

CHCC

CORPORATE HEALTH CARE COALITION

October 21, 2011

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
RIN 1210-AB52

Sent via email to E-OHPSCA2715.EBSA@dol.gov

Ladies and Gentlemen,

The Corporate Health Care Coalition (CHCC) appreciates the opportunity to submit comments on the proposed regulations, including the draft template and corresponding instructions (collectively, the “Proposed Rules”) issued with respect to the summary of benefits and coverage (“SBC”) requirement set forth in new Section 2715 of the Public Health Service Act (“Section 2715”).¹ CHCC is a public policy organization comprised of leading companies from varying industries that compete in the global marketplace. CHCC member companies sponsor health plans for the benefit of their eligible employees and eligible dependents located in every state in the nation. CHCC members are leaders in providing high quality health benefits in an efficient and effective manner. For more than 15 years, CHCC and its members have advocated for public policies that make health care more affordable, accessible, accountable and sustainable.

We applaud the agencies’ continuing efforts to issue guidance regarding the requirements of the Patient Protection and Affordable Care Act (“ACA”), including but not limited to the Proposed Rules, that facilitate the efficient and effective implementation of the rules by group health plans. Nevertheless, we are very concerned about the impact the Proposed Rules will have on our members and their health

¹ Public Health Service Act Section 2175 was created by Section 1001 of the Patient Protection and Affordable Care Act of 2010 (“ACA”). The ACA incorporated Section 2715 into ERISA Section 715 and Internal Revenue Code Section 9815 by reference.

plans. If the Proposed Rules are adopted as is, without change, plan sponsors will expend significant time, cost and effort to comply with a rule that, in our opinion, is duplicative of documents and materials that are already required to be furnished (e.g. summary plan descriptions). Much change is needed to reasonably align the goals of Congress set forth in Section 2715 with the practicalities associated with group health plan administration.

The reasons for our concern are set forth in detail below. Thank you in advance for your consideration of these comments.

Comment #1: Delay the effective date until the annual enrollment period for the first plan year that begins on or after the date that is one year after the final regulations are issued

The applicable effective date for group health plans is March 23, 2012. Even if the requirements set forth in the Proposed Rules were final today (which they aren't), plans would experience great difficulty implementing the new rules by the effective date, which is only 5 short months away. The level of difficulty to comply increases significantly as the period between the date that the final regulations are issued and the effective date decreases, which it certainly will if the effective date is not delayed. Sufficient time is required to digest the new legal requirements; identify roles of vendors and find vendors to fulfill that role; negotiate and execute change orders with vendors for the new services; and develop, test, and operationalize a compliant SBC distribution system. Consequently, the effective date must be delayed until the annual enrollment period for the first plan year that begins on or after the date that is one year after the final regulations are issued. We believe such a delay is supported by Section 2715.

As noted in the preamble to the Proposed Rules, the March 23, 2012 effective date is based on the following language from Section 2715:

Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) . . .²

Although March 23, 2012 is indeed 24 months from the enactment date of the ACA, compliance with the new rule is contingent on the agencies issuing the specific standards *no later than 12 months after the effective date of the ACA* (i.e. March 23, 2011) . Thus, the statute necessarily contemplates *no less than 12 months* between the date the agencies establish the standards and the date group health plans must implement the new rule. Further delaying it to the next annual enrollment period best facilitates an efficient and effective transition from the old enrollment process to the new enrollment process that is molded and shaped by the SBC rules. The annual enrollment period represents the most natural point at which this transition should occur, primarily because plan changes are often communicated during the annual enrollment period. If the SBC rules are effective prior to the annual enrollment period for the plan year beginning on or after the date that is one year after the final regulations are issued, then group health plan sponsors must create SBCs for mid –year enrollments and then shortly thereafter revise the SBCs for annual enrollment to incorporate plan changes, which unnecessarily duplicates the plan's efforts to comply.

² Section 2715(d)(1)

Comment #2: Apply electronic disclosure rules that are consistent with an approach that reflects increased access through improved technology

Under the Proposed Rules, SBCs furnished through electronic media (e.g. email, website, etc.) must satisfy ERISA’s distribution requirements.³ ERISA requires plans to send materials required to be furnished under ERISA by “measures reasonably calculated to ensure actual receipt of the material by the plan participant.”⁴ To assist plans with satisfaction of the fundamental disclosure requirement, the Department of Labor has created a safe harbor for documents materials furnished through electronic media.⁵ Under the safe harbor, recipients may receive documents otherwise required to be provided by ERISA only after providing affirmative consent or confirming consent electronically *unless* (i) the recipient is able to effectively access the materials at any location where the recipient works as an employee of the plan sponsor and (ii) the recipient is expected to access the employer’s electronic information system as integral part of his/her duties.⁶

Many of the enrollees to whom a plan is required by the Proposed Rules to furnish an SBC will have to first provide consent before receiving the SBC electronically; however, obtaining that consent will impose significant obstacles on plans such that the requirement, if not waived, will essentially prevent plans from furnishing SBCs electronically. This creates a substantial burden on electronic commerce that fails to consider improvements in technologies that have increased access to electronic media⁷ and alternative measures used by a plan in conjunction with the electronic media that ensure actual receipt of the SBC that would otherwise satisfy the fundamental disclosure standard under ERISA.

By way of illustration, a plan that makes the SBCs available on a website would satisfy the fundamental disclosure requirements under ERISA to the extent that the plan also satisfies the following requirements:

- (i) At the time of enrollment, the plan provides written notice of the right to request a copy (e.g. a postcard), and
- (ii) The written notice identifies the hardware and software requirements to access the electronic media in which the SBC is furnished.

Under this approach, if the individual is not effectively able to access the electronic media, the participant will be able to request a paper copy. Thus, the measures under this approach reasonably ensure actual receipt of the SBC without having to first obtain consent.

Such an approach is also consistent with the employee benefit plan related electronic disclosure rules under the Internal Revenue Code⁸, which do not require consent where the recipient is effectively able to access the information, and the E-Sign legislation, which authorizes federal agencies to exempt an

³ See 29 C.F.R. 2520.104b-1. Under the Proposed Regulations, nonfederal governmental plans may furnish an SBC electronically in accordance with ERISA’s disclosure rules or rules established in the Proposed Regulations for issuers in the individual market.

⁴ See 29 C.F.R. 2520.104b-1(b)(1).

⁵ See 29 C.F.R. 2520.104b-1(c).

⁶ See 29 C.F.R. 2520.104(b)-1(c)(2)

⁷ The Department of Labor has recently acknowledged that technology improvements have likely lead to increased access such that the current electronic disclosure safe harbor should be revisited. See 76 Fed. Reg. 19285 (April 7, 2011).

⁸ See 26 C.F.R. 1.401(a)-20(c)

electronic document from the consent requirements where the consent requirement would impose a substantial burden on electronic commerce and waiving the consent does not materially increase the risk of harm to the recipient.⁹

Comment #3: Require plans to automatically furnish the SBC only to “participants”

Section 2715(d) requires group health plans and issuers to furnish SBCs to “enrollees”. The term “enrollees” is not defined in the statute but the Proposed Rules define “enrollee” to mean a “participant” or “beneficiary” as defined by ERISA. Beneficiaries (other than qualified beneficiaries under COBRA and perhaps survivors) typically have no right to enroll apart from the employee. Thus, if the employee chooses not to enroll the spouse or dependent child, the spouse or dependent child typically has no independent right to enroll.

We acknowledge that the SBC contains information that impacts a beneficiary’s enrollment decisions for other plans; however, we note that both the summary plan description required under ERISA for welfare plans and the notice of the plan’s special enrollment rights under HIPAA’s portability regulations contain information that impact the spouse’s enrollment decisions yet neither is required to be provided to the beneficiary.¹⁰ Historically, unless the beneficiary has participant-like rights (i.e. the right to enroll), documents and materials provided to the participant are deemed to be provided to a spouse or other dependent.

Consequently, the final regulations should only require group health plans to automatically furnish the applicable SBCs to the “participant” as defined under ERISA, even where the beneficiary is enrolled separately or resides at a different address, provided that the beneficiaries are entitled to request a copy of the SBC free of charge.

Comment #4: Allow a reasonable period of time to furnish the SBC where annual enrollment materials are not otherwise provided.

The Proposed Rules require plans that do not provide written materials with the initial enrollment to furnish the SBC no later than the first day that the enrollee is permitted to enroll in the plan. This creates an unworkable rule for plans with enrollment periods that begin on the date of hire or eligibility date (e.g. plans that provide coverage effective as of the date of hire). A rule similar to that applied to the general pre-existing notice required under HIPAA’s portability regulations is more appropriate in this instance.¹¹ Thus, applying a similar rule to SBCs, then plans would be required to furnish the SBC by the earliest date on which the plan, acting in a reasonable and prompt fashion, could provide the SBC.

Comment #5: Allow a reasonable period of time to furnish the SBC upon request.

Section 2715 does not prescribe a time period for furnishing the SBC upon request; however, the Proposed Rules require group health plans to furnish the SBC within 7 days of a request by the participant or beneficiary (including a request for special enrollment). For large employers such as our members, it is simply not feasible to furnish an SBC within 7 days of the request. Our members are

⁹ See 17 U.S.C. 7004(d)(1)

¹⁰ See 29 C.F.R. 2520.104b-2(a) (requirement to furnish a summary plan description to participants in a welfare plan). See also 29 C.F.R. 2590.701-6(c) (requirement to furnish a notice of the plan’s special enrollment provisions).

¹¹ See 29 C.F.R. 2590.701-2(c)(1)

often de-centralized and/or utilize multiple vendors to assist with plan administration, which will prevent compliance with such a short turn around. For example, once a request is made, our members would send the notice to an enrollment vendor, who would then identify the options for which the individual is eligible (if not enrolled) and then, forward the applicable SBC to a fulfillment vendor who would mail or send electronically the SBCs to the participant (or beneficiary, if required to receive an SBC). Even if the participant or beneficiary requested the SBC directly from the enrollment vendor, it would not be feasible to deliver the SBC by mail within 7 days.

Instead, a rule similar to that which is applicable to the general pre-existing condition notice identified in Comment #4 is more appropriate for SBCs furnished upon request.¹² Thus, applying that rule to SBCs furnished upon a request, group health plans would be required to furnish the SBC by the earliest possible date following a request that the plan, acting in a reasonable and prompt fashion, could provide the SBC.

Comment #6: Establish a safe harbor for plans that provide information to participants through a combination of plan materials, including but not limited to the summary plan description, that meets the content requirements set forth in Section 2715.

Section 2715 and the Proposed Rules identify general format and content requirements applicable to the SBC. The NAIC has also drafted a template with rigid instructions that require strict compliance designed to lead to absolute uniformity. These rules attempt to facilitate an “apples to apples” comparison--no matter what the circumstance—through absolute uniformity, but absolute uniformity implemented through a rigid template isn't feasible for the self- insured group health plans sponsored by our members.

Sponsors of self-insured health plans have significant flexibility with regard to plan design, which ultimately leads to a panoply of unique benefit package options that cannot be adequately accounted for in a uniform template. For example, the terms in the uniform glossary will often be inconsistent with the same terms set forth in the plan's summary plan description or plan document (such as medical necessity and usual, customary and reasonable), terms that are critical to health plan administration. Likewise, benefit package options may have extensive and/or complex exclusions and limitations that cannot be adequately summarized in accordance with the Proposed Rules. Applying the template to self-insured health plans will almost certainly lead to miscommunication and inaccuracies that will further lead to confusion. Consequently plans must be provided with flexibility to satisfy the requirements through alternative means.

The need for such flexibility is underscored by the fact that our members already satisfy the requirements set forth in the statute and the Proposed Rules as a result of applicable law (e.g. ERISA's reporting and disclosure obligation and the cafeteria plan rules set forth in Code Section 125) and/or “best practices” implemented to ensure an effective and efficient administration. For example, ERISA requires plans to distribute a summary plan description to each participant that describes benefits offered under the plan, including cost sharing requirements and any applicable exclusions or limitations.¹³ The cafeteria plan requirements further require plans to provide participants with information necessary to make an

¹² See 29 C.F.R. 2590.701-2(c)(1)

¹³ 29 U.S.C. 1022; 29 C.F.R. 2520.102-2.

informed election, which would necessarily include the employee contribution amount. Moreover, it has long been a priority of our members to provide information to participants through means appropriate to the plan's unique circumstances that adequately describe the options available to them to mitigate mistaken elections and mid-year changes that, in many cases, are often prohibited under applicable law (e.g. the cafeteria plan rules). Thus, the Proposed Rules impose unnecessarily burdensome obligations on plans to duplicate that which they are already do in a manner consistent with applicable law and the applicable facts and circumstances.

In response, we propose that the agencies establish a safe harbor where group health plans are deemed to be in compliance with the SBC requirements set forth in Section 2715 to the extent that the plan satisfies the following requirements through one or more documents provided to participants:

- The documents and materials are written in English with clear and concise contact information for assistance;
- The documents and materials enable participants to compare their share of the costs to enroll in any plan(s) available in their area (e.g. payroll deduction amounts, premium contributions, co-pays, percent of in-network versus out-of-network cost covered);
- The documents and materials describe the plan's key terms such as co-pay, co-insurance, skilled nursing facility, in-network and out-of-network providers;
- The documents and materials describe covered services and excluded services;
- The documents and materials are sent to the participant's last known address, and/or participant provided e-mail account (in conjunction with return/failed receipt verification functionality), and/or is provided at a web site on which participants individually register to use and/or is readily accessible in the course of their employment;
- The documents and materials notify participants of their claims and appeal rights; and
- The plan notifies participants of material changes within existing ERISA's applicable timelines.

Documents and materials that plans would use to disseminate this information would include a combination document such as summary plan descriptions (including summaries of material modifications), health care plan comparison updates and enrollment materials, all of which would be provided in paper form or electronic form (e.g. email or web sites). If the combination of documents provided to participants both during and after enrollment satisfy the requirements identified above, then the plan (or health insurer, if applicable) would deem to satisfy Section 2715.

Again, we appreciate the opportunity to submit comments and suggestions.

Sincerely Yours,

Corporate Health Care Coalition

The Corporate Health Care Coalition (CHCC) is a public policy coalition of large, multi-state, self-insured companies that operate health benefit plans for employees and their families as well as retirees. For more information, please visit corporatehealthcare.org.