AMERICAN BENEFITS COUNCIL

October 21, 2011

Submitted electronically via http://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9982-P; CMS-9982-NC
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Summary of Benefits and Coverage and the Uniform Glossary (CMS–9982–P); Templates, Instructions, and Related Materials (CMS–9982–NC)

Sir or Madam:

We write to provide comments on behalf of the American Benefits Council ("Council") in response to the Notice of Proposed Rulemaking ("NPRM") on the Summary of Benefits and Coverage and Uniform Glossary, 76 Fed. Reg. 52,442 (Aug. 22, 2011) and the Templates, Instructions, and Related Materials, 76 Fed. Reg. 52,475 (Aug. 22, 2011).

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

INTRODUCTION

Section 2715 of the Public Health Service Act ("PHSA"), added by the Patient Protection and Affordable Care Act ("Affordable Care Act"), directs the Departments of the Treasury, Labor, and Health and Human Services (collectively, the "Agencies") 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." The NPRM

and related documents propose such standards.

We support the intent of PHSA section 2715 to provide assistance to help individuals make better informed decisions. We believe that disclosures and other communications regarding health benefits are an important component of benefit plan administration and design.

We appreciate that the standards have been issued in proposed form, thus providing all stakeholders the opportunity to comment on them prior to any implementation. This is particularly important given the significant compliance challenges that PHSA section 2715 and the NPRM pose for large self-insured plan sponsors.

Below are our comments and recommendations with respect to final regulations or other guidance implementing PHSA section 2715.

APPLICABILITY DATE

For the reasons discussed below, the Council requests an immediate sub-regulatory communication clarifying that new PHSA section 2715 will not apply with respect to enrollment restrictions occurring on or after March 23, 2012. This clarification is needed immediately to ensure that plan sponsors do not expend resources unnecessarily in the next several weeks or months to implement the proposed rules. Additionally, the Council requests that any eventual applicability date be delayed for group health plans until plan years beginning on or after January 1, 2014. In the alternative, and at minimum, the Council requests that the applicability date be no sooner than with respect to plan years beginning after the close of the 18th month following the issuance of any final rule.

The applicability date should be delayed for group health plans until no sooner than the 2014 plan year. Congress's intent in enacting new PHSA section 2715 was to permit individuals to make meaningful and informed decisions among different coverage options. While the Council and its members fully support this objective – and in fact have been innovators over the years in providing employees with tools and materials to allow for meaningful choice and informed decision making – at least with respect to group coverage, the SBC is unnecessary prior to 2014. This is because in nearly all instances group coverage will be a favorable coverage option to coverage that can be purchased through the individual insurance market. There are many reasons for this, some of which are: certain economies of scale; better insurance risk with respect to group coverage; and the fact that a great many employers pay a substantial portion of the premium for group coverage (in some cases, up to 100% of self-only coverage).

Thus, except for a few limited circumstances (*e.g.*, where a husband and wife both work

and have access to employer-sponsored coverage through their respective employers), it is generally the case that, at least through the end of 2013 (*i.e.*, prior to the establishment of any state exchanges), employees who are eligible for group coverage are unlikely to need to make coverage comparisons with respect to non-group coverage options. Moreover, in situations where employees have a choice of *group* coverage options through their employers, as discussed throughout this letter, employers have been and continue to be innovators in providing easy to read and understandable information to employees regarding their various coverage options to facilitate informed and sound coverage decisions.

For these reasons, we request that the applicability date be delayed with respect to employer-sponsored group coverage until at least the start of the 2014 plan year.

In the alternative, we request that the applicability date be delayed for at least 18 months following the issuance of any final rule. PHSA section 2715 provides that an SBC with respect to enrollment restrictions is to be provided not later than March 23, 2012. PHSA section 2715 also directs the Secretary to develop standards not later than March 23, 2011. The NPRM was issued five months after this deadline.

Given the late issuance of the NPRM and for other reasons discussed below, it would be very difficult, if not impossible, for large plan sponsors to come into compliance with the SBC requirements by March 23, 2012. This is due, in part, to the fact that the SBC requirements will require substantial modification of the systems of both self-insured plan sponsors and health insurance issuers. For example, plan sponsors will need to gather data from insurance companies, health plan consultants, communications experts, and outsourcers, which will take time to complete. In addition, the information technology staffs of employers and/or their outsourcers will need to implement and test system changes. Moreover, to avoid duplicative or confusing disclosures, some plan sponsors may need time to reevaluate their disclosure practices in light of the new SBCs.

In addition to the above, most large plan sponsors are already very far along in planning for and/or administering their fall annual open enrollment with respect to the 2012 calendar plan year. In this regard, plan designs and communication materials are already confirmed for the 2012 plan year or are in final review. Thus, designing, building and implementing SBCs that comply with yet-to-be released final regulations in time for 2012 plan years would require major rework and severely disrupt existing budgeting and sourcing. Because participants and potential participants already have access to effective communications to compare health plan options, the Council does not believe that the delay will harm individuals.

The Council believes the requested delay in the applicability date is also warranted given the likelihood that the NPRM will be significantly modified as part of a final

rulemaking, as evidenced by the NPRM itself and its request for additional comments on a host of outstanding issues. Our members indicate that, regardless of whether they undertake these efforts in-house or use the services of a third-party administrator, it is their expectation that the implementation process could take well over a year following the issuance of a final rule. Given the significant costs and burdens to employers in complying with these new rules, we believe an 18-month delay following delivery of a final rule is warranted to ensure that all parties involved have sufficient time to make delivery systems changes and other needed modifications to take account of these new rules.

In summary, the Council strongly recommends that the Agencies issue immediate guidance to delay the applicability date of the SBC requirements for group health plans until plan years beginning on or after January 1, 2014. At minimum, the Council requests that the applicability date be based on the start of a given plan or policy year (as opposed to being based on enrollment restrictions) and apply no sooner than 18 months following the issuance of any final rule.

A Safe Harbor Is Needed for Employer-Sponsored Group Health Plans

Large plan sponsors have long provided summary information to eligible participants as part of their enrollment processes and through related plan materials to assist employees in making meaningful decisions regarding their benefit choices. Large plan sponsors have been innovators in providing employees with communications that effectively allow them to compare their benefit choices.

Flexibility is needed to allow employers to continue to innovate and implement such practices. In this regard, the Council urges the Agencies to adopt a safe harbor that recognizes current plan sponsor practices as compliant, so long as they provide the SBC-required content.

Statutory Basis for Safe Harbor. The Council's intent in proposing the safe harbor is to ensure that implementation of the SBC requirements does not disrupt existing successful and efficient processes, so long as such practices already provide (or are modified to provide) the required SBC content. Notably, when Congress enacted new PHSA section 2715, it imposed a specific penalty for failure to comply with the new SBC provisions (beyond the penalties that generally apply under the Affordable Care Act to violations of the market reforms generally). Significantly, the provision imposes a monetary penalty for a plan or issuers failure to provide the requisite "information" rather than for failure to adhere to any specific formatting requirements or the new PHSA section 2715 more generally.

Lastly, the statutory language of new PHSA section 2715 requires only that the

Agencies "consult" with the National Association of Insurance Commissioners ("NAIC"). This, coupled with the Agencies' broad regulatory authority under the Affordable Care Act and the related statutes (i.e., the PHSA, ERISA and the Internal Revenue Code), provides the Agencies with discretion to issue rules establishing a safe harbor for large employer plans.

Discussion. When employers offer different levels or types of coverage, in addition to providing a Summary Plan Description ("SPD") and summaries of material modifications ("SMMs") as required by the Employee Retirement Income Security Act of 1974 ("ERISA"), they very often provide a host of tools to eligible participants to allow such participants a meaningful opportunity to compare their coverage options. These tools include side-by-side charts and analyses showing the material benefits and exclusions of each type of coverage, including relevant premium and cost-sharing information (such as copayments, deductibles, out-of-network charges, and annual and lifetime limits on other than essential benefits).

Additionally, many large group sponsors have moved to a "paperless" enrollment process whereby plan enrollment (including the provision of summaries of benefit information) is accomplished via electronic means. Notably, the Office of Personnel Management ("OPM") has instituted a similar practice in connection with the Federal Employees Health Benefits Plan ("FEHBP") for this year.[1] In addition, many employers provide charts that facilitate comparison of the key features of the plan choices available to employees, as well as interactive, on-line tools that assist decision making by allowing individuals to select the specific features of various health plan choices which they choose to compare. Other employers may assist employees by helping them obtain more detailed information on their health plan choices by maintaining it on a dedicated website.

Proposed Safe Harbor. Under the safe harbor contemplated by the Council, plan sponsors would be required to include all information required by PHSA section 2715 as part of existing plan materials and plan comparison decision tools provided to eligible plan participants. Under this safe harbor option, plans would be in compliance with the SBC rules as long as enrollment materials provided to individuals eligible to participate in a plan contain all of the SBC-required information. No separate stand-alone document would be required to be provided and plans would not be required to use the uniform template prescribed in the proposed rules.

As part of the safe harbor, the Council strongly urges the Agencies to consider implementing an expanded electronic delivery rule beyond that set forth in the NPRM. The NPRM incorporates the existing ERISA electronic delivery rule for purposes of

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[1] *See* "FEHB Is Going Green," *available at* http://www.opm.gov/insure/health/gogreen/index.asp. OPM expects to save $5 million in premiums by dropping the brochure mailing requirement.

furnishing the SBC. We do not believe that the Affordable Care Act mandates that the ERISA electronic delivery rule be used for this purpose. PHSA section 2715 states merely that the SBC be permitted to be delivered in "electronic form." Nowhere does PHSA section 2715 reference the application and/or use of the ERISA electronic delivery rule. Moreover, although section 2715 of the PHSA is incorporated by reference into section 715 of ERISA, ERISA section 715 clearly states that, to the extent the PHSA and ERISA conflict, the PHSA shall control.

We believe, therefore, that the Agencies possess the necessary authority to develop an electronic delivery rule that is best suited to reflect current technology and customer behavior, regardless of whether it mirrors that which currently applies by regulation under ERISA. To this end, we encourage the Agencies to adopt a broader electronic delivery rule for purposes of PHSA section 2715 including, for example, one that permits issuers and plan sponsors to post the SBC to a continuous access website. Such "paperless" enrollment is being used successfully by the vast majority of large employers (including OPM for FEHBP starting in 2012, as mentioned above). Thus, requiring the printing and mailing of the SBCs would be for many employers a "step backward" in terms of innovation and would impose substantial costs on employer sponsors for little, if any, value to employees.[2]

COMMENTS SPECIFIC TO NPRM REQUIREMENTS

As discussed above, the Council strongly believes that a safe harbor is needed with respect to the SBC requirements. However, to the extent that the Agencies choose not to establish a safe harbor, or to establish a modified safe harbor, we provide the following comments, which are applicable to specific requirements of the NPRM that would apply outside the safe harbor recommended in this section.

Provision of SBC "Upon Request." When a participant or potential participant requests an SBC, the NPRM would require that the SBC be provided as soon as practicable following the request, but no later than seven days (not business days) following the request.

Although the Council understands that the Agencies' intent is for participants and/or potential participants to have the most up-to-date information regarding coverage and potential coverage, we urge the Agencies to allow more time for SBCs to be provided

[2] For further discussion of our recommended rule regarding electronic delivery, we encourage the Agencies to review our written comments to the Department of Labor in response to its request for comments regarding its existing regulatory safe harbor for electronic delivery of ERISA-governed disclosures. *See* Council Response to Request for Information - E-Disclosure (RIN 1210-AB50) at 4 (June 6, 2011).

upon request. From an administrative perspective, it would be very difficult for a large self-insured plan sponsor to respond to every request for an updated SBC within 7 consecutive days. To this end, the Council respectfully urges the Agencies to provide for a period of at least 7 business days in which a plan sponsor or issuer may electronically provide an SBC upon request.

"Single Address" Rule. To prevent unnecessary duplication with respect to group health coverage, the NPRM proposes, among other things, that, 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. Permitting one SBC to satisfy the obligation with respect to multiple individuals will be useful to plan sponsors in decreasing the cost of producing and delivering the SBC. Accordingly, we support the rule contained in the NPRM and urge that it be included in any final rulemaking.

Frequency Upon Reenrollment. The Council supports the rule in the NPRM providing that, with respect to renewal of an employee already enrolled in a given plan or benefit option, during annual enrollment such employee needs only to receive the SBC for the option in which they are enrolled and not all of the other options for which they may be eligible.

CONTENT

Premium/Cost Coverage Tiers. The NPRM invites comments as to whether the SBC should include premium or cost information and, if so, the extent to which such information should reflect the actual cost to an individual net of any employer contribution, as well as the extent to which the cost information should include costs for different tiers of coverage (*e.g.*, self-only, family) ("Cost Features").

A rule requiring the development and issuance of a separate SBC for each coverage tier would be very costly to implement and maintain. The Council recommends that future guidance clarify that health plans and issuers may issue one SBC with respect to a given plan or benefit option and accompany the SBC with one or more attachments specifying the Cost Features of each coverage tier. For example, where a plan has three self-insured options (no deductible, moderate deductible, and high deductible) and five HMOs with four coverage levels (employee only, employee plus spouse, employee plus children and family), the plan would be permitted to prepare 8 SBCs, one for each self insured or HMO option, and then attach a uniform table showing all of the available coverage levels and the premium cost for each option with respect to that coverage level.

In this way, a plan that has several benefit options would be permitted to provide one

SBC for each benefit option and include relevant Cost Features in one or more corresponding attachments (such as a table with side-by-side premium information, etc.). We believe this rule is preferable to that set forth in the NPRM as it would ensure that all necessary information is provided to eligible participants, while maximizing efficiency and minimizing cost (by allowing employers needed discretion to present and deliver information regarding Cost Features).

Coverage Examples. PHSA section 2715 requires that an SBC include a "coverage facts label." The NPRM proposes to satisfy this statutory requirement by including "coverage examples" illustrating benefits provided under the plan or coverage for common benefits scenarios, including pregnancy and serious or chronic medical conditions. Such coverage examples appear to be intended to allow participants or potential participants to use this information to compare their shares of the cost of care under different plan or coverage options. The NPRM permits the Agencies to identify up to six coverage examples that may be required in an SBC. The NPRM proposes to implement three coverage examples upon the applicability date of the regulations, reserving the possibility to adopt three additional examples in the future.

The Council is very concerned that coverage examples will require plan sponsors to expend considerable cost and time to develop and implement them, and there is a significant potential for causing confusion among employees. The Council recommends that the coverage example requirements be delayed until the Agencies receive and consider public comments and issue guidance reflecting the Agencies' consideration of such comments.

Following issuance of such further guidance, or, as an alternative to the recommendation in the preceding sentence, the Council proposes that the coverage examples be phased in on a more gradual schedule than what is proposed in the NPRM. The inclusion of coverage examples in disclosure documents is an entirely new concept, and it seems sensible to "test out" the concept with implementation of only one coverage example rather than all three at once. In this regard, the Council supports a phase-in of the coverage examples over a period of time, *e.g.*, one coverage example would be required in Year 1, two coverage examples would be required in Year 2, and three coverage examples would be required in Year 3.

List of Common Medical Events. The SBC template issued with the NPRM requires a significant amount of information regarding what the plan covers and does not cover. The list of required coverage information is expansive and is generally duplicative of that found in an employer's SPD with respect to a given benefit option. In fact, in many regards the discussion contained in the SPD is more comprehensive and meaningful than that which would be mandated as part of the SBC. Accordingly, the Council urges the Agencies to reduce the number of common medical events that must be included in the SBC to the following six events:

- office visit
- outpatient services
- hospitalization
- prescription drugs
- mental health
- preventive services

To this end, the Council requests that the Agencies, to the extent necessary, make clear in the final regulations that the SBC include a statement that an eligible participant should consult the relevant SPD for a complete list of covered services and/or exclusions.

Uniform Glossary. The Uniform Glossary included in Appendix E of the NPRM contains terms frequently used in insured health plans, but that do not necessarily reflect terminology or definitions used in self-insured plans. For example, the Uniform Glossary repeatedly uses the term "health insurer" which could confuse participants in a self-funded plan that does not have a health insurer. In addition, there is a significant likelihood that the definitions of terms contained in the proposed Uniform Glossary will not match definitions in a participant's health plan documents, including SPDs and other materials.

The Council requests that future guidance allow plan sponsors to include a statement in the SBC where the Uniform Glossary is referenced (similar to that included at the beginning of the proposed Uniform Glossary) that makes clear that the terms and definitions in the Uniform Glossary may not reflect the group health plan terms and conditions and should not be relied on for that purpose. In the absence of such a statement, participants may be misled in relying upon the Uniform Glossary to help them understand specifics of their coverage options, eligibility or other important aspects of their employer-sponsored coverage.

APPEARANCE

Length of the SBC. PHSA section 2715 provides that the SBC is to be presented in a uniform format, utilizing terminology understandable by the average plan participant that does not exceed four pages in length, and does not include print smaller than 12-point font. Outside of the safe harbor set forth above, the Council supports permitting double-sided 4 pages for a total of 8 pages.

Coordination of the SBC with other relevant documents. The Council requests that the final regulations permit an SBC to be packaged together or otherwise coordinated with an SPD and/or any other existing group health plan disclosure requirements (rather

than requiring it to be distributed as a stand-alone document as set forth in the NPRM). Allowing plan sponsors to include the SBC with an SPD and/or other relevant information (such as annual enrollment materials) will reduce costs and administrative burdens for employers and participants by reducing the need for duplicative and unnecessary mailing and printing costs.

Template. The preamble to the NPRM states that the Agencies recognize 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. The NPRM also notes that the SBC template and related documents were drafted by the NAIC primarily for the use of health insurance issuers.

We agree that the structure of the SBC template and its terms do not generally reflect those used in the self-insured plan context. Requiring the sponsor of a self-insured plan to summarize plan benefits using the template in its proposed form could lead to confusion or misinterpretation by participants. We request clarification that plan sponsors are permitted to modify the SBC as necessary to accommodate the plan options offered to their employees.

The Council also requests clarification in future guidance that the SBC template does not require disclosure of network design or geographic programs (such as centers of excellence or clinics). We suggest that the sections of the template entitled "Rights to Continue Coverage" and "Your Grievance and Appeals Rights" be eliminated for self-insured group health plans as these terms and disclosures are standard for ERISA plans and are not necessary for purposes of comparing coverage options.

FORM AND MANNER – ELECTRONIC DELIVERY

The NPRM would permit the SBC to be delivered either in paper format or via electronic means, so long as the requirements of the Department of Labor's existing electronic delivery rule are satisfied. The Council urges the Agencies to develop broader electronic delivery rules for purposes of the SBC requirements. Even if the Agencies decline to adopt the safe harbor to the SBC requirement discussed in detail above, we strongly recommend that the Agencies include a more flexible electronic delivery rule as described above.

As noted above, the Affordable Care Act does not mandate that the ERISA electronic delivery rule be used for this purpose. Rather, PHSA section 2715 simply states that the SBC may be delivered in "electronic form" without reference to the ERISA electronic delivery rule. Moreover, although section 2715 of the PHSA is incorporated by reference into of ERISA, ERISA section 715 clearly states that, to the extent the PHSA

and ERISA conflict, the PHSA shall control. As a result, we believe the Agencies possess the necessary authority to develop an electronic delivery rule that is best suited to reflect current technology and customer behavior, regardless of whether it mirrors that which currently applies by regulation under ERISA. We urge the Agencies to adopt a broader electronic delivery rule for purposes of PHSA section 2715 including, for example, one that permits issuers and plan sponsors to post the SBC to a continuous access website with appropriate notice.

LANGUAGE

PHSA section 2715 requires that the SBC be "presented in a culturally and linguistically appropriate manner." In this regard, the Council supports the NPRM's proposed application of the standard set forth in the internal and external claims review guidance, *i.e.*, generally requiring that plans provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages.[3] Specifically, the Council recommends that a written translation of the SBC only be required to be provided upon qualifying request, as proposed in the NPRM. In addition, the Council requests confirmation that written translations of the uniform glossary will be made available by the Agencies in advance of the applicability date with respect to PHSA section 2715.

ADVANCE NOTICE OF MATERIAL MODIFICATIONS

The NPRM would require plans and issuers to provide a notice of material modification to participants no later than 60 days prior to the date on which the change will become effective, to the extent such material modification (i) is not reflected in the most recent SBC provided, and (ii) occurs other than in connection with a renewal or reissuance of coverage. The NPRM would require the issuance of such a notice only if the material modification would affect the content of the SBC.

The Council supports limiting the advance notice requirement to only those material modifications that would render invalid or incorrect information contained in the most recently issued SBC. We believe such a rule is appropriate for a host of reasons. ERISA already requires meaningful disclosure of material modifications via the required issuance of a summary of material modifications ("SMM") within a certain time period following any material modification. Thus, interpreting new PHSA section 2715 to require advance notice of material modifications beyond those affecting the SBC is unnecessary in light of ERISA's requirements. Additionally, a contrary rule would

[3] *See* 75 Fed. Reg. 43,330 (July 23, 2010) as amended by 76 Fed. Reg. 37,208 (June 24, 2011).

render the SMM requirement essentially useless and would impose unnecessary and duplicative costs and burdens on employers and plan participants. We note that a contrary rule would likely result in participant confusion as participants would be receiving notices of a material change both before and after the change occurs. This would likely confuse participants and lead some to erroneously believe that the plan may be undergoing more than one material change.

Lastly, we request that the Agencies issue additional guidance clarifying what constitutes a material modification for purposes of the SBC advance notice requirement. As part of such clarification we request that the Agencies make clear that a material modification does not occur solely by virtue of a change in the provider network.

PENALTY FOR FAILURE TO PROVIDE THE SBC

PHSA section 2715(f) provides that a group health plan (including its administrator) and a health insurance issuer offering group or individual health insurance that willfully fails to provide the information required will be subject to a fine of not more than $1,000 for each such failure. For this purpose, it appears to us that not providing the requisite information with respect to each enrollee could be treated as a separate failure. Given the severe nature of these penalties, the Council urges the Agencies to consider whether a corrections program might be appropriate, at least with respect to the first few years of implementation, to ensure that employers and issuers do not find themselves subject to substantial monetary penalties notwithstanding appropriate efforts to comply with these new rules.

APPLICABILITY

International plans. The NPRM requests comments as to whether any special rules are necessary to accommodate expatriate plans. The Council requests that the Agencies except international plans – in particular, expatriate plans – from the application of the SBC requirements. Typically, employees eligible to participate in international plans only have one coverage option and often would not have the need for a comparative document such as the SBC. In the event that the Agencies do not wish to except international plans as a whole from the SBC requirement, the Council requests that the Agencies clarify in the final SBC regulations the types of international plans that are subject to the SBC requirement. At the very least, the Council does not believe that the SBC requirements should apply to nonresident aliens, without regard to whether they are participating in an ERISA-covered plan.

Stand-Alone Health Reimbursement Arrangements. The Council urges the Agencies to issue guidance excepting stand-alone health reimbursement arrangements ("HRAs") from the SBC requirements. As with international plans, employees eligible to participate in a stand-alone HRA will not have multiple options among which to

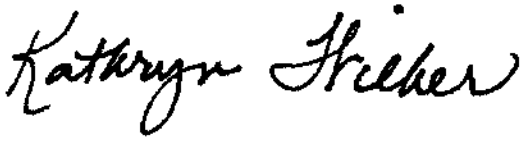
choose. Thus, such employees would have no practical need for an SBC with respect to a stand-alone HRA. In addition, the SBC template would not translate well to the stand-alone HRA context, given that the template was designed for insured plans providing comprehensive medical coverage. The terms and contents required to be used in the SBC template often would not be applicable -- and in fact may simply induce confusion -- in the HRA context.

Retiree health, HIPAA-excepted coverage and EAPs. In addition, the Council requests that future guidance affirm that the SBC requirements do not apply to retiree health plans, HIPAA-excepted benefits, or employee assistance programs.

* * *

We appreciate the opportunity to provide comments regarding the NPRM and related documents, which would implement the SBC requirements of PHSA section 2715. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



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October 21, 2011

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Re: CMS-9982-P; Summary of Benefits and Coverage and the Uniform Glossary, Notice of Proposed Rulemaking

Dear Sir or Madam:

The Business Roundtable (BRT) is an association of chief executive officers of leading U.S. companies. Together, our member companies employ more than 12 million individuals and provide health care coverage to over 35 million American workers, retirees and their families. BRT is invested in addressing health care costs that hamper essential economic growth.

BRT appreciates the opportunity to submit comments in response to the Notice of Proposed Rulemaking on the Summary of Benefits and Coverage and the Uniform Glossary, CMS-9982-P (SBC). Business Roundtable members currently provide summary information to their employees regarding their health plan options in the absence of these proposed requirements. Therefore, we are writing to express **strong** opposition to this Proposed Rule because it unduly requires employer-sponsored plans to amend their current practices, solely to incorporate the use of a government-created form. Our members have demonstrated their appreciation for the significant value of educating employees about each health insurance coverage option, and will continue to do so. But the potential costs of complying with the new requirements in this proposed regulation are conservatively estimated to be over $100 million.

We do not believe that requiring a "one-size-fits-all," 4-page form for *each* option offered is a reasonable approach to ensuring our employees understand what health plan option is best suited for their needs. As an alternative, we believe that the statute provides broad flexibility for the Secretary to permit a safe harbor so that innovative approaches can be permitted. Allowing employers this flexibility will ensure that employees can continue to carefully review available health care benefit options and make informed enrollment decisions based on their individual needs. Such flexibility is also necessary to ensure that employers are able to meet new expectations set for them under the Affordable Care Act, while continuing to lead on innovations in benefit designs that drive quality, contain costs and are highly valued by our employees.

Therefore, we request that the final rule be modified in the following ways:

1. ***Permit employer-sponsored plans to provide Summary Plan Documents (SPDs) through various innovative approaches.*** A safe harbor should be developed that permits employers to continue using current plan comparisons and other materials. This safe harbor should allow the use of such materials in their present form, including electronic and paper versions, so long as they include all the elements required to support employee decision-making. We need to promote more electronic means to educate consumers. Whether through the web or mobile applications, education is critical to the success of understanding benefits offered by employers.

2. ***Immediately delay the effective date of this requirement until the start of the plan year beginning no more than 18 months after the final rule is promulgated.*** The new law requires health insurers and health plans to begin issuing SBCs no later than March 23, 2012. We have serious concerns that employers are preparing for this deadline, and the requirements of the proposed rule, before the rule itself is final. We ask that the deadline be immediately moved to ensure resources are expended in compliance with the final rule, not the proposed rule. We recommend that the new effective date be the start of the plan year beginning no more than 18 months

after promulgation of the final rule. We also suggest that before these forms go into effect on any segment of the insurance industry, the Department of Health and Human Services (HHS) undertake a demonstration to understand the enormous costs, administrative burdens and time it will take to shift to the use of these governmental forms.

3. ***Additional issues.*** Address additional issues within the proposed rule to permit greater flexibility and ensure the continued offering of innovative employer sponsored health coverage.

Safe Harbor for Employers

We encourage the Agencies to include within the final rule a safe harbor that permits employers to continue using plan comparisons and other materials. This safe harbor should allow the use of such materials in their present form, including electronic and paper versions, so long as they include all the elements required to support employee decision-making.

Business Roundtable members have significant experience in providing enrollment materials to their employees in formats that ensure employees understand their options and enrollment selections. Employees are used to receiving these materials from their employers and are familiar with the format, the information, the terminology and the design. Business Roundtable members continually work to improve communication with their workforce so that employees are making well-informed decisions that best meet their needs. In many cases, our members also offer between five and ten health plan options. Requiring a 4-page government-developed form for each of these plan options will undercut the years of refining and improving employers' communication and enrollment information, aimed specifically at each company's employees and their families.

In addition, most health plan review and enrollment is now done online. The internet-based programs available today provide employees with decision support tools that permit employees to identify whether their physician is in a plan's network, identify whether the drugs they are prescribed are covered and provide other important information that helps them select the plan to meet their current needs.

We also believe that the statute provides sufficient flexibility to warrant a safe harbor for employers to provide currently-used materials that support employee decision-making, so long as these materials include all of the required elements. Section 2715 of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-148 and 111-152) (collectively the Affordable Care Act or ACA) states that "the Secretary shall develop **standards** for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage

explanation that accurately describes the benefits and coverage under the applicable plan or coverage." (Emphasis added.) We believe the use of "standards" does not imply that all parties must provide the same information, through the same form and in the same manner.

In addition, these new requirements should be aligned with existing ERISA Summary Plan Document requirements and should not duplicate or impede those rules. Employers should not be subjected to multiple rules and requirements that may be inconsistent or which divert resources which would otherwise be best spent on health care coverage towards ensuring compliance with multiple rules.

We believe that the ACA gives the Secretary full authority to permit employees who work for large employers to receive "a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage" in the same manner that they are accustomed to, in support of their decision-making, so long as the materials include all the required elements. Such a safe harbor should consider multiple approaches to comply with the statutory requirement, including on-line decision tools, effective written materials that allow employees to compare plan choices, the use of websites to make the required information available or making the information available upon request. All of these options, which are similar to means employers use today should be permitted vehicles for meeting the SBC requirements.

Effective Date

The new law requires health insurers and health plans to begin issuing the SBCs no later than March 23, 2012. We respectfully request that you immediately delay the effective date until a final rule is published.[1] Health plans and plan sponsors need time to meet the requirements

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[1] The required rules have not yet been promulgated and thus the Departments' failure to issue the regulations is contrary to law in violation of the Administrative Procedures Act (APA) 5 U.S.C. 551 et.seq. In fact, the Departments released only a Proposed Rule on August 22, 2011, which itself may be modified through the notice and comment process, leaving employer-sponsored plans awaiting final requirements. This delay by the Departments raises the legal question of whether the proposed regulations themselves would be valid and enforceable, as the Departments have failed to issue them by the deadline specified in the Act. We ask that the Administration delay the enforcement and timing of this regulation to ensure that comments may be read and a final rule is published.

Given that it is the Departments that will enforce the regulations, the Departments should publicly announce that they will delay enforcement to allow plans and issuers adequate time to implement the requirements of the final regulations. This would be a permissible exercise of the Departments' enforcement discretion under *Heckler v. Chaney*, 470 U.S. 821 (1985). Under *Heckler v. Chaney*, administrative agencies have great ability to exercise enforcement discretion not to enforce particular statutory or regulatory provisions. HHS, for example, has already exercised its enforcement discretion in a number of situations under the Act. HHS's enforcement discretion was used to provide enforcement grace periods with respect to certain requirements under interim final regulations relating to the internal claims and external review requirements added by the Act. *See* DOL Technical Releases 2010-02 and 2011-01. As another example, HHS has stated that it will not

and comply with these new rules. Employers will need to update their systems and administrative processes in order to make changes to comply with the final rule. We encourage the effective date of the requirements to instead be the start of the plan year beginning no more than 18 months after the date of publication of the final rule. In fact, we believe that this form should be tested to determine the costs and benefits that it will ultimately provide prior to employers and insurance companies expending any money on changing their systems to accommodate this new form.

Additional Issues

We encourage the Agencies to use common sense industry practices with respect to when dissemination of the SBC is required under the final rule. A majority of enrollees will receive this information during the open enrollment period. We also encourage the Agencies to reevaluate the requirement that plan sponsors obtain an acknowledgement from an enrollee that they have received the SBCs. This acknowledgement of receipt is not required in the statute and is likely to cause administrative difficulties and enrollment delays for employer-sponsored coverage.

In addition, concerns have been raised about the requirement to disclose the total premium. Today, most employers provide information to the employee on the required contribution of the employee. To maintain consistency in what enrollees are accustomed to, we encourage the final rule to eliminate the total premium cost requirement.

As described above, we believe that employee education and plan selection are fully supportable through on-line decision-making tools. We encourage you to embrace the technological advances made by employers and plan sponsors, and evaluate alternatives to some of the items in the proposed rule, such as the coverage facts label, to find more innovative approaches to educating employees about their benefits.

Glossary of terms

The Departments' Solicitation for Comments on the Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions and Related Materials, includes a specific invitation to comment on the applicability of terms or any required changes in the terminology used for certain types of plans, especially information provided in the large group market. In general,

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exercise its enforcement authority with respect to certain types of plans that are generally exempt from the health insurance reforms under the Internal Revenue Code and ERISA and as to which HHS identified some possible statutory ambiguities under the PHS Act. *See* Preamble, Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed Reg 34,538, 34,539-62 (June 17, 2010). Such a delay would be particularly appropriate given the potential costs of complying with this requirement and the issues that have been raised in these and other comments about the need to develop a safe harbor for other ways to comply with the requirements.

we agree that the glossary of terms as drafted includes many terms, notably the terms "preauthorization" and "grievance," that are specific to insured health plans and not appropriate for use in the self-insured marketplace. Again, we ask that these types of specific issues be left to employers to find the best way to communicate these terms so that employees understand them. These terms have been used in employer-sponsored benefit coverage materials for many years and we believe that modifying or changing them will only cause confusion among employees.

Coverage Facts Label

We believe that the intent of this provision of the ACA is to give employees and those buying insurance products outside of the employment setting short summary information about the plan benefits and design. We are concerned that the requirements of the coverage facts label are too onerous and do not take into account the intent to provide summary information. By requiring SBCs to include numerous coverage examples, the increased length and detail of the SBC may diminish the willingness of employees to read through the document and in turn the usability of SBCs as a readable disclosure. In addition, under current approaches, employers typically provide access to information on specific coverage options either through a secure website or by phone. The coverage examples that the enrollee can see on a tailored website will be more relevant to the employee's situation compared to coverage examples for the whole population predetermined by the Departments.

Accordingly, we support replacing predetermined coverage examples with the Federal portal mentioned in the preamble to the proposed regulations. We do not endorse the alternative idea of employers directly sending plan files to a portal, as that would create a new and complicated administrative procedure.

Expatriate Health Plans

We appreciate the acknowledgment in the Preamble to the proposed regulation regarding the unique characteristics of expatriate and international health plans. As relates to Section 2715, coverage information that is particularly important to expatriates (e.g., medical evacuation and repatriation benefits and country-appropriate care) should also be under the proposed safe harbor and even be exempt from the requirements of this provision. The forms are U.S. centric and have no applicability outside of the United States and should be recognized as such and fall under the safe harbor or qualify for an outright exemption. In recognition of those unique characteristics, we urge that expatriate health plans be exempt from all requirements of the Affordable Care Act as was intended under the law.

Conclusion

As sponsors of health care coverage for over 35 million Americans, Business Roundtable members are deeply concerned about any new regulation that will ***unnecessarily*** increase the cost of coverage for our employees and their families. Any new administrative requirement must be implemented as seamlessly and efficiently as possible. We believe this proposed rule, which requires employers to provide each employee with a government-designed, 4-page form on ***each*** of their plan options, is unworkable and will impose a significant administrative burden and cost on each of our companies.

We believe that there are new and innovative ways, through electronic methods that use web-based and mobile applications, to reach our employees. This rule does not acknowledge these types of efforts and how important they are to fostering greater understanding of benefits and how to handle enrollment.

We encourage you to act quickly to delay the effective date of the proposal, evaluate what information is currently being provided to employees who have employer-sponsored coverage and modify the rule to permit a safe harbor authorizing other approaches to satisfy the substantive requirements for giving summary benefit information to employees. We support the goal of ensuring that enrollees are fully-informed when selecting health care plans that best suit their needs, but we also believe that this goal can be met while maintaining efficiency and supporting innovation.

Sincerely,

Maria Ghazal
Director, Public Policy and Counsel

MG/ce

Content Comparison
Uniform Summary of Benefits

Content	SPD Regulations (DOL Reg. §2520.102-3)	NAIC Proposal Uniform Summary of Benefits	Statute Section 2715
Name of plan	X	X	X
Type of administration e.g., insured/self	X		
Plan provisions related to eligibility to participate and conditions pertaining to eligibility to receive benefits[1]	X		
Any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible	X	X[2]	X
Coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines		X	X
Any annual or lifetime caps or other limits on benefits under the plan	X	X	X
Extent to which preventive services are covered under the plan	X	X	X
Whether existing and new drugs are covered under the plan	X	X	X
Whether coverage is provided for medical tests, devices and procedures	X	X	X
Description of use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services[3]	X	X	X*
Any conditions or limits on the selection of primary care providers or providers of speciality medical care	X	X	X*
Any conditions or limits applicable to obtaining emergency medical care	X	X	X*
Date of the end of the year for purposes of maintaining the plan's fiscal records	X	X	X*
Any provisions requiring preauthorizations or utilization review as a condition to obtaining benefits	X	X	X*
Statement of any health insurance coverage offered under the plan, relating to	X	X	X*

[1] The SPD regulations (DOL Reg. 2520.102-3(j)(2)) provide that with respect to a description of extensive schedules of benefits under a plan, only a general description of such benefits is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests it.

[2] The NAIC proposal is much more prescriptive than the SPD regulations related to the detail required to be disclosed to participants. For example, the SPD regulations provide simply that deductibles must be communicated. The NAIC proposal describes in more detail what that may mean. For example in the NAIC proposal, in addition to any annual deductible, the three most significant deductibles other than the annual deductible must be communicated. In the interest of trying to keep this chart at a relatively high level, the chart does not cover all of NAIC's detailed proposals related to how each benefit should be described and cost sharing disclosed.

[3] In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.

Content	SPD Regulations (DOL Reg. §2520.102-3)	NAIC Proposal Uniform Summary of Benefits	Statute Section 2715
hospital length of stay in connection with childbirth for the mother or newborn child			
Description of certain services the plan does not cover		X	X*
Disclaimer and rights language (e.g., grievance and appeals, right to continue coverage)		X	
Uniform definition of standard terms and medical terms		X	X
A statement of whether the plan or coverage (i) provides minimum essential coverage and (ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60% of such cost			X
A statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions		X	X
Contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual certificate of coverage can be reviewed and obtained		X	X
Name and address of employer	X		
Employer identification number (EIN)	X		
Type of welfare plan, e.g. group health plan	X		
Name, business address and business telephone number of plan administrator	X		
Name of person designated as agent for service of legal process, etc.	X		
Name, title and address of principal place of business of each trustee of the plan	X		
If a plan is maintained pursuant to collective bargaining agreements, special statement that the plan is so maintained, etc.	X		
Statement clearly identifying circumstances which may result in disqualification, ineligibility, etc. of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide	X		
Summary of any plan provisions governing the authority of the plan sponsors or others to terminate or amend the plan	X		
Summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination or amendment of the plan	X		
Summary of any plan provisions governing the allocation and disposition of	X		

Content	SPD Regulations (DOL Reg. §2520.102-3)	NAIC Proposal Uniform Summary of Benefits	Statute Section 2715
assets of the plan upon termination.			
Summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary the payment of which is a condition of receipt of benefits	X		
Description of the rights and obligations of participants and beneficiaries with respect to continuation coverage	X		
Sources of contributions to the plan—employer, employee—and method of calculation	X		
Any funding medium used for the accumulation of assets through which benefits are provided, etc.	X		
Procedures governing claims for benefits–may be furnished as a separate document that accompanies the plan's SPD	X		
Description of procedures governing qualified medical child support order (QMCSO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures	X		
Statement of ERISA rights	X		

*This provision was not specifically prescribed by the law. However, we believe it was likely intended to be included based on the general description of the content requirements.

3-18-11