



October 21, 2011

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
US Department of Labor
200 Constitution Ave
Washington, DC 20210

Attention: RIN 1210-AB52

To Whom It May Concern:

Background. The International Foundation of Employee Benefit Plans ("the International Foundation") is an educational organization focused on subjects affecting employee benefit plans and their sponsors, fiduciaries, service providers and professionals (herein "the Employee Benefits Industry"). The International Foundation's membership and volunteers which support the educational activities, includes a broad cross-section of employee benefits such as 2,400 U.S. multiemployer pension and health benefit plans,* 16,000 union and employer Trustees of those multiemployer plans, 2,500 corporate pension and health benefit plans, 800 public sector pension and health benefit plans and in excess of 5,000 service providers and professionals providing services regarding the operation and administration of those employee benefit plans. On occasion, the International Foundation's membership identifies subjects that may impact employee benefit plans in an unexpected manner and the International Foundation is asked to provide background to assist in a full understanding on the subject.

The International Foundation offers the following comments with respect to the proposed regulations and draft template of the Uniform Summary of Benefits and Coverage (SBC) proposed by the Departments of Labor, Treasury and Health and Human Services as required by the Affordable Care Act. *[The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.]* As proposed, this template is scheduled to be effective beginning March 23, 2012. Comments have been requested on the template and the feasibility of the proposed effective date and the International Foundation submits these comments in connection with your request.

*For clarification, when this paper refers to multiemployer plans, it refers to trust funds which are jointly administered employee benefit plans and are maintained pursuant to one or more collective bargaining agreements with one or more labor organizations and more than one employer (ERISA section 3(37)(A)).



A LEGAL DISCUSSION OF THE SUMMARY PLAN DESCRIPTION IN RELATION TO OTHER PLAN DOCUMENTS AND COMMUNICATIONS

Departments Request:

“The Departments have heard concerns about the potential redundancies and additional cost associated with elements of the SBC requirement; including the uniform glossary and the coverage facts labels, particularly for those plans and group health insurance issuers that already provide a Summary Plan Description (SPD) under 29 CFR 2520.104b”

Analysis and Comment:

The Summary Plan Description

Whether fully insured or self-insured and whether multiemployer or single employer, welfare plan fiduciaries are obligated, with few enumerated exceptions, to provide to plan participants a Summary Plan Description (“SPD”). See 29 U.S.C. §1022. The SPD is a welfare plan’s primary method of communicating participants’ rights and benefits, and it is intended to be a document that will be easily understandable and on which participants can reasonably rely with respect to their health insurance benefits.

In creating the ERISA disclosure requirements, Congress sought to ensure that plan participants knew “what benefits [they] may be entitled to, [and] what circumstances may preclude [them] from obtaining benefits...” H.R. Rep. 533, 93rd Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4639. Accordingly, an SPD must be “written in a manner calculated to be understood by the average plan participant, and ... sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.” See 29 U.S.C. § 1022(a). Moreover, ERISA “contemplates that the [SPD] will be an employee’s primary source of information regarding benefits, and employees are entitled to rely on the descriptions contained in the summary.” Pierce v. Security Trust Life Ins. Co., 979 F.2d 23, 27 (4th Cir.1992).

Grant v. Sprint Nextel Corp.

720 F.Supp.2d 732, 737 (W.D. Va. 2010). The contents of an SPD are specifically governed by 29 C.F.R. §2520.102-3, and fiduciaries continue to struggle with these requirements to provide participants with a meaningful description of their benefits without communicating incorrect or incomplete information to plan participants.



The legal effect of SPD's has been recently called into question by the U.S. Supreme Court: "...[W]e cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a) (1) (B)) as the terms of the plan itself." CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1877, 179 L. Ed. 2d 843 (2011). Although the SPD in Amara involves a pension plan, the United States Supreme Court does not limit its language solely to pension plan SPD's.

To make the language of a plan summary legally binding could well lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers. Consider the difference between a will and the summary of a will or between a property deed and its summary. Consider, too, the length of Part I of this opinion, and then consider how much longer Part I would have to be if we had to include all the qualifications and nuances that a plan drafter might have found important and feared to omit lest they lose all legal significance. The District Court's opinions take up 109 pages of the Federal Supplement. None of this is to say that plan administrators can avoid providing complete and accurate summaries of plan terms in the manner required by ERISA and its implementing regulations. But we fear that the Solicitor General's rule might bring about complexity that would defeat the fundamental purpose of the summaries.

Id at 1877-78, 179 L. Ed. 2d 843.

The Combined SPD and Plan Document

The Amara decision calls into question the common practice of combining a SPD with a Plan Document. In a combined Plan Document and SPD, the document is routinely called an SPD, and welfare plan fiduciaries must balance the competing objectives of full disclosure of plan benefit without becoming overly technical to the point of alienating plan participants.

If a welfare plan has both a Plan Document and an SPD, then there is a risk of inconsistent and conflicting descriptions of benefits. In such cases, fiduciaries face the consequences of conflicting promises of benefits. Conflicts can arise if an SPD is silent on a particular benefit. See Grant, 720 F.Supp.2d at 737. "Generally, the courts have ruled that if a conflict exists, then the terms of the SPD prevail, because it is the SPD on which the participants relied with regard to benefits. Rather than blindly apply a rule that the summary plan description always prevails, we must give the language of the two documents a 'common and ordinary meaning.' [Barker v. Ceridian Corp., 122 F.3d 628, 632 (8th Cir. 1997)]. We must construe the documents 'as a reasonable person in the position of the [plan] participant, not the actual participant, would have understood the words.'" Id. Jobe v. Med. Life Ins. Co., 598 F.3d 478, 485 (8th Cir. 2010).



The Summary of Benefits and Coverage

While welfare plan fiduciaries continue to wrestle with inconsistencies and conflicts between the Plan Document and the SPD, the passage of the Affordable Care Act created a new disclosure concern for all welfare plan fiduciaries, whether the plan is self-insured, fully insured, single employer or multiemployer. By March 23, 2012, welfare plan fiduciaries must supply participants with an SPD, they must also provide a Summary of Benefits and Coverage ("SBC"), a document no longer than four pages (both-sided) describing the participant's benefits and coverage. See Section 2715 of the Public Health Service Act.

Contrary to fully insured plans, self-insured plans are not regulated by states. See 29 U.S.C. 1144(b)(2)(B), ("Deemer Clause"). Self-insured plans are free to tailor benefit packages according to the needs of the participants without state law intervention. There are several factors that are considered when determining whether to be a fully insured plan or self-insured plan, and those reasons are the subject of another report.

The SBC was produced largely by the National Association of Insurance Commissioners ("NAIC"), the U.S. Department of Labor and the U.S. Department of Health and Human Services. The NAIC is devoted solely to state law insurance regulation. The NAIC does not work with self-insured plans. From the NAIC website, one learns the following:

OUR MEMBERS

NAIC members are the elected or appointed state government officials, who along with their departments and staff regulate the conduct of insurance companies and agents in their respective state or territory.

OUR MISSION

The mission of the NAIC is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its members:

- ...protect the public interest,***
- ...promote competitive markets,***
- ...facilitate the fair and equitable treatment of insurance consumers,***
- ...promote the reliability, solvency and financial solidity of insurance institutions, and...***
- ...support and improve state regulation of insurance.***



By enlisting the NAIC's expertise in the development of the SBC, there is an emphasis on fully insured plan compliance with the SBC without accounting for the nuances of self-insured plan compliance. This imbalance of expertise in favor of fully insured plans creates a void regarding self-insured plans and their ability to adapt to the SBC requirement. Many single employer and multiemployer plans have substantially changed to fully or partially self-funded arrangements because of the cost savings and the flexibility to tailor coverages for the benefit of participants and beneficiaries. The absence of that flexibility could adversely affect those key advantages to self-funding.

Like the SPD, the SBC has specific content requirements, and its purpose, like the SPD, is to provide plan participants with a uniform report of the benefits and costs of coverage to enable plan participants sufficient information to make an informed conclusion of the plan of benefits available. The SPD and the SBC have overlapping purposes, and the redundancy creates more administrative difficulty for the welfare plan fiduciary than the benefit of a supposedly better informed plan participant. From the "SPD vs. Plan document" case law cited above, welfare plan fiduciaries face unintended disclosure consequences whenever multiple documents are used to describe a plan of benefits. The U.S. Department of Labor and the U.S. Department of Health and Human Services have imposed a new layer of potential disclosure risk on self-insured plans.

Moreover, the SBC provisions governing material modifications require disclosure of the proposed modification sixty (60) days prior to the modification's effective date. This is a dramatic departure from the existing provisions governing a Summary of Material Modification, which is generally 210 days after the end of the Plan Year during which the modification was adopted. See 29 C.F.R. §2520.104b-3(a). The timing requirements for plan modifications under the SBC rules and under the U.S. Department of Labor regulations leave welfare plan fiduciaries perplexed as to when, or if, plan amendments can be made.

Conspicuously absent from the regulations governing SBC's is a discernible declaration of legal effect. Although there are express disclaimers on the NAIC's sample form SBC, based on the case law cited above, disclaimers do not necessarily insulate fiduciaries from liability that may arise from inconsistent or incomplete plan disclosures. With the newly introduced SBC requirement, welfare plan fiduciaries face a new layer of potential liability for disclosure liability. If a plan participant has a four-page SBC that is intended to do the same thing as a fifty-page SPD, then the plan participant will more reasonably rely on the SBC than the SPD. From case law cited above, self-insured welfare plan fiduciaries will be concerned about information not in the SBC that can be used by a participant in a subsequent law suit for benefits.

In the self-insured welfare plan universe, SBC's would create the potential for increased administrative expense, including duplication and redundancy, litigation costs defending against plan disclosure liability. Increased administrative expense creates a larger burden on the self-insured plan sponsor, and plan sponsors often address increased cost with benefit reductions. In other words, the SBC could potentially serve as a detriment to plan participants, as opposed



to a benefit to plan participants. The U.S. Department of Labor and the U.S. Department of Health & Human Services should adapt the SBC requirements for self-insured welfare plans to prevent the SBC from becoming an increased administrative burden.

A DISCUSSION OF MULTI EMPLOYER ADMINISTRATIVE ISSUES REGARDING THE PROPOSED REGULATION AND SBC TEMPLATE

Departments Request:

“Comments are solicited 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 (for example, immediately after a cover page and table of contents), and if the timing requirements for providing the SBC ... are satisfied.”

Analysis and Comment:

The Departments state that the goals of the proposed regulations for the Summary of Benefits and Coverage (SBC) and the uniform glossary are “effective communication and ease of comparison for individuals with a minimization of cost and duplication for plan sponsors and health insurance insurers.”

The SBC template designed by the National Association of Insurance Commissioners (NAIC) is designed for individuals who will be comparing and purchasing insurance options provided by the state exchanges or from the individual insurance market. In fact, the Departments state “the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers.”

Plan sponsors providing coverage are already required to communicate effectively with participants and beneficiaries so that they can understand the coverage options offered to them which include beneficial features such as subsidized continuation of coverage for out of work individuals before COBRA. However, many plan sponsors only offer a single source of health care coverage which renders the SBC’s comparison of coverage types and coverage examples meaningless.

The agencies requested comments on situations where the requirements of the SBC regulations and the information in the template should be modified. These comments recommend modifications for single employer and multiemployer self-insured health plans that offer their employees one comprehensive health plan package.

Request for an Extension of the Effective Date:

The effective date is scheduled for March 23, 2012. The International Foundation suggests that the effective date be extended at least 12 months. The comments in this letter and the comments from other organizations familiar with the significant administrative issues and costs presented by the SBC will clearly show that developing and implementing an SBC by



March 23, 2012 will be extremely difficult and costly. In addition, the sponsors of single employer and multiemployer plans will need guidance on many items that will be contained in the final regulations. There are certain issues in the proposed regulations that need to be clarified. For example, there are no provisions that coordinate with the laws that require the employer to provide continuation of coverage such as COBRA, FMLA, USERRA, and the pregnancy discrimination act.

Guidance will also be needed if there is one self-insured comprehensive plan but there are different service providers for medical, dental, vision, prescription drug, smoking cessation and other benefits. Also the Agencies must coordinate the SBC regulations with other regulations such as IRS notice 2011-34 that will define if an eligibility or probationary period can determine the point of eligibility for the 90-day coverage rule.

Additionally, the proposed universal glossary will require plan sponsors to amend their plan documents and SPDs to comply with the regulations. Since a 60-day notice to participants is required, plan sponsors will need time to draft the amendments and enact the amendments at a formal meeting. Many plan sponsors meet on a quarterly basis which means that the March 23, 2012 effective date of compliance with the proposed regulations will be impossible to meet. Additionally, if the universal glossary terms are changed in the final regulations, plan sponsors will be required to amend their plans and SPD's again creating unnecessary costs and burdens on plan sponsors.

The plan participants in a self-insured plan will not be harmed by the extension because the relevant information required by the SBC is already contained in the Summary Plan Description (SPD) and open enrollment materials provided by plan sponsors.

SBC Coordination with the SPD:

In most self-insured single employer and multiemployer plans, the plan sponsors provide a single comprehensive health care package to employees and dependents. In some plans, the sponsors also provide coverage for non-working (laid-off) employees and retirees. The individuals covered by the self-insured plan do not have a choice of several plan options. Also they do not have a choice of opting out of the plan to obtain health coverage elsewhere. (Employees do not want to opt out because the employer pays for all or the substantial part of the cost). The purpose of the SBC is for individuals "to easily determine the best health insurance options for themselves and their families". This purpose does not apply when there is only one comprehensive medical plan package for employees, and the cost is primarily paid for by the employer. In addition under the PPACA an employee eligible to enroll under an employer's affordable plan is not eligible for tax credits to assist them in purchasing health care.



RECOMMENDATION:

An SBC is not necessary for a single employer or multiemployer self-insured comprehensive health care package provided for employees and their dependents. An SPD is provided to all plan participants. The SPD contains all of the information the participant needs to understand and access the plans benefits.

Providing an SBC does not meet any goal or purpose and is an unnecessary administrative cost to the financial assets of a self-insured plan. The Agencies should recognize that in a self-insured plan the contributions and income made by employers go into a pool to provide the participants with benefits. In a multiemployer plan, the contributions employers make to the plan provide coverage for the working employees, non-working, laid-off employees and in some plans retirees and their dependents. The cost of compliance with regulations is paid from the fund pool as an administration expense. The overall purpose of the PPACA is to make available affordable quality health care. The cost of complying with developing and communicating an SBC where it does not meet any useful purpose detracts from the overall goal of the PPACA. If for some reason, the Agencies do not grant the exception to self-insured single employer or multiemployer health plans that offer its employees one comprehensive health care package, then the Agency should permit flexibility for the plan sponsors to use the most effective and efficient way to provide the plan participants with the information. This will allow the plan sponsors to modify the SBC content to refer the participant to the relevant page in the SPD or other document to obtain the applicable information. Some examples of the need for flexibility to modify the SBC content to refer the participant to the applicable pages in the SPD or other document are outlined in the comments below. The flexibility to modify the SBC will avoid duplication and any potential misunderstanding by plan participants.

Content of the Proposed SBC That Should Be Changed:

(a) What Is The Premium?

The proposed regulations provide the entry in the SBC entitled "What is the premium". Should this be the amount the employee pays discounting the employer's payment? Perhaps this should be entitled "What is the employees portion?" so employees do not misunderstand that the amount shown is the total premium paid by employees.

In multiemployer plans, what the employee may pay, if any, is dependent upon the terms of the collective bargaining agreement (CBA) between the union representing the bargaining unit employees and their employer. Most participants in multiemployer plans pay nothing in addition to the employer contribution, especially in the constructions industry where the allocation of the wage package makes it clear that the full cost of the "employer" contribution (which is mostly designed to satisfy the tax code) actually comes from the negotiated employees' wage package. Even though many employers may participate in a multiemployer plan, the terms of



each employer's CBA may vary. The formula that determines the employee's share of the contribution can vary from CBA to CBA. For example, one CBA may provide the employee's contribution is 5% of the premium and another CBA may provide the employee's share is 10%. The employer deducts the employee's share from payroll and submits the total amount of the premium to the plan administrator. In this example, assume the premium is \$1000 per month. One employee's share is \$50 ($\$1000 \times 5\% = \50) whereas the other employee's share is \$100. ($\$1000 \times 10\% = \100). The employer's share is \$950 and \$900, respectively. In other funds, the collective bargaining parties establish a maximum contribution the employer will make during the term of the CBA.

If the premium exceeds the maximum amount the employer under its CBA is obligated to contribute to the multiemployer fund, wages of the employees will be reduced to make up the difference between the employer's maximum payment and the current medical care cost. For example, assume wages are reduced by \$.25 per hour. An employee working 200 hours in a month will contribute more ($\$.25 \times 200 = \50) than an employee working 170 hours ($\$.25 \times 170 = \42.50) in a month. In other CBAs, the lower wage earners will pay a smaller self-payment contribution than higher wage earners. This can be several tiers of wage rates.

As shown by the examples where the employee's share in the contribution, the plan sponsor will have to develop different SBC's for every employer participating in the multiemployer plan to accurately provide the employee's with information on their share of the premium cost. In the other examples where the employee's contribution will vary, it is impossible to provide accurate information on the employee's share of the premium. Allow the plan sponsor and administrator the flexibility to refer the employee to the CBA for this information. The local union normally provides its members with a copy of the CBA. Also, the plan administrator is required by law to have a copy of the CBA on hand for the employee's inspection. In "right to work" states, and in plans where the terms of the trust permit non-bargaining employees to participate in the plan, deferring to the local union generally will not be an effective solution.

(b) Template Headings – Policy References

The titles and information on the top of page one (1) of the template are not applicable to a self-insured plan. There is no policy or policy period with a self-funded health plan.

(c) Other Information

All of the information categories on the first (1), second (2) and third (3) pages of the template are provided more accurately in the SPD of a self-insured plan where there is only one comprehensive medical plan package offered. The participant will not be comparing benefits and costs.



In a self-insured single employer or multiemployer sponsored health plan, there is a package of medical, vision, dental, prescription drug and other programs (smoking cessation, wellness, case management etc.). Each type of coverage may have different deductibles, co-pays, out-of-pocket limits, network providers, required referrals and exclusions. For example, the smoking cessation program may have a \$1000 annual limit on prescription medications, but there are no limits on other prescription medications. The specialty drug program may require prior authorization but non specialty medications do not. If there is a hospital stay, is it for a heart attack, a broken leg or a communicable disease? There are different requirements and limits for hospital rooms for intensive care, general care and isolation.

All of the information the participant will require to evaluate and use the many differences in treatment options and benefits for the medical services provided in a self-insured medical package are contained in the SPD. Attempting to make a summary in small boxes where the participant does not need to compare plans is not necessary. The SPD's for self-insured plans generally have a six (6) to twelve (12) page summary included in the front pages of the SPD that provide an overview to the benefits and services provided by the plan. If the plan sponsor has to create a separate SBC for each part of the medical plan package, (medical, dental, vision, prescription drugs, etc.) the cost will be unnecessary because the participant does not gain any additional knowledge because it is clearly provided in the SPD.

(d) "Your Right To Continue Coverage"

The template does not coordinate the obligations an employer has to continue coverage under other laws such as COBRA, FMLA, USERRA, and possibly the pregnancy discrimination act or Title VII of the Civil Rights Act. In addition, many self-funded plans provide continuation of coverage beyond what is required by law. The SPD for a single employer or multiemployer self-insured plan provides the employee with all the necessary information to receive the continuation coverage. The template on page four (4) for the entry "your right to continue coverage" is designed for the exchanges and private single person insurance market and not for the self-funded arrangements described above.

In some multiemployer plans, such as construction industry plans, an employee in one union's jurisdiction may work in another union's jurisdiction. For example, a welder in the Oregon jurisdiction may go to work for a contractor who is repairing bridges in a California jurisdiction. The multiemployer plans in each jurisdiction grant reciprocity to the welder to continue medical coverage if he/she follows the reciprocity rules. Therefore, using a jurisdictional move as an example, as stated in the proposed template, may not apply to a multiemployer plan. How to obtain reciprocity is fully explained in the SPD for the multiemployer plan.

In many multiemployer plans, the plan sponsor provides continuation of coverage for an employee who is laid off and the employer stops making the contributions on the employee's behalf. These programs are generally subsidized and may include hours or dollar banks, a "look back" system or subsidized self-pay.



RECOMMENDATION:

For the continuation of coverage entry in the SBC, permit the plan sponsor of a single employer or multiemployer self-insured plan the flexibility to refer the participant to the pages in the SPD that describe the procedures to continue coverage under the plan.

(e) Coverage Examples

The proposed regulations provide the SBC will contain, on page five (5), the three examples in the template (pregnancy, breast cancer and diabetes) and the plan sponsor must update the figures in the examples annually as published by HHS. When developing the examples the Agencies should take into consideration that in a typical self-insured plan approximately two thirds of the claims filed are under \$500 and three fourths of the claims filed are under \$1,000. The number of claims filed over \$10,000 that are shown in the three examples in the template (pregnancy, breast cancer and diabetes) represent only 3% of the total claims filed. While claims over \$10,000 represent two thirds of the total claims dollars, they only impact a small percent of participants.

RECOMMENDATION:

Provide claims examples for typical claims under \$500 and \$1,000 which will represent the majority of actual claims participants will incur.

The template contains a number of disclaimers as to the person's use of the example claims for the purpose of predicting the person's own claims expenses and benefits. In a recent article in the Pittsburgh Tribune (Sunday September 25, 2011), the article reports that the costs for identical medical treatments varied widely. For example, an MRI cost \$1,300 in South Texas but \$300 in South Florida. A cholesterol test cost \$11 in a national lab and \$150 in a San Francisco hospital. The state of Maine publishes a list of 30 medical procedures online. The cost variance within the state for a colonoscopy is \$537 to \$3,151.

Many single employer and multiemployer health care packages cover employees and dependents in multiple geographical areas and some cover employees in all 50 states. The use of examples that provide cost and benefit information, and then informing the participant that the information will not apply to them is not productive. This especially applies to single employer and multiemployer plans that provide a single comprehensive health benefit package. The participant does not compare cost and benefit data between plan options, which is one of the uses of the examples that the template cites on page six (6).

RECOMMENDATION:

Allow single employer and multiemployer plans that provide one comprehensive benefit package to participants the flexibility to use the plan's SPD for the purpose of showing examples that are relevant to the respective plan and the geographic area(s) where it provides coverage.

In the case where a plan sponsor only offers a single source for health coverage, the coverage examples are meaningless. In fact, participants will be confused if their cost of treatment for the medical condition differs from the example. To the extent the participant's cost is considerably more, they will want to invoke their claims and appeal rights pursuant to 29 U.S.C. Section 1133; 29 CFR Section 2560.503-1; 45 CFR Section 147.136; 39 CFR Section 2590.715-2719; and 26 CFR Section 54.9815-2719T. Accordingly, such plan sponsors should be allowed to omit the coverage examples from the SBC.

(f) What's Not In The Template?

Many self-funded single employer and multiemployer plans utilize wellness programs, case management, value-based health care, smoking cessation and other similar programs as part of the health care package. Some of these programs have mandatory provisions and some offer rewards for compliance. Other single employer and multiemployer self-insured plans have participant reimbursement or saving accounts which may have favorable tax features for the participant as part of their plan design.

RECOMMENDATION:

Allow the plan sponsor/administrator the flexibility to refer the participant to the pages in the SPD that provide the information on the programs and how they relate to the participants health package.

(g) Notice Requirement For Renewal

The renewal notice requirements in the proposed regulations are applicable to the exchanges and individual insurance market. In a single employer and multiemployer sponsored self-insured health package there are no insurance or renewal requirements for employees and dependents. The coverage is based upon employment. In many single and multiemployer plans, there are provisions and procedures for an employee to continue coverage when not working. These programs can include hours or dollar banks, "look back" systems or plan subsidized self-pay. In addition, there is COBRA which allows continuation of coverage. There are also laws that require an employer to continue coverage for employees on leave such as FMLA and USERRA.



In a multiemployer plan when an employee loses coverage after exhausting the plan-paid coverage, there may be a procedure for the employee to be automatically reinstated after meeting certain employment requirements. Each plan has different reinstatement procedures which are explained in the SPD. Under the law, persons returning from FMLA or USERRA leave are immediately reinstated. The FMLA and USERRA reinstatement rules are explained in the plan's SPD.

The proposed regulations require a renewal notice to be sent 30 days prior to the first day of coverage in the plan year when renewal is automatic. This requirement will require an employer or multiemployer plan sponsor to send the SBC to every working and non-working individual who has ever participated in the plan and has a right of reinstatement. This requirement will be very expensive, and locating some former employees will make this requirement impossible to meet.

The complications of the notice requirement become astronomical when there is a question of how the plan sponsor will prove that it sent the SBC renewal/reinstatement notice. Will the COBRA notice delivery rules apply to the SBC notice? Will the plan sponsor have to keep records of mailings the same as the COBRA records? The cost of compliance is not justified considering that the SBC is not necessary for comparison when the employer or multiemployer self-insured plan offers one health package and all of the reinstatement procedures are contained in the SPD.

RECOMMENDATION:

Do not impose the notice requirement when the renewal/reinstatement for a single employer or multiemployer plan that offers one medical benefit package and the reinstatement procedures are fully explained in the SPD.

(h) The 60 Day Material Modification Notice Requirement

For single employer and multiemployer sponsored self-insured health plans, the 60-day notice requirement before implementing a material modification can be very harmful to plan participants in certain situations. The self-insured plans pool income and contributions made on behalf of working employees to provide coverage for the working employees, the non-working laid off employees and in some plans, subsidized retiree coverage. These arrangements require the plan to be nimble to address economic changes so that they do not over react or take inadequate action. Employment based contribution arrangements such as a self-funded employer and multiemployer plan arrangement require flexibility to face changing situations from time to time and currently those changes are adequately recognized in the notification requirements of the Summary of Material Modifications under current law.



If the plan has to provide 60 days' notice before modifications can be made, the pool of financial resources in times of substantial layoff will reduce funding levels. The end result is the plan sponsors are likely to overreach or under react which would adversely impact plan participants and dependents.

A 60-day notice requirement may restrict the ability of the plan sponsor to implement modifications that address the situation presented by the economic changes mentioned above because remedial action will be unnecessarily delayed for 60 days.

RECOMMENDATION:

Exempt self-insured single employer and multiemployer plans from the 60-day notice requirement and substitute the current Summary of Material Modifications Procedure.

A DISCUSSION OF SINGLE EMPLOYER/CORPORATE ADMINISTRATIVE ISSUES REGARDING THE PROPOSED REGULATION AND SBC TEMPLATE

Departments Request:

"The Departments also welcome further comments 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 about their coverage and make it easy for them to compare coverage options while also avoiding undue cost or burden on plans and group health issuers"

Analysis and Comment:

As a general matter, participants are getting more and more overwhelmed with all of the required disclosures that must be sent out every year. With all of the annual health care notices that are now included in open enrollment materials, as well as the disclosures that need to go out on the retirement plan side (including the annual funding notice for pension plans and the "much anticipated" 401(k) disclosures coming next year), one fear is that employees are not reading anything and are missing out on important information that they should be focusing on. In particular, regulations should promote the use of online tools and resources made available to participants which have been developed to enable participants to make fully informed decisions.

Additionally, these summaries appear to oversimplify some items and if employees rely on these, rather than the more sophisticated medical cost estimators and plan comparison tools that are provided to participants, this confusion created by the SBC could cause the participant to underinsure or over insure health benefits. This means that some employees may end up paying too much for unnecessary coverage and others will be surprised by out-of-pocket expenses they may incur because they are only focusing on the limited examples that are required in the SBC and may not think about the actual care they may need during the year.



Building on this theme, the information required in the SBC is generally also required to be included in the SPD. One concern is that employees would rely on the SBC rather than refer to the SPD. It can be difficult to get employees to focus on benefits issues, and one can easily see the SBC creating more confusion while providing few answers. As an example, the uniform glossary is not required to be included as part of the SBC (presuming this was done to keep the SBC to the initial commitment to a fixed number of page numbers). However, many participants may not be able to fully understand the SBC without referring to the glossary. But how many employees will actually request this, much less read it? If they referred instead to the SPD, they would have access to this information all in one place.

This confusion only increases when one considers that employers have to prepare this SBC for each coverage option they provide. Employees are going to have to sift through multiple SBCs for each coverage option available to them and try to figure out how to read them collectively.

From the employer's perspective, the amount and level of information to be included is a trap for the unwary. Employers are now going to make sure that they update their SPD, annual enrollment materials and SBC with all of the same information. In the event that an update is missed in any one of these documents, will the DOL hold employers to the provision that is most favorable to the employee despite any disclaimers to the contrary?

In terms of the content and format of the SBC, it may be difficult for employers to keep the document to the eight (8) page limitation. For example, on the first (1) page of the template, employers are required to provide premium, deductible and out-of-pocket information. However, even though the document describes only one coverage option, the design may include tiered premium pricing (based on salary level or exempt/non-exempt status and/or based on single/employee + 1/family/etc.) which will be difficult to fit in the text box using the required font size. Then when you take into account additional explanations that may be required for explaining the deductible and what it does and does not apply to (e.g., preventive services and differences attributable to network vs. non-network providers), it is unrealistic to think that all of this information can fit on one page subject to the restrictions imposed on formatting.

On page two (2), the space reserved for Rx does not give enough room to describe important concepts like mail order requirements and generic substitutions (with employees paying the difference between brand and generic for voluntary elections to fill brand).



On page four (4), the description of the grievance and appeals right is misleading. There are very strict requirements about how plan sponsors must communicate the claim and appeal procedure under their plans, now including the external appeals process. The limited text on the template does not reflect the timing requirements for claims and appeals, voluntary appeals, external appeals, etc. If an employee relies on this document, rather than the SPD, they may miss important deadlines for submitting claims and prejudice their rights to make the claim. Moreover, many employers now offer participant advocacy services to assist employees with filing claims – this is not mentioned here and employers may be hesitant to include it because it is not specifically required by the content rules, but it is an important part of many plans' claims procedure.

On page five (5), while the required coverage examples are important to understand, they may not speak to most employees. The examples should be designed to apply to a greater percentage of plan populations (for example, treating depression/anxiety or asthma) or perhaps include more examples. Perhaps the regulations can provide additional examples as it reserved the right to do so in the request for comment.

In conclusion, the SBC may be helpful for individuals who are looking for coverage on the open market and need to compare options. The information required by the SBC, as noted above, is already being provided in one form or another and to a much greater extent by single employer and multiemployer plans that offer a single comprehensive coverage package. The result of requiring this additional disclosure will be administrative burden and expense for the employer at the risk of creating confusion for employees.

SUMMARY

The SBC and model template is designed for people who will purchase insurance through the state exchanges or on the private insurance market. The SBC is designed to permit the person to compare plan cost and benefit alternatives.

In a single employer or multiemployer self-insured plan that provides employees with one comprehensive medical benefit package, the employee does not make a comparison and the costs are substantially paid by employer contributions. Current law requires the plan sponsor to provide the employee and dependents with an SPD. The SPD contains all of the information that will be required on the SBC. It will be very cost ineffective to duplicate the information from the SPD into a SBC where there is neither opportunity nor necessity for comparison of medical options.



As shown in the examples above, a single-employer and multiemployer self-insured plans compliance with the proposed SBC template will require the administrator to develop multiple SBCs to provide the employee's premium cost where the CBAs of the participating employers differ. This duplication can be avoided by referring the employee to his/her own CBA.

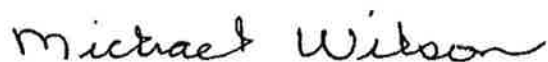
A legal analysis indicates a potential issue with legislation and litigation over plan documents and the SPD. A legal search in Westlaw, next with the search "plan document summary plan description conflict self insured" shows 108 litigation cases, 38 statutes, 5020 regulations and 6163 administrative decisions and guidance. If the SBC is added to self-insured plans, the conflict numbers will only increase.

The PPACA will require fourteen (14) new notices or reporting requirements. The department of HHS currently has six (6) notices or reporting requirements and the DOL currently has nineteen (19). The agencies should recognize that each notice or reporting requirement has an administrative cost. Each administrative cost in a self-insured plan, especially in a single and multiemployer plan where the contributions are fixed during the term of the CBA, takes away benefits from the working employees, non-working employees, retirees and their dependents. A recent Aon Hewitt survey report indicates that the average employer health plan cost for each employee in 2012 will be \$10,475. The average employee premium cost share will be \$2,306. The primary purpose of the PPACA is to provide quality affordable health care. Requiring an SBC where an SPD and other documents would be a more effective cost and communication tool, is not meeting the purpose of the PPACA.

Thank you for the opportunity to respond to your request. If you wish to receive additional information on any of the points or references mentioned herein or other aspects of group health plans, please do not hesitate to me know.

Your consideration of the above comments is appreciated.

Very Truly Yours,



Michael Wilson
Chief Executive Officer

