

Wednesday, October 19, 2011

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS 9982-P  
Mail Stop C4-26-05  
7500 Security Blvd.  
Baltimore, Maryland 21244-1850

To Whom It May Concern:

Thank you for the opportunity to comment on the Summary of Benefits and Coverage and the Uniform Glossary Notice of Proposed Rulemaking, published at 76 Fed. Reg. 52442 *et seq.* (August 22, 2011). This proposed rule implements section 2715 of the Public Health Service Act (PHS Act) as added by section 1001 of the Patient Protection and Affordable Care Act (PPACA). We appreciate having the opportunity to express our views on this draft regulation.

HighRoads, Inc. (HighRoads) provides technology-enabled health and welfare employee benefit and ERISA communications consulting to large- and medium-sized employers located throughout the United States. Therefore, we feel that it is important to share our thoughts with the Department of Labor, Employee Benefits Security Administration, Department of Health and Human Services (HHS), and Department of Treasury, Internal Revenue Service (IRS) (collectively and hereafter in this comment letter, “the agencies”) as they finalize the rule.

Our clients typically self-insure and will, as plan administrators for self-insured employee benefits plans, be affected by this regulation and the policy decisions that the agencies make in implementing it. On behalf of our clients, we prepare Summary Plan Documents (SPDs) and Summary Material Modifications both within and outside a content management system.

#### Summary of Benefits and Coverage (SBC)

##### *General Comments*

We agree with the agencies that the proposed rule provides important protections to individuals who obtain health care coverage in the individual health insurance marketplace. These protections are especially helpful in light of the individual mandate that will become effective in 2014. We also recognize that section 2715 of the PHS Act clearly applies to self-insured group health plans.<sup>1</sup>

We believe, however, that the application of the statute to group health plans is redundant. It will cause additional burden for these plans, especially those who self-insure, with no real tangible benefit for the lives covered under the self-insured plan. This redundancy arises

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<sup>1</sup> Public Health Service Act §§ 2715(a); 2715(d)(3)(B).

because employers already engage in an annual enrollment communication campaign that is conducted before the start of the next plan year. Much of the information required in the SBC is already present in the annual enrollment communication material that employers provide their employees.

Similarly, the proposed requirement that an SBC accompany the enrollment material for each plan for which an employee is eligible is redundant. Most employers already employ plan comparisons or benefit estimator tools that help new participants with the plan selection process. Thus, we would urge the agencies to specify in the final rule that employers that already provide plan comparisons or benefit estimator tools are not subject to the SBC requirement, or, in the alternative, that compliance with ERISA's requirements regarding distribution of summary plan descriptions (SPDs) will suffice for purposes of compliance with section 2715 of the PHSA.

### *Specific Comments*

- The SBC as currently proposed needs considerable re-work with respect to group health plans, for the reasons stated below.
  - For example, the proposed regulations regarding the SBC use the word “premium,” which applies to the individual market. For group health plans in which the employer and employee share the cost of coverage, the comparable term is “contribution.”
  - In addition, the SBC template, as it is proposed, does not appear to accommodate the structure of the High Deductible Health Plan (HDHP). Many employers are currently moving in the direction of HDHPs and tiered networks. We would urge revisions in the final rule that would allow for employers to list HSA and HRA funding, which is crucial to the function of the HDHP pricing structure.
- We appreciate that the agencies asked for commenters' views on whether to permit employers to include the SBC with the SPDs. While we do appreciate the agencies' consideration of that option – and many of our clients may take advantage of that policy if it is finalized – we do not think that it is sufficient to resolve our concerns with the proposed rule.
- The SBC represents logistical challenges for large employers who offer multiple health plan options. For example:
  - How will large employers comply with the many distribution mandates: at annual enrollment, prior to automatic renewals, upon amending the SBC, prior to special enrollments, upon request? For example, employers will effectively need to produce full sets of SBCs for two years at a time, to address new hires, special enrollments and requests for the current years as well as the SBCs for the upcoming year, adding an undue burden on already time-strapped HR departments at open enrollment time.

- How will large employers comply with the 60-day advance notice of material changes in health plans, given that this requirement essentially shortens the communication window by 120 days?
  - How will large employers overcome accessibility challenges in a password protected environment?
  - How will employers who offer “build your own” plan options be able to cost-effectively produce SBCs based on eligibility?
  - How will any employer subject to ERISA maintain accuracy between two required documents (SBC and SPD), one of which is a subset of the other? Two documents increase the opportunity for error.
- If the requirements proposed in the draft regulations are finalized, we believe employers—and insurers--will be forced to eliminate plan choices to compensate for the burden of meeting the increased communication responsibilities.
  - Coverage examples tell only part of the story. More cost upfront in the form of premiums or contributions generally translates to less out-of-pocket cost when care is obtained. To tell the complete story, the reader needs to see annual premiums or contributions to the “You pay” column.
  - For group health plans with insured plans, preparation of the SBC falls on the insurer while distribution falls on the plan sponsor since the insurer knows enrollment but only the plan sponsor knows eligibility. The plan sponsor and the insurer will require considerable lead time to determine the logistics for distributing the SBC.
  - We do appreciate that the agencies have requested whether electronic distribution of the SBC should be permitted, if the distributor complied with the DOL guidelines on electronic distribution of the SPD. While our clients would support a policy that would permit electronic distribution of the SBC, we also believe that the DOL guidelines on electronic distribution of the SPD need to be updated to reflect the world of technology that exists today. The existing DOL policy was written nearly a decade ago and does not reflect the current state of electronic technology. Earlier this year, we commented on the DOL request for information on updating the SPD electronic distribution guidelines.
  - We know that the most common forms of “excepted” benefits are dental and vision plans, and that, as such, the SBC requirements do not apply to these. We would further request that the agencies clarify in the final rule which, if any, other “excepted” benefits may *not* apply to the SBC requirement. For example, would the following benefits be considered “excepted” benefits for the purpose of complying with the SBC?
    - Health Reimbursement Accounts (HRAs)
    - Health Spending Accounts (HSAs)
    - Employee Assistance Plans (EAPs)
    - Wellness Programs

- Wellness clinics (onsite)
- In addition, we believe it would be useful for the agencies to specify whether employers and plans may include details for how their plans compare to those on the Exchanges within the SBC’s “Covered Services” section.

#### The Uniform Glossary

- The uniform glossary is meaningless for participants in a group health plan because it is not specific to plan provisions. For example, it is very important for group health plan participants to know if the deductible is included or excluded in the out-of-pocket maximum. It is not helpful, however, to merely advise the participant that either situation may apply. Further, there may be terms in the glossary that do not apply (e.g., an indemnity plan is unlikely to have a copayment, but will have coinsurance).
- Requiring the use of uniform glossary terminology burdens group health plans and insurers with the task of changing printed material to match the uniform glossary terminology. For example “network,” “in-network,” and “preferred provider” have the same meaning, but if the uniform glossary uses “in-network” then group health plans and insurers will need to adapt the uniform term and change communication material accordingly.

#### Pre-Emption

We are quite concerned over the agencies’ statement of policy that state laws that are stricter than the proposed regulation are not subject to pre-emption. We do recognize that section 2715(e) of the PHS Act does pre-empt contrary state laws, but the agencies’ implementation of that policy could give states an opportunity to directly regulate employee benefit plans. As the agencies know, this is contrary to the policy of ERISA pre-emption, which pre-empts all state laws that relate to an employee benefit plan.<sup>2</sup> We urge the agencies to limit the ability of states to regulate employee benefit plans.

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<sup>2</sup> 29 U.S.C. § 1144(a).

### Timing of the Comment Period and Implementation of the Final Rule

We appreciate the agencies' request for comment regarding timing of the final rule, especially in light of the delay in publishing these draft regulations, which were required to be published by March 23, 2011.<sup>3</sup> Sixty days is not sufficient time for most plan sponsors and insurance companies to comment on the proposed regulations, given that this is the busiest time of the year with many organizations currently participating in the annual open enrollment process for their employees. Moreover, the window of opportunity between the date that the regulations are finalized and the implementation date of March 23, 2012, is insufficient to implement the SBC requirements. Plan sponsors, insurance carriers and outsourcers all need time to repurpose plan data to produce SBCs.

Thus, we urge the agencies to extend the 60-day comment period to allow plan sponsors and insurers to thoughtfully review the draft regulations and prepare meaningful comments. Additionally, we request a postponement of the March 23, 2012 implementation date in light of the narrow window of opportunity to meet compliance obligations.

### Conclusion

Again, we thank the agencies for the opportunity to comment on the proposed rule. We would be pleased to answer any questions that you may have regarding our comments.

Sincerely,



Kim A. Buckey, Practice Lead, SPD Services

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<sup>3</sup> Public Health Service Act § 2715(a).