Summary of Benefits

Elizabeth Jacob, CM

Elizabeth Jacob: Thank you, Stacy. Good morning, everyone. I'm Elizabeth Jacob.

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The Summary of Benefits is a marketing material to summarize cost sharing to potential enrollees. As most of you know, we made changes to the Summary of Benefits. In 2015, we redesigned the SB to improve the accuracy and readability of the document. In 2017 we gave flexibility to plans to build their own SB following our requirements.
During the session I will go over a brief history of the SB, why we changed the SB, goals of the new SB, findings of the retrospective review, and what's new for 2018.

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Prior to the 2017 change, the SB was tied to the Plan Benefit package and automatically generated standardized sentences. In some cases, these standardized sentences did not fully explain Plan benefits, and we had several Plans requesting changes to their Summary of Benefits. And this process was called Hard Copy Change Requests.

Let's take a look at our first polling question. Have you requested SB Hard Copy Change Request in the past?
A for yes, and B for no. There is no right or wrong answer with this.

Wow! Now you know why we changed the SB.

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We made changes to the Summary of Benefits based on industry feedback, consumer testing, and marketing practices. We conducted informal surveys and discussions with the Plans. We heard that the standardized SB was distributed because it was required and not because it was viewed as a useful tool for members.
We did hear that it was a useful tool to train staff.
We also learned that most Plans produced their own Summary-like documents called “Benefit Highlights” or “Benefits At a Glance.” The Plan-produced document was distributed with the Summary of Benefits for a variety of reasons, the chief being that they felt it communicated the information better than the Summary of Benefits. The documents used by Plans were typically two-to-four-pages long, concise and in an easier-to-read format.
All our Plan-based feedback supported a non-standardized summary document.

Let’s take a look at our next polling question. Again there is no right or wrong answer with this.

Did you use a summary document like benefits highlight rather than or in addition to the SB this year?

Sixty-four percent.

Through consumer testing we learned beneficiaries struggled to understand the benefits clearly due to the length and complexity of the SB. A big eye opener for us was that they misunderstood the term “Original Medicare.” One thing was clear that the beneficiaries preferred a simple, clear, and easy-to-use document. Through testing we identified

the important elements that the beneficiaries looked for when comparing plans. Eventually this led us to provide new guidance for 2017.

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As stated earlier, the beneficiaries preferred a simple, clear, and easy-to-use document. Since the Plans were already using some sort of benefit highlight document, we gave Plans the flexibility to build their own SB following our requirements and still maintaining a standardized format to compare plans. This flexibility is also to ease the burden for Plans from having to produce more than one summary-like document. Because of the new flexibilities, we expect Plans to use the Summary of Benefits in place of documents such as “Benefit Highlight” or “Benefits At a Glance.” And for those of you who have worked with me in the past, we have no more Hard Copy Change Requests.

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Since this was our first year of the new Guidance, we wanted to see how the SB worked or the process worked. For this review our sampling methodology included a review of one SB for each parent organization. A random sample of the SB included MAPD, PDP, SNPs, and 1876 cost plans.

We recently completed our initial review of the SB to send to plans. If you have not heard from us, there were no issues identified.

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We reviewed the SB for meeting requirements outlined in the memo dated April 15, 2016, including if benefits are in the right order, accuracy of cost sharing, and for applicable disclaimers. Overall the Plans performed well. We are seeing a lot of positives and some truly wonderful looking SBs. Having said that, I would like to spend a little bit of time highlighting some general areas of concern.

One of the concerns is not using the correct order of the required benefits. Plans are expected to maintain a specific order of the benefits as outlined in our memo. For example, you would keep the monthly premium, the deductible, and maximum out-of-pocket on top, followed by the drug benefits or the medical benefits. We noticed several plans changed the order of the benefits by alphabetizing the benefits and inserting non-required benefits.

Another concern is leaving out non-covered benefits, for example, if transportation or wellness programs were not covered, it was not reflected in the SB. The memo clearly states that if any of the required benefits are not covered, it should be indicated as not covered.

It is important to maintain the order of these elements because this is useful for beneficiaries when comparing plans across other organizations.

Another issue was inaccurate cost sharing. The cost sharing in the SB did not match what was in the Plan Benefit Package or the bid. In some cases, when you had multiple SBs in one document, the same cost share appeared for all Plans when it should have been different.

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Some of the other findings are: using various fonts within the same paragraph or sentence; Failing to remove brackets; Leaving track changes in the document. Please ensure when the SB is uploaded into HPMS it is the final document that will be used for marketing.

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The 2017 requirements will continue for 2018. We are not planning on issuing an annual memo this year. The 2018 Guidance will be incorporated into the Medicare Marketing Guidelines with some minor changes.

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So let's look at what are the new requirements for 2018.

We received questions from Plans about including outpatient hospital coverage in the SB. So for 2018, we have added this to the list of required benefits. It should be inserted after Inpatient Hospital.
If you provide optional supplemental benefits, Plans must include the additional premium amount in the SB. For example, if dental is one of your optional supplemental benefit, note the additional premium amount in the SB.

The document should be labeled as Summary of Benefits. The Plan Year should be visible.

We received a few questions from the Plans asking if they could label the SB using terms such as "Decision Guide." For the purpose of consistency and to avoid any confusion locating this document, this document should be labeled as "Summary of Benefits." We had difficulty locating the SB on some of the Plan websites because of similar-looking documents.

Please note that the 2018 SB Guidance will be in the Medicare Marketing Guidelines this year. Pay attention to the order of required benefits, the accuracy of cost sharing when you prepare your SB for next year.

You may contact the Regional Office, Marketing Reviewer or the Marketing Mailbox for questions.

That concludes the Summary of Benefits presentation. Thank you.

Stacey Plizga: Okay, do we have any questions from our in-house audience? If so, please step to the center aisle. Please tell us your name and your organization.

Vanessa Turner: Hi. My name is Vanessa Turner. I'm from Emblem Health. I feel that the added flexibility really does aid Plans in communicating most efficiently with their specific membership, but I do feel that there was some specific value to the auto generation feature from the PBP. So I'm wondering if there is some way to return to that feature and generating the exact cost sharing and benefits from the PBP in the proper order that you would like but then yielding a document that could then be modified with the flexibility now allowed in this new memo.

Elizabeth Jacob: So you're looking for a report that you can go and verify the cost sharing?

Vanessa Turner: Well, the cost sharing order. So if you generated an SB like it used to do, but in a format that could then be tailored to allow for this new flexibility that might address two of the concerns you had where the cost sharing wasn't always accurate and the order wasn't always accurate. But it would allow Plans to have a more accurate way of pulling down the data.

Elizabeth Jacob: Okay. The order of elements is provided in the SB, so you would follow that. And the cost sharing has to be taken from your bid report, so they should match.

Vanessa Turner: Oh, no, I understand that. But the auto-generated feature I think would –

Elizabeth Jacob: Is helpful?

Vanessa Turner: Yeah.

Elizabeth Jacob: All right. Thank you.

Stacey Plizga: Okay, any other questions from our in-house audience? Okay, then we will address some questions that were received from our virtual audience. And the first one is, can Plans add drug benefits before the medical benefits?

Elizabeth Jacob: Yes. You have the option to add drug benefits before the medical benefits. But remember you need to place the deductible, premium, and maximum out-of-pocket costs on top. And then you can either put medical benefits or drug benefits. Either one is fine.

Stacey Plizga: Okay. The next question we received from our virtual audience, can Plans add other benefits to the SB that are not listed in the memo?

Elizabeth Jacob: Yes, you can add other benefits that are not listed in the memo to the SB, and you can label the section as "Additional Benefits." And, yes, you are allowed to add Additional Benefits.

Stacey Plizga: Okay. And I have one last question here, and that is, can Plans continue to use Benefit Highlights or Benefits at a Glance documents?

Elizabeth Jacob: We prefer that you do not label the document as Benefit Highlights. You can use them, but make sure you label the Summary of Benefits as Summary of Benefits. This is to avoid confusion. And one of the reasons we gave flexibility to Plans is to use the Summary of Benefits in place of other documents, and this is to ease burden for Plans.

Stacey Plizga: It looks like we do have an in-house guest with a question.

Britton Whitbeck: Sorry, I'm always kind of late to the game. Britton Whitbeck from Loomeris

Stacey Plizga: Can you pick up the microphone again?

Britton Whitbeck: Sorry about that. You said that the Summary of Benefits requirements will be in the 2018 Medicare Marketing Guidelines?

Elizabeth Jacob: Yes.

Britton Whitbeck: Just to make sure, they were not in the proposed, right?

Elizabeth Jacob: No. We are not going to be issuing an additional memo this year.

Britton Whitbeck: Okay.

Elizabeth Jacob: So there are not too many changes, other than what is mentioned in the slide. We may have some minor tweaks, and it's going to be a copy of the memo, basically.

Britton Whitbeck: Okay. Do you see any clarifications based on your retrospective review?

Elizabeth Jacob: They may have some.

Britton Whitbeck: Okay.

Elizabeth Jacob: But not a whole lot.

Britton Whitbeck: Because we saw a couple Plans that had trouble with the medical equipment and supplies. So I think that ties to Section 11 of the PBP.

Elizabeth Jacob: Okay.

Britton Whitbeck: They're just kind of – DME, prosthetics, and diabetic supplies. And so I wasn't sure, do all those go under medical equipment and supplies or should any of those go after the required elements at the bottom?

Elizabeth Jacob: So both are subcategories under medical equipment. So you have the flexibility, depending on what you have put in the PBP or your bid report and put those benefits in the SB.

Britton Whitbeck: Okay.

As long as the major category is there, you do have some flexibility as long as it is consistent with your PBP.

Britton Whitbeck: Okay. Thank you.

Elizabeth Jacob: You're welcome.

Stacey Plizga: Okay, those are all the questions that we have for today, so I would like to thank Elizabeth for providing an understanding of where we are today with the Summary of Benefits document. Thank you.

All right. If you would like to evaluate this session, go ahead and select A, and click on that link that you receive. And respond to the questions.

One of our goals today is to stay on time and stay as close to the agenda times as we can, and we're running a little bit ahead of schedule right now so we are going to take approximately a ten minute break right now. And we will return and begin our next session promptly at 11:15. So if you'd like to get up and stretch, please return at 11:15 when we will be starting again. Thank you.

Stacey Plizga: Hey, welcome back, everyone. We are going to go ahead and get started.

We're going to go ahead and get started. CMS is committed to providing effective communications and accessible information to individuals with disabilities. As such, this session will provide an understanding of the requirements regarding accessible public-facing communications, the importance of having accessible communications, and the role that you play.

From the Customer Accessibility staff at CMS, please welcome Bridget Berardino and Kimberly Snowden.