accordingly, the Departments have modified the description to provide a clearer explanation. In addition, commenters requested clarification regarding coverage of benefits before and after the deductible has been

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<sup>5</sup> See Frequently Asked Questions about Affordable Care Act Implementation Part 30 (available at <http://www.dol.gov/ebsa/faqs/faq-aca30.html> and <https://www.cms.gov/cciiio/resources/fact-sheets-and-faqs/index.html>).

met. Accordingly, the Departments have modified the instructions to more clearly indicate the relationship between the deductible(s) and the coverage of benefit(s).

The NAIC and other stakeholders commented that the proposed SBC template and instruction guides include a number of formatting issues that could make printing difficult or costly. The Departments have made several clarifications and changes to the instruction guides to address this concern. Plans and issuers may increase or decrease the margins of the SBC as necessary. Page numbers in the SBC may be moved along the bottom of the document in order to accommodate barcodes, control numbers, or other similar language. Additionally, plans and issuers do not need to include dashes next to the term “None” where it appears in the “Limitations, Exceptions, & Other Important Information” column of the Common Medical Events chart.

The NAIC also commented that the inclusion of specific deductibles in the calculations for the coverage examples in the SBC may confuse consumers where the costs shown for deductibles exceed the overall deductibles for the plan or policy. Accordingly, if a plan or policy has deductibles for specific services included in the coverage examples that cause the deductible amount in that example to exceed the overall deductible amount, plans and issuers must include explanatory language at the bottom of the page.